

HEALTH CARE SOLUTIONS: INCREASING PATIENT CHOICE AND PLAN INNOVATION

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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CONTENTS

	Page
Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement	1
Prepared statement	3
Hon. Fred Upton, a Representative in Congress from the State of Michigan, opening statement	4
Prepared statement	5
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	5
Prepared statement	7
Hon. Gene Green, a Representative in Congress from the State of Texas, opening statement	8

WITNESSES

Scott Gottlieb, M.D., Resident Fellow, American Enterprise Institute	10
Prepared statement	13
Answers to submitted questions ¹	73
Avik Roy, Senior Fellow, Manhattan Institute	24
Prepared statement	26
Sabrina Corlette, J.D., Research Professor, Center on Health Insurance Reforms, Georgetown University	34
Prepared statement	36
Answers to submitted questions	75

SUBMITTED MATERIAL

Statement of the Committee for Economic Development, submitted by Mr. Pitts²

¹ Mr. Gottlieb did not respond to questions for the record.

² Available at: <http://docs.house.gov/meetings/if/if14/20160511/104905/hhrg-114-if14-20160511-sd003.pdf>.

HEALTH CARE SOLUTIONS: INCREASING PATIENT CHOICE AND PLAN INNOVATION

WEDNESDAY, MAY 11, 2016,

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 9:58 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Engel, Capps, Schakowsky, Butterfield, Sarbanes, Matsui, Schrader, Kennedy, Cárdenas, Pallone (ex officio).

Staff Present: Adam Buckalew, Professional Staff Member; Rebecca Card, Assistant Press Secretary; Graham Pittman, Legislative Clerk; Chris Sarley, Policy Coordinator, Environment & Economy; Jennifer Sherman, Press Secretary; Kyle Fischer, Minority Health Fellow; Tiffany Gurascio, Minority Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Minority Policy Analyst; and Arielle Woronoff, Minority Health Counsel.

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

Mr. PITTS. The time of 10 o'clock having arrived, we will call the subcommittee to order. The chair will recognize himself for an opening statement.

The subcommittee is holding a hearing today to take a closer look at healthcare solutions centered on promoting patient choice and innovation in the design of health coverage.

Health care is the most personal of any political issue, and 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.

A country in which 45 million people went without health insurance was certainly in need of health reform. However, the Affordable Care Act is not the health reform this country needed. In fact, I believe it is a setback that makes true reform even harder to accomplish.

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. And yet the ACA has done little to decrease healthcare spending. In fact, many Ameri-

cans 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 and give people the freedom to choose the insurance that they want, with the benefits that they value most, at a price that is fair. More government bureaucracy, regulations, and spending never successfully reduced 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 and small businesses and 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.

Some of the free enterprise solutions that I believe would truly help control costs and improve health care for all include portability, more pooling options, strengthening consumer-driven arrangements like health savings accounts, and innovation through less Federal benefit mandates.

Employer-sponsored insurance is a critical part of our healthcare system and must be protected, but for many their health insurance is too closely tied to employment. People who are laid off, fired, or have to quit working can find themselves uninsured at a time when they can least afford it. We need better options so patients can truly own a plan of their choosing on the individual market.

Before the President's healthcare law, I introduced the Small Business Choice Act, which would allow small businesses to form private health insurance cooperatives to buy insurance at lower rates while transferring catastrophic costs to a larger insurer, and the bill helps make small employers offer health insurance through a refundable tax credit of 65 percent, and self-employed people would save \$5,000 a year on health insurance, and other small firms would save more than 34 percent.

Similarly, association health plans, AHPs, could allow rotary clubs, professional associations, and other groups to band together across state lines, form their own health plans, increasing their purchasing power and lowering costs.

Health savings accounts should also be strengthened, and these accounts allow individuals to save money in an account they control, using the money to pay for everyday medical expenses. Only when major medical expenses are incurred does the insurance company step in after a high deductible paid out of the HSA is met. HSAs encourage individuals to make smart spending decisions, and cost them less over time than traditional insurance.

We should never forget that innovation comes almost exclusively from the private sector. New drugs, therapies, and cures will only be developed if the companies that develop them are able to commercialize them. Empowering Washington is not the way we are going to promote innovation and invention.

So our hearing today will examine options to reform insurance markets to better serve patients and examine better paths forward.

My time has expired. With that I recognize Ms. Matsui, who is filling in as ranking member, for 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The subcommittee will come to order.

The Chairman will recognize himself for an opening statement.

Today's hearing will take a closer look at health care solutions centered around patient choices and limiting, or even ending, government's role as an insurance regulator to allow insurance plans to innovate.

Health care is the most personal of any political issue. When Congress gets involved in health policy, we are changing peoples' lives. Decisions we make in Washington can have a tremendous effect on the well-being of families and their budgets.

A country in which 45 million people went without health insurance was certainly in need of health reform. However, the Affordable Care Act is not the health reform this country needed.

In fact, I believe it is a tremendous setback and makes true reform even harder to accomplish.

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 ACA has done nothing to decrease health care spending. In fact, many Americans are paying more for health insurance and care as a result of the law.

We can do better. Government bureaucracy and rules can never hope to contain costs. We must make health care costs more transparent and give people the freedom to choose the insurance that they want.

I do not believe that more government bureaucracy, regulations, and spending will ever successfully control the price of health care. We have to put individuals and families in charge of their own health care. They need adequate information in order to make smart decisions and the freedom to choose what works best for them. Some of the free market solutions that I believe would truly help control costs and improve health care for all includes portability, more pooling options, consumer-driven arrangements, and innovation through vibrant plan competition.

For many, their health insurance is too closely tied to employment. People who are laid off, fired, or have to quit working can find themselves uninsured at a time when they can least afford it. Patients should be able to own their insurance plan, and take it with them, even if they enter into the individual market.

Before the president's health care law, I introduced the Small Business CHOICE Act, which would allow small businesses to form private health insurance cooperatives to buy insurance at lower rates while transferring catastrophic costs to a larger insurer. The bill helps small employers offer health insurance through a refundable tax credit of 65 percent. Self-employed people would save \$5,000 a year on health insurance, and other small firms would save more than 34 percent.

Similarly, association health plans (AHPs) could allow Rotary clubs, professional associations and other groups to band together across state lines and form their own health plans, increasing their purchasing power and lowering costs.

Also, lack of consumer control has the effect of reducing people's motivation to make their own responsible decisions. There is little incentive to make wise decisions about when to see a doctor or to make healthy lifestyle choices. Instead, insurance companies try to reduce costs by requiring doctor referrals and insurance pre-certification. A better way to help people make responsible decisions is to transfer the motivation to be frugal from the insurance company to the individual.

Health Savings Accounts (HSAs), created in 2003 by Republicans but still underused, allow individuals to save money in an account they control, using the money to pay for everyday medical expenses. Only when major medical expenses are incurred does the insurance company step in, after a high deductible (paid out of the HSA) is met. HSAs encourage individuals to make smart spending decisions and cost them less over time than traditional insurance.

We should never forget that innovation comes almost exclusively from the private sector. New drugs, therapies, and cures will only be developed if the companies that develop them are able to commercialize them. We should not nationalize healthcare and we should not weigh down innovation and invention with unnecessary new taxes and regulations.

Our hearing today will examine options to reform insurance markets to better serve patients.

Ms. MATSUI. Mr. Chairman, I would like to reserve the time for Mr. Green until he returns.

Mr. PITTS. All right. That is fine.

Does anyone else seek time?

All right. We will go to our chairman of the full committee, Mr. Upton, for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Thank you, Mr. Chairman.

Today's hearing is an important discussion on what Congress can do to help Americans across the country access better care at, indeed, a lower cost. Individuals and families across the country are seeing growing premiums and deductibles, yet are seeing provider networks narrow and restrict access to life-saving medicines and treatments. Folks in my State, as well as across the country, are frustrated. The healthcare system was turned upside down. Promises were not kept. Costs have gone up, while quality has often deteriorated.

So we have to chart a better path forward to reforming our insurance markets so that they can better serve the patients. That is what this effort is all about. We can strengthen health coverage by expanding plan offerings that allow for real choice, as well as incentivizing market innovation without the mandates.

I have laid out a number of ideas to do this in the Patient CARE Act that I authorized with Senators Hatch and Burr, and our committee members have laid out dozens and dozens of ideas that put the power to choose in the hands of patients.

So let's establish another point from the start. House Republicans believe that no patient should be denied coverage or experience coverage shortages simply because they are sick. There are various ideas of how to accomplish our goals without interrupting the health insurance market, including guaranteed issue and continuous coverage protections. Continuous coverage means that if a patient gets a new job or retires or switches plans because their family moves, whatever, they will not be charged more than the standard rates, even if they are dealing with a serious medical issue or, as we know it, preexisting condition.

Protecting our most vulnerable patients with preexisting condition safeguards is just as much about helping them keep health coverage as it is about creating an environment for them to get health coverage. Continued enrollment can lead to lower costs and stable markets, which gives consumers a pathway to choose more innovative options.

So today we are going to talk about ways to achieve this through market reforms instead of government mandates, by encouraging States to lower costs through premium reduction programs. Options like advanced high-risk pools can also open new access points to the market while helping keep patient costs down.

Headlines across the country confirm that patients are paying higher premiums and seeing fewer options. Patients are exiting the marketplace. Plans are leaving the exchanges. So simply put, we are 6 years into the President's healthcare law, and it is not working the way people thought it might.

One disturbing fact that confirms the need for reform is that 19 of the 37 States on healthcare.gov—19 of the 37—saw double-digit premium increases for the second-lowest-cost silver plan. Even worse, three of those States saw benchmark rates go up to 30 per-

cent. And S&P reported Monday that individual market costs jumped 23 percent in 2015.

That is why we are here today, to discuss the merits of idea for increasing patient choices and incentivizing plan innovation. I look forward to the witnesses' testimony and would yield to any Republicans on my side. I yield back the balance of my time.

[The prepared statement of Mr. Upton follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Today's hearing is an important discussion on what Congress can do to help Americans across the country access better care at a lower cost. Individuals and families across the country are seeing growing premiums and deductibles, yet are seeing provider networks narrow and restrict access to life-saving medicines and treatments. Folks in Michigan and the country are frustrated. The health care system was turned upside down, promises were not kept, costs have gone up while quality has deteriorated.

We have to chart a better path forward to reforming our insurance markets so they better serve the patients. That's what this effort is all about. We can strengthen health coverage by expanding plan offerings that allow for real choice—as well as incentivizing market innovation without mandates. I have laid out many ideas to do this in the Patient CARE Act that I authored with Senators Orrin Hatch and Richard Burr. And our committee members have laid out dozens of ideas that put the power to choose in the hands of patients.

Let's establish another point from the start: House Republicans believe that no patient should be denied coverage or experience coverage shortages simply because they are sick.

There are various ideas of how to accomplish our goals without interrupting the health insurance market; including providing guaranteed issue and continuous coverage protections. Continuous coverage means that if a patient gets a new job, retires, or switches plans because their family moves, they will not be charged more than standard rates—even if they are dealing with a serious medical issue.

Protecting our most vulnerable patients with pre-existing condition safeguards is just as much about helping them keep health coverage as it is about creating an environment for them to get health coverage. Continued enrollment can lead to lower costs and stable markets, which gives consumers a pathway to choose more innovative options.

Today, we will talk about ways to achieve this through market reforms instead of government mandates, like encouraging states to lower costs through premium reduction programs. Options, like advanced high risk pools, can also open new access points to the market while helping keep patient costs down.

Headlines across the country confirm that patients are paying higher premiums and seeing fewer options. Patients are exiting the marketplace. Plans are leaving the exchanges.

Simply put, we are 6 years into the president's health care law and it is not working. One disturbing fact that confirms the need for reform is that 19 of the 37 states on HealthCare.gov saw double-digit premium increases for the second-lowest cost silver plan. Even worse, three of these states saw benchmark rates go up 30 percent. And S&P reported Monday that individual market costs jumped 23 percent in 2015.

This is why we are here today—to discuss the merits of ideas for increasing patient choice and incentivizing plan innovation. I look forward to the witness testimony and I encourage a thoughtful dialogue about ideas.

Mr. PITTS. The chair thanks the gentleman.

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

I believe we all share a common goal. We want a healthcare system that is more affordable, accessible, and higher quality, a system that works for all Americans.

Now, how we achieve this goal tends to be a topic of intense debate, and it should be. The Affordable Care Act has greatly expanded access to quality, affordable health insurance in our country. There is, however, more that we can do to improve our health system for everyone.

I believe the ACA has been a success. Twenty million more people now have health insurance. Women, minorities, and young people in particular have experienced substantial gains in coverage. Since 2013, the uninsured rate amongst young adults has dropped by 47 percent. And together we should be discussing how we can build on this success to give even more Americans the peace of mind that quality health insurance provides.

The law also put in place important consumer protections that prevent insurers from discriminating against the most vulnerable, and it eliminated out-of-pocket costs for important preventative services, such as immunizations and cancer screenings.

While we know the marketplaces still need time and room to grow, we can't forget what the individual market was like before the Affordable Care Act. Double-digit rate increases on subpar plans were the norm. The ACA gave HHS and States the tools they need to monitor insurers and put a stop to these harmful practices.

This rate review program brings transparency to the process, greater stability to the market, and protects individuals from unreasonable price increases. It also resulted in subpar plans simply no longer being sold if they don't cover hospitalizations or prescription drugs or have limits on how much health care will be covered in a given year.

The medical loss ratio ensures that insurers spend at least 80 percent of premium dollars on actual health care and not executive bonuses or advertising.

The ACA also created an entirely new marketplace that expanded coverage to individuals who prior to the Affordable Care Act had little to no hope of finding affordable health insurance. Our witnesses today will talk about giving consumers more choices, but let's not lose sight of the fact that before the ACA, millions of Americans with preexisting conditions had no choices at all.

These marketplaces are still in their infancy and will continue to mature over time as insurers become more accustomed to calculating risk and as more individuals transition from grandfathered and grandmothered plans to marketplace plans.

Creating a competitive and successful market in a system as complex as our own is certainly no small feat. Millions of Americans count on this coverage and therefore we should do everything we can to make sure that these marketplaces grow even stronger.

And this hearing has the potential to be a starting point for a real discussion on bipartisan improvements that will strengthen the systems already in place and bring us even closer to high-quality, universal coverage. However, I also recognize that this hearing has the potential to be a continuation of a 6-year Republican assault against the Affordable Care Act and the millions of Americans who benefit from it.

The ACA's marketplaces put power back into the hands of consumers, gave everyone the right to buy insurance, and forced insurers to compete based on price and value. We can't return to a time when insurers competed to find the healthiest, least-expensive consumers and left millions of Americans to fend for themselves. I think we have a duty to overcome partisan politics and work together to come up with the best solutions, and I am hoping that we will use our time today to do just that.

And I would like to yield the remainder of my time to the gentlewoman from California, Ms. Matsui.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Good morning everyone and thank you to the witnesses for being here today. I believe we all share a common goal: we want a health care system that's more affordable, accessible, and higher quality—a system that works for all Americans. Now, how we achieve this goal tends to be a topic of intense debate, and it should be. The Affordable Care Act has greatly expanded access to quality, affordable health insurance in our country. There is, however, more that we can do to improve our health system for everyone.

The ACA has been a success. Twenty million more people now have health insurance. Women, minorities, and young people in particular have experienced substantial gains in coverage. Since 2013 the uninsured rate among young adults has dropped by 47 percent. Together, we should be discussing how we can build on this success to give even more Americans the peace of mind quality health insurance provides. The law also put in place important consumer protections that prevent insurers from discriminating against the most vulnerable, and it eliminated out of pocket costs for important preventative services, such as immunizations and cancer screenings.

While we know the marketplaces still need time and room to grow, we cannot forget what the individual market was like before the ACA. Double-digit rate increases on sub-par plans were the norm. The ACA gave HHS and states the tools they need to monitor insurers and put a stop to these harmful practices. This rate review program brings transparency to the process, greater stability to the market and protects individuals from unreasonable price increases. It also resulted in sub-par plans simply no longer being sold if they don't cover hospitalizations or prescription drugs or have limits on how much health care will be covered in a given year. The Medical Loss Ratio ensures that issuers spend at least 80 percent of premium dollars on actual health care, not executive bonuses or advertising.

The ACA created an entirely new marketplace that expanded coverage to individuals who prior to the ACA had little to no hope of finding affordable health care. Our witnesses today will talk about giving consumers more choices, but let's not lose sight of the fact that before the ACA, millions of Americans with pre-existing conditions had NO choices.

These marketplaces are still in their infancy and will continue to mature over time as insurers become more accustomed to calculating risk, and as more individuals transition from "grandfathered" and "grandmothered" plans to marketplace plans. Creating a competitive and successful market in a system as complex as our own is no small feat. Millions of Americans depend on this coverage, and therefore we should do everything we can to make sure these marketplaces grow even stronger.

This hearing has the potential to be a starting point for a real discussion on bipartisan improvements that will strengthen the systems already in place and bring us even closer to high quality universal coverage. However, I also recognize that this hearing has the potential to be a continuation of a six year Republican assault against the ACA and the millions of Americans who benefit from it. The ACA's marketplaces put power back into the hands of consumers, gave everyone the right to buy insurance, and forced insurers to compete based on price and value. We cannot return to a time when insurers competed to find the healthiest, least expensive consumers and left millions of Americans to fend for themselves.

We have a duty to overcome partisan politics and work together to come up with the best solutions. I'm hoping that we will use our time today to do just that. Thank you.

Ms. MATSUI. Thank you very much.

The Affordable Care Act is improving millions of Americans' lives. Thanks to the ACA, nearly 18 million previously uninsured Americans no longer have to worry that they are one illness away from financial ruin.

The Affordable Care Act is intertwined into the fabric of our healthcare system. It is time to recognize the ACA as the law of the land so we can move forward with the business of ensuring that every American has the opportunity to live a healthy life. As members of the Health Subcommittee, that should be our mission.

Today we are talking about market reforms that increase transparency and access for patients. Because of the ACA, patients with preexisting conditions who never had a choice when it came to their health care now have options. These protections are particularly important for those over 30 million individuals in this country who suffer from rare or serious chronic diseases.

The ACA has helped millions of families gain access to quality, affordable coverage, and I do hope that our committee can work together to continue this progress to improve the health and lives of Americans.

I yield the remainder of my time back to the ranking member.

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

The chair now recognizes the ranking member of the subcommittee, 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 will ask for dispensation because I was actually speaking to Bill Flores, the Chamber of Congress, and they asked too many questions. I may have been the only Democrat they heard from that day.

I want to welcome our panel. Good morning, and thank you all for being here today.

It has been almost 2 1/2 years since the full reforms of the Affordable Care Act went into effect. The third open enrollment period built off the successes of the first and second, and there is even reason to believe that the fourth open enrollment period will continue this trend. The marketplaces created under the Affordable Care Act are in their relative infancy. As with any other, almost every new market, particularly in the healthcare space, there will be changes and adjustments in the early years. Insurers will both enter and exit as they navigate the new landscape of millions of new consumers, protections, and requirements.

Medicare, when it was first created, experienced growing pains, as did Medicare Advantage and the part D plans. You will hear reports sounding the alarm that in 2016, 39 insurers left the Federal marketplace. Maybe actuary reports fail to mention that in the same year, 40 insurers entered the marketplace.

The number of issuers in every State has grown each year at a year-over-year average of 8 in 2014, 9 in 2015, and 10 in 2016. Nearly 90 percent of consumers that had coverage in 2015 had a choice of three or more insurers for the 2016 coverage.

The unfiltered facts clearly indicate that the marketplace is an attractive place for issuers to do business and for consumers to

purchase quality, affordable insurance, many for the first time in their lives.

Health insurance is a product that Americans want and need. 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 the right for all Americans.

The Affordable Care Act has been resoundingly successful, but like any law, it is not perfect. As I have been known to say, if you want something done perfectly, don't ever come to Congress. That is why, after passing major reforms, Congress has very often revisited the legislation and come together to improve it.

While I don't expect us to agree on a lot of solutions debated during this hearing, it is a welcome departure from the politically motivated hearings we have had over the last 6 years which were only designed to score points and attack the law rather than look for ways to improve the exchanges on behalf of the American people. I am hopeful this is a genuine step toward getting back to the business of legislating. I thank the chairman for calling it.

The core strength of the ACA is that it puts power back in the hands of consumers, contains key provisions, and requires insurers to compete based on their ability to offer high-quality insurance at an affordable price. In the pre-ACA world, the individual market was unstable, unfair, and inaccessible to many. Insurers competed to find the healthiest and cheapest consumers, and those with pre-existing conditions were largely priced out. Women could be charged more just because of their gender, annual and lifetime limits hindered patients' ability to get care when they needed it, and people could be dropped from their plan when they got sick and needed it the most.

In the post-ACA individual market, where everyone has the right to buy insurance and choices are transparent and easy to compare, consumers make issuers compete based on price and value, and with any market, some insurers are adapting faster than others to the new landscape. This is the nature of competition.

Some insurers have already figured out how to succeed in the marketplace and they are growing and expanding their exchange business. Others will learn to adapt or else lose market share to those who already have. These are the features of a healthy market. This is the proof that ACA's market-based reforms are working.

There are definitely ways to improve the ACA, to expand coverage to more Americans, and to lower cost. I look forward to exploring these with my colleagues. And, for example, my friend and Texan, good friend Joe Barton and I have a requirement for 12-month continuous enrollment in Medicaid and CHIP. Continuous coverage brings down administration burden, provides for continuous care, and keeps folks healthier while bending the curve in the long run.

Again, I want to thank our witnesses for being here today, and I look forward to getting back to the business of legislating. Thank you.

Mr. PITTS. The chair thanks the gentleman.

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

I seek unanimous consent to submit the following document for the record: a statement from the Committee for Economic Development.¹ Without objection, so ordered.

Mr. PITTS. We have one panel before us today. I would like to thank you for coming. And I will introduce our panelists in the order of their giving testimony.

First, we have Dr. Scott Gottlieb, resident fellow, American Enterprise Institute; Mr. Avik Roy, senior fellow, Manhattan Institute; and Sabrina Corlette, research professor, Center on Health Insurance Reform, Georgetown University.

Thank you for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your testimony.

So at this point, Dr. Gottlieb, you are recognized for 5 minutes for your summary.

STATEMENTS OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE; AVIK ROY, SENIOR FELLOW, MANHATTAN INSTITUTE; AND SABRINA CORLETTE, J.D., RESEARCH PROFESSOR, CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY

STATEMENT OF SCOTT GOTTLIEB

Dr. GOTTLIEB. Mr. Chairman, Mr. Vice Chairman, thank you for the opportunity to testify here today.

My name is Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute. I previously worked at CMS and FDA and have experienced and evaluated the insurance market as a provider, as a policy analyst, and as an investor in the space, and it is from three perspectives I want to offer some thoughts today. We face some continuing challenges with respect to our current insurance market and some new pressures, and I want to focus not on how we got here, but what we can do about it.

Improving the existing market for insurance inside the state-based exchanges or transitioning to an entirely new framework for how we pool risk and help consumers buy coverage should include, in particular, four principles that I want to outline today.

First, more rating and regulatory flexibility for insurance products to enable more competition between different and, hopefully, more innovative plans. I believe that regulatory standards and how CMS is interpreting its own rules limit the ability of plans to offer innovative designs.

Because health plans must adhere to a narrow formula to fall within the discrete metal tiers, it leads to an environment where plans are designed from the top down, off actuarial targets, rather than based on a bottoms-up approach to build off principles that may lead to more innovation and coverage.

To these ends, insurers can be required to simply report the actuarial value of their plans so long as they meet a minimum level of coverage. Instead of making decisions based on rigid targets that are tied to metals, consumers can make choices based on the actual actuarial value of the plan.

¹The statement has been retained in committee files and is available at: <http://docs.house.gov/meetings/ij/if14/20160511/104905/hhrg-114-if14-20160511-sd003.pdf>.

I believe allowing more regulatory flexibility around rating and plan design would enable a wider selection of high-value options, such as value-based insurance designs or designs that reduce premiums and other costs for consumers that stay with an insurer over time.

Second, we need clear rules on open enrollment periods to enable a viable risk pool while using incentives rather than mandates as a way to keep people in the insurance market. We absolutely must maintain some exemptions for people who confront some discrete challenges obtaining coverage during open enrollment periods. But carefully defined enrollment windows can form a key element of rules that use incentives to encourage people to enter the insurance market and stay continuously insured, rather than relying on penalties to enable these same outcomes.

Right now the lack of tightly defined enrollment periods, verification requirements, and fluid exemptions largely forecloses the ability to use the requirement for continuous coverage as a way to create incentives for people to get into and stay in the insurance market.

Third, subsidies need to be tied more closely to risk, and risk adjustment must provide plans with incentives to enroll and improve the health of people with chronic conditions. In the plan that I helped co-author at AEI with my colleagues, we advocate a system of tax credits. These are set initially as a fixed-dollar amount based on age. Under our framework, older individuals would get larger subsidies reflecting their tendency to use more healthcare services.

Another option is to match the magnitude of the tax credits more closely to the varying insurance costs that real purchasers will face in a less regulated market. This second option would make the tax credit amounts more open-ended initially in response to the premiums that may vary with age, geography, and perhaps some form of preexisting risk. This initial floating cost subsidy structure could then be adjusted in later years to set a ceiling on maximum tax benefits to curb overspending and add additional subsidies for more economically or medically vulnerable populations.

Any approach should be coupled to proper risk adjustment so that health plans have an incentive to enroll individuals with certain preexisting conditions and improve their health.

The credit the health plans receive can be adjusted prospectively based on a defined set of healthcare conditions and a methodology that the insurers agree to in advance, since they are the ones who know best where the economic sensitivities are.

Fourth, and finally, we need to contemplate policies that offer incentives for new plan formation and alternatives to the hospital-led consolidation of providers that are driving up costs. With respect to health plans, there has been no new net health plan formation since 2008. By this, I mean new health carriers. I believe that a big culprit is the caps on the operating margins, which makes it hard for new plans to enter the market even with some of the concessions that are made available to startup plans.

On the provider side, we need to consider policies to create alternatives to the consolidation of physicians around local hospitals, which is increasing in a number of markets and is giving a single

health system the sort of monopoly position that is driving up costs.

Our healthcare reform should be aimed at increasing choice and competition as a way to give consumers more options and more opportunities to access affordable coverage. I hope that these concepts I outline here today can advance some of these goals, and I am grateful for the opportunity to testify before the committee. Thanks a lot.

[The prepared statement of Dr. Gottlieb follows:]



Testimony before the United States Congress
House Committee on Energy and Commerce
Subcommittee on Health

Health Care Solutions
Increasing Patient Choice and Plan Innovation

Scott Gottlieb, MD
The American Enterprise Institute
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In recent years we've seen health insurance costs continue to increase, while the commercial health insurance options available to consumers have shrunk. More health plans are adopting narrow provider networks and closed drug formularies as a way to hold down costs, while aspects of the health plan market have become less competitive on the whole.

The elephant in the room is how much the Affordable Care Act is to blame for these trends. The truth is that prior to implementation of the ACA, American healthcare was hardly a low cost, high-quality, free market utopia. So however one decides to parse blame for our current challenges -- and I have admittedly been a critic of the ACA since its inception -- my goal today is not to revisit that legislation's pros or cons. Instead I want to briefly consider some of the current trends that we are observing, and offer market based reforms that I believe are universal. They could make the market for coverage more competitive and affordable, whether the ACA remains in force, or we adopt a different framework for healthcare reform.

Toward these ends, today I want to do two things. First, I want to make some brief observations about trends in the insurance market that are occurring both inside and outside the exchanges. These are developments that I believe impede the common goals we seek of fostering a market of high quality and more affordable coverage options. Second, I want to offer some ideas for reforms that I believe can help reverse some of these trends, and make the market for health insurance more robust, competitive, and high value.

The Current Market

Looking at today's market, we're seeing a number of simultaneous trends that I believe are inconsistent with the outcome that we collectively seek. These relate to the breadth and quality of coverage, the cost of healthcare services, and the increasingly narrow economic demographic of consumers who are able to affordably access the existing market.

First, it's now widely recognized that health plans are narrowing provider networksⁱ and drug formularies as a way to reduce the cost of their benefits.ⁱⁱ Insurers are faced with an increasing number of mandated costs and more limited tools to price and manage their actuarial risk. So the principal tools they retain as a means to reduce costs is to lower the cost of the underlying benefit. While the narrowing provider networks are well documented, there's been far less attention paid to the narrowing of coverage for drugs. By my analysis, almost all of the silver plans have adopted closed formularies.^{iv} Many of these closed formularies are coupled to narrow formulary lists. The combination of these two approaches means consumers are increasingly responsible for the full cost of a rising number of drugs, and this consumer spending doesn't count against deductibles or out of pocket limits.

At the same time, the cost of medical care continues to rise at a faster rate than overall inflation. I know a lot of the focus on rising healthcare costs has turned on the price of technology, especially drugs. But the fact is that the real price of drugs, after discounts are applied, is growing, but not at a historically rapid pace.^v A much bigger factor in rising drug spending overall is not prices, but population-related factors. More people are taking more medicines, especially higher-cost specialty medicines, and in large part, because today's medicines are delivering much more benefit than older drugs, and replacing other healthcare inputs. According to a recent analysis conducted by the Assistant Secretary for Planning and

Evaluation, population growth account for 10% of the increase drug spending between 2010 and 2014. Increased number of prescriptions being written per patient accounted for 30% of this growth. In other words, fully 40% of the increased spending was related to population factors.^{vi} Other analysis, for example from Caremark CVS^{vii}, has found similar results.

Why is this relevant to our discussion today? Because on the issue of healthcare costs, I would submit to you that an equal if not greater concern should be the consolidation that's underway on the provider side of the market, where local institutions are monopolizing local healthcare providers. This is leaving the delivery side of the market less competitive, in ways that could ultimately limit patient choice and plan innovation. In some instances, deliberate policy steps -- some taken by this body -- have encouraged, or at least enabled, this consolidation, often as a vehicle for trying to achieve other goals. The consolidation raises two immediate concerns related to healthcare costs. First, there's a direct concern that as local institutions monopolize the local provision of care, they're able to subvert market based pricing of services and force payers to absorb above market rate increases.^{viii ix} The Federal Trade Commission repeatedly expressed misgivings around these possibilities.^{x xi xii}

A lot of the data on these outcomes is backward looking. It may understate the scope of the consolidation, which has accelerated in the last few years. A 2012 survey by American Hospital Association showed that between 2000 and 2010, hospital employment of physicians increased by 32%. As of 2012, the majority of physicians were employees instead of owners, according to a survey conducted by the American Medical Association. Nearly 58% of family physicians and 50% of internists identified themselves as employees.^{xiii} Similar trends are observed with certain medical specialties, especially cardiology and oncology, where we have seen accelerating consolidation and hospital ownership of medical services. Across these specialties, there's convincing data on the impact consolidation has on costs.^{xiv}

The second concern relates to the efficiency of medical care. There's evidence to show that healthcare productivity often declines as providers enter these arrangements where they become employees, typically of large hospital systems.^{xv} If we believe that the only way to solve our long term fiscal challenges as they relate to healthcare is to get more and better healthcare for every dollar of GDP that we spend on it, the last thing we should contemplate are policies that will lead to a deliberate reduction in the productivity of healthcare delivery.

There's no reason to assume that the opportunities that many believe are offered by consolidation, whether it's a view that there will be better integration of care or more rapid adoption of healthcare IT, will offset these productivity declines. On the contrary, there's evidence that economic integration between providers and hospitals does not automatically lead to functioning clinical integration. Even after combinations, a lack of alignment between physicians and hospitals can threaten the success of these models.^{xvi} Moreover, I believe that many of the sought after goals -- for better integration of care -- could be achieved through a multitude of new arrangements, and not solely by consolidating doctors around hospitals.

Pricing More People Into The Market

The third issue relates to the economic accessibility of coverage purchased outside of employer relationships. It's generally agreed that the state-based exchanges were intended to fully replace the individual market and most of the small group market that existed prior to

the implementation of the ACA. But the data on enrollment suggests that the exchanges are increasingly accessible to a narrowing income demographic. In one part, this is as a result of the rising premium and out-of-pocket costs and in other parts, the way existing subsidies are structured to help offset those costs. As premiums rise, and as more plans adopt very high deductibles and cost sharing as a way to offset mandates and a risk pool that's increasingly costlier than that was anticipated, the benefit itself is becoming less economically accessible to all but those who fall inside a narrowing income range. Typically, it's where special cost sharing subsidies attach.^{xvii xviii xix} These are individuals who earn less than 250% of the Federal Poverty Level, but don't qualify for Medicaid. Because of the way the cost sharing subsidies are structured, the zone of affordability may increasingly fall below 200% of FPL.

It's my belief that the continuing rise in premium costs, coupled to the narrowing of coverage and the rising cost sharing, are combining to gradually confine the opportunity to purchase coverage to those who qualify for these cost sharing subsidies. As a consequence, rising portions of the overall pool of people enrolling in the exchanges are those who fall in this income demographic. The end result, if these trends continue, will be a program that is largely an income-based program. To the extent that the ACA intentionally supplanted the individual and small group markets, and largely foreclosed the opportunity to buy other kinds of coverage outside of the new exchanges, if the opportunity to enter the exchanges becomes one that is increasingly narrowed to a very specific income range, it could leave other middle and working class consumers strained to afford coverage outside of ESI.

I am sure that none of these trends are what the law's architects intended. I believe there are ways to structure insurance market reforms that would enable more access to a wider choice of lower cost and high value insurance options, whether it's under the structure of the ACA or under a new model of healthcare reform that creates different pooling mechanisms.

More Rating and Regulatory Flexibility When it comes to Insurance Products, to Enable More Competition Between More Innovative Insurance Plan Designs

I believe that regulatory standards – and how the Centers for Medicare and Medicaid Services is interpreting its own rules – limit the ability of plans to offer innovative designs. This gets to a universal policy issue that's not particular to the ACA. It's something that I believe we should consider within any policy context that aims to reform the insurance marketplace to enable a wider selection of affordable, high value options for consumers.

Because health plans must adhere to a narrow formula in order to fall within the discrete metal tiers stipulated by current law, it limits the ability to offer novel plan designs that may fall outside of these narrow boundaries. In other words, insurers must back their plan designs into the discrete actuarial levels stipulated by law. This leads to an environment where plans are designed from the top down, off actuarial targets, rather than based on a bottom up approach to build off principles that may lead to more innovation in coverage.

I know that the metal tiers and the actuarial values that they represent were meant as a way to simplify the selection of coverage for consumers. And I know there's been some discussion of adopting a new, lower actuarial tier as a way to provide a more affordable option for younger consumers. Instead, I believe that a viable market that encourages

innovation should enable more rating and regulatory flexibility when it comes to health plans, to enable more competition between different approaches to designing health plans.

To these ends, insurers can be required to simply report the actuarial value of their plans, so long as they meet a minimum level of coverage. Instead of making decisions based on rigid targets that are tied to metals, consumers can make choices based on the actual actuarial value of the plan. We should solicit objective research to find ways to express these variables in ways that will reduce confusion and leave consumers more, not less informed.

I trust consumers could be properly educated on the meaningfulness of the actuarial targets and incorporate these variables into their selection process. The metals were meant to simplify these considerations. But in our effort to streamline choices, we also limited them. Tools that allow consumers to estimate how the actuarial value of a plan correlates with practical descriptions of the scope of coverage they'll have for different scenarios have become much more sophisticated. This includes modules already incorporated into the healthcare.gov website. These kinds of tools can help consumers understand the relative value of different actuarial targets, and make comparisons between different actuarial levels.

I believe allowing for more regulatory flexibility around rating and plan design would enable a wider selection of higher value options such as value-based insurance designs, or designs that reduce premium and other costs for consumers that stay with an insurer over time. This can enable health plans to invest in care and build the kind of informational relationship that can lead to better targeting of services. This concept of a vanishing premium would not be able to fit under the existing rating approach, and would be viewed as discriminatory under the current rules. These are just some of the examples where regulatory flexibility enables more innovation. Instead, CMS appears to be moving forward a standardized benefit design that's optional now, but some fear could become mandatory at a future date.^{xx xxi} In other words, CMS seems to be moving in the opposite direction, requiring more uniformity between different plan options, and reducing the opportunity to create more genuine choice.

Clear Rules on Open Enrollment Periods to Enable a Viable Risk Pool, While Using Incentives Rather than Mandates to Get and Keep People in the Insurance Market

I know CMS has taken steps in recent months to tighten rules around when consumers must enroll in coverage and close exemptions that let many people enroll "off cycle".^{xxii} Clear enrollment periods, with reasonable penalties for those who pursue coverage outside these windows (coupled to effective verification for those who request a special enrollment period) are an essential part of a well functioning risk pool. We need to maintain some exemptions for people who confront some discrete challenges obtaining coverage during open enrollment periods. But carefully defined enrollment windows can also form a key element of rules that use incentives to encourage people to enter the insurance market, and stay continuously insured, rather than relying on penalties to enable these same outcomes.

As I outlined with colleagues in a report published through the American Enterprise Institute, as part of a comprehensive proposal to reform American healthcare, I believe that protections for people with preexisting conditions could therefore involve rewarding continuous coverage rather than punishing lack of insurance. As we noted, one way to do

this is for the federal government to extend the reach of a long-standing provision of law to ensure that people with preexisting conditions have access to coverage wherever they seek it.

Under this approach, people who maintain continuous insurance coverage (under our plan, measured as three or fewer months without coverage over the preceding three-year period) would be guaranteed access to coverage and protected against higher premiums because of a preexisting condition. Under such an approach, insurers would also be prevented from charging higher premiums to customers with continuous coverage who subsequently develop serious health conditions and from imposing coverage restrictions tied to changes in a person's health status. In other words, people couldn't be dropped from coverage or re-rated, so long as they met the requirement for maintaining continuous coverage. Some consumers would need to receive help to maintain coverage, especially through hardships that might impact their ability to meet premium costs. People would also need to receive waivers from the continuous coverage requirements if they hit certain definable hardships.

The requirement for continuous coverage, as a way to avoid restrictions on the coverage of preexisting conditions, serves as a powerful incentive for people to obtain and maintain coverage. It can form the basis of an effective alternative to using penalties to force people to purchase insurance. Such an approach should be coupled to some mechanism to help offset the cost of those with significant preexisting conditions who haven't already secured continuous coverage, to help them get into the market and maintain that coverage.^{xxiii}

Right now, the lack of tightly defined enrollment periods, verification requirements^{xxiv}, and fluid exemptions, largely forecloses the ability to use a requirement for continuous coverage as a way to create incentives for people to get into, and stay in, the insurance market. I believe 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.

One recent analysis, undertaken to evaluate the impact that special enrollment periods have on the non-group market, confirmed that these constructs serve to skew the overall risk pool, ultimately leading to a higher cost, and a less stable market. In the analysis, which evaluated data from the 2014 insurance enrollment season, claim costs for individuals that enrolled in SEPs were 10% higher than those that enrolled during the standard open enrollment period, and per-month per-member (PMPM) claim costs for SEP enrollees were 24% higher on average during the first three months of enrollment than for OEP enrollees.

In the same analysis, in 2015, the difference in PMPM claim costs increased to 41% for the first three months of enrollment. Moreover, SEP enrollees were found to be 40% more likely, on average, to lapse coverage than those that enroll during the OEP. The scope of the SEPs in the current exchanges (over 30 unique occurrences) far exceeds what's available under ESI, Medicare,^{xxv} and presumably what's required to address special circumstances.^{xxvi}

Subsidies for Risk, not only Need, Including Risk Adjustment that Provides Plans with Incentives to Enroll and Improve Health of People with Serious Conditions

Any plan to enable more universal access to basic health coverage will have some people who are priced out of the market because they simply don't earn enough to afford qualified health coverage. For these individuals, there must be some mechanism to provide a subsidy

that can help them get into, and stay in, the insurance market. In the plan that I helped co-author that was released by the American Enterprise Institute, my colleagues and I advocate a system of tax credits. These are set initially as fixed-dollar amounts based on age. Under our framework, older individuals would get larger subsidies, reflecting their tendency to use more health services. These subsidies would be sufficiently generous to ensure that people can afford, at a minimum, a basic health plan that provides insurance against serious illness.

Another option is to match the magnitude of the tax credits more closely to the varying costs of care and insurance costs that real purchasers will face in a less-regulated market. This second option would make the tax credit amounts more open-ended initially and responsive to premiums that may vary by age, geography, and perhaps some form of pre-existing risk (through a risk adjustment mechanism). We outline this approach in the plan that we released through AEI. Structuring the tax credits as a uniform fixed percentage of premium costs would provide all purchasers with the same subsidized discount rate in choosing insurance plans. This initial floating cost-based subsidy structure then could be adjusted in later years to set a ceiling on maximum tax benefits (to curb overspending) and add additional subsidies for more economically or medically vulnerable populations.

Under this approach, to qualify for the tax credit, individuals would need to purchase qualified health insurance that would be defined in advance.^{xxvii} Among other things, there would need to be a federal requirement that insurance plans purchased with the credit must provide coverage for medical care above an out-of-pocket limit of consumer spending.

Any approach to providing subsidies should be coupled to proper risk adjustment, so that plans have an incentive to enroll individuals with certain pre-existing conditions, and improve their health. Risk adjustment provides an inducement for health plans to seek out people with costlier conditions, and get them better.

CMS took some recent steps to adjust the agency's mechanism for risk adjustment under the Affordable Care Act, by incorporating data on drug utilization as a way to account for the higher cost of caring for patients with certain chronic conditions. It remains unanswered whether these limited steps will have a meaningful impact.^{xxviii} It is my belief that in a properly functioning market, plans should be able to profit from the arbitrage that exists between the implicit subsidies that are provided through the risk adjustment, and the actual costs that accrue if health plans are able to meaningfully improve peoples' outcomes.

Insurance is expected to pay for unexpected, random "bad things," like accidents. But, for chronic conditions like diabetes (relatively low but regular costs) or cystic fibrosis (very high and regular costs), actuaries know that there may be a lifetime of extra expenses. To address these costs, risk adjustment chooses a limited number of discrete, ongoing, costly conditions and pay insurers extra for them, in addition to regular premiums from individuals or employers. Proper risk adjustment systems choose a limited number of discrete, ongoing, costly conditions and pay insurers extra for them, in addition to regular premiums from individuals or employers. The approach was used effectively in Medicare Part D.^{xxix} Under the ACA, risk adjustment is budget neutral, where insurers who have a large share of chronically ill people receive payments, and other insurers who have fewer than average ill people pay into a "risk adjustment pot" to make the payments.^{xxx}

Typically, risk adjustment provides assistance directly to insurers, based on measuring their pool. It's conceivable that risk adjustment could be enabled through a scheme that prospectively bakes some of this assistance into the tax credits provided to consumers to help them buy coverage. One can perhaps eventually envision a system where consumers in a large, well-functioning pool, who suffer from certain costlier conditions, could have their subsidies adjusted automatically (at the time of enrollment) to reflect their higher costs. This can even provide incentive for health plans to recruit such individuals, and actively manage their health and reduce the cost of care. There are plenty of practical challenges and concerns that would arise from such an approach. The designations that follow individuals in such a hypothetical insurance pool, that would indicate the existence of their adjusted subsidies and thus their underlying medical condition, would need to be completely de-identified in advance of enrollment and impenetrable to disclosures. But there are other economic constructs that trade contractual information along with units of value, and that allow these exchanges to be made anonymously. Block chain, for example, incorporates some of these features. In the end, ideally, we want to make risk adjustment prospective.

Unlike the risk adjustment model that's used under the ACA, the scheme adopted by Medicare is prospective. This means it's used to predict costs for the upcoming year based on the mix of conditions an insurer enrolls each year. A prospective model is thought to improve incentives to manage care more efficiently, when this prior data are available. Under such a general framework that incorporates the concept of state-based exchanges for pooling, insurers could agree to a risk adjustment system as a condition of participating in a state exchange. The credit that the health plans receive can be adjusted prospectively, based on a defined set of healthcare conditions and a methodology that the insurers agree to in advance, since they're the ones who know best where the economic sensitivities are.

Policies aimed at Creating Additional Opportunities and Incentives for New Plan Formation and Alternative Arrangements to the Consolidation of Providers

Finally, all health care is local. Once local market competition is made less robust, through the consolidation of providers around single health systems, or the elimination of plan options, the opportunity to rely on competition as a way to improve options and lower costs is reduced. We should take steps to foster more competition in local markets between health plans and providers. This should start by reconsidering some of the policy steps that I believe have fueled the consolidation that's now underway among providers, and policies that have made it more difficult for new health plans to enter the market. At the same time, we can take steps to encourage the formation of new health plans and alternatives to the consolidated health systems that have been the primary purchasers of physician practices. Alternatives would allow doctors to maintain ownership of their practices while forming the larger practice units that can accommodate the new pay reforms that have gained political fashion, most of which favor forms of capitation that transfer actuarial risk to providers.

With respect to health plans, there has been no new net health plan formation since 2008. I believe that a big culprit are the caps on operating margins, that make it hard for new plans to enter the market, even with some of the concessions that are made available to start up plans. New health plans have much higher start up costs over an extended period of time. They must continue to spend a higher proportion of their premium revenue on those costs.

Moreover, caps on operating margins create disincentives to investment capital that might enter these markets to help underwrite the formation of new health plans.

On the provider side, there's incomplete data on the scope of the consolidation that's underway, but we know it is rampant. We need to consider policies to create alternatives to the consolidation of physicians around local hospitals, which in an increasing number of markets is giving single health systems the sort of monopoly position that's going to lead to less competition and higher costs. This starts by eliminating some existing Medicare payment rules that are biased in favor of the hospital-based delivery of outpatient care.

At the same time, new policies can enable virtual entities like practice management firms to negotiate and report on behalf of doctors for purposes of Medicare reporting requirements. Right now, regulation is an obstacle to these arrangements. Government guarantees can also be used to help offset the cost of capital reserves for provider-based integrated delivery vehicles. This would enable provider-led organizations to more easily compete to form the integrated systems that are favored under current law and take capitated risk.

Our health care reforms should be aimed at increasing choice and competition as a way to give consumers more options, and more opportunities to access affordable coverage. We all agree that access to continuous health coverage and good primary care is a basic element of good health care. It's an opportunity that should be available to every American regardless of their economic means. Whether we are aiming to reform our existing framework, or craft an entirely new policy approach to how we encourage consumers to pool risk and shop for coverage, there are some universal principles that should govern any policy prescription. I hope that the concepts that I outlined here today can represent a starting point to some of these concepts, and I'm grateful for the opportunity to present them to the committee today.

Dr. Gottlieb is a physician and Resident Fellow at the American Enterprise Institute. He consults with healthcare companies and firms that invest in them. He previously served on the Board of Directors to a Medicare Advantage plan, Bravo Health, which was acquired by Healthspring.

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- ^{xiii} Monopolizing medicine: Why hospital consolidation may increase healthcare costs. Scott Baltic, *Medical Economics*. February 24, 2014. <http://medicaleconomics.modernmedicine.com/medical-economics/content/tags/hospital-employment/monopolizing-medicine-why-hospital-consolidation-?page=full>
- ^{xiv} The impact of provider vertical consolidation on outpatient prescription drug-based cancer care spending. Rena M. Conti, Mary Beth Landrum, Mireille Jacobson. “We estimate a one percentage point increase in the proportion of medical providers affiliated with a health system is associated with a 5-22 percent increase in one year lagged inflation adjusted average per person annual spending and a 3-7 percent increase in one year lagged inflation adjusted prices for cancer treatment. The spending results appear partially but not solely driven by price increases... the main results that provider consolidation increases one year lagged spending and price for outpatient oncology treatment are robust to a variety of sensitivity checks on key variable definitions and inclusion and sample restrictions.” <file:///Users/ScottGottliebMD/Downloads/Impact-of-provider-vertical-consolidation.pdf>
- ^{xv} See Cory Capps, David Dranove, Walter J. McNeerney, Christopher Ody. The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending. The Institute for Policy Research Northwestern University Working Paper Series. February 2015 <http://www.ipr.northwestern.edu/publications/docs/workingpapers/2015/IPR-WP-15-02.pdf> and Lawton Robert Burns and Ralph W. Muller. Hospital-Physician Collaboration: Landscape of Economic Integration and Impact on Clinical Integration. *Milbank Quarterly* 2008;86:375–434 and Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Impact of payment method on behavior of primary care physicians: a systematic review. *Journal of Health Service Research Policy* 2001 Jan;6(1):44-55 Advisory Board, 1999 and Gosden T, Forland F, Kristiansen IS, Sutton M, Leese B, Giuffrida A, Sergison M, Pedersen L. Capitation, salary, fee-for-service and mixed systems of payment: effects on the behavior of primary care physicians. *Cochrane Database Systematic Reviews* 2000;(3) and Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24 and Douglas E. Hough, Kai Liu, David N. Gans. Size Matters: The Impact of Physician Practice Size on Productivity Innovation and Research, Medical Group Management Association. JEL Classification Codes: I11, D24
- ^{xvi} What We’ve Learned from Horizontal and Vertical Integration of Physicians. Lawton R. Burns and Aditi Sen. *Advances in Health Care Management’s Annual Review of Health Care Management*, April 25, 2014.
- ^{xvii} Is ACA Coverage Affordable for Low-Income People? Perspectives from Individuals in Six Cities. Kaiser Family Foundation Issue Brief. April 2016. Jennifer Tolbert, Robin Rudowitz, and Melissa Majerol. <http://files.kff.org/attachment/issue-brief-is-aca-coverage-affordable-for-low-income-people-perspectives-from-individuals-in-six-cities> “Participants expressed concern about their ability to afford the out-of-pocket costs related to their plan deductibles, especially those participants with higher deductible plans. Nearly all

participants reported their plan included an annual deductible that required them to pay out of pocket for services before their insurance would take effect. These deductibles ranged from less than \$500 to over \$6,000 for those with individual coverage and double these amounts for those with family coverage. When asked whether they could afford their full deductible, if needed, responses varied. While some said no, others had included the deductible in the calculation of their costs for the coverage and felt they could afford it. For participants enrolled in high deductible bronze plans, the costs associated with the deductibles prevented them from getting care they felt they needed”

^{xviii} High patient cost-sharing is the elephant in the room during election. Harris Meyer, Modern Healthcare. May 4, 2016. <http://www.modernhealthcare.com/article/20160504/BLOG/160509960/blog-high-patient-cost-sharing-is-the-elephant-in-the-room-during>

^{xix} The increasing instability of Obamacare. James C. Capretta, April 22, 2016. <http://www.aei.org/publication/the-increasing-instability-of-obamacare/> “But households with incomes above about 250 percent of the poverty line already find the plans offered on the ACA exchanges unattractive. Very few of these households have purchased plans through the exchanges.”

^{xx} ACA Standardized Plans, Star Ratings Pilot to Start in 2017. Sara Hansard, Bloomberg, May 2, 2016

^{xxi} Proposed Benefits And Payment Rule Includes Standardized Plans, New Network Adequacy Standards. Timothy Jost, Health Affairs Blog. November 20, 2015 <http://healthaffairs.org/blog/2015/11/20/proposed-benefits-and-payment-rule-includes-standardized-plans-new-network-adequacy-standards/>

^{xxii} On January 19, 2016, CMS issued new guidance regarding special enrollment periods that will no longer be used by the federal and state-based marketplaces and outlined future regulatory action on special enrollment periods. CMS also stated that the agency will conduct assessments of two frequently used special enrollment periods (related to loss of minimum essential coverage and permanent moves) to validate their proper use.

^{xxiii} Improving Health and Health Care, an Agenda for Reform. The American Enterprise Institute, Joseph Antos, James C. Capretta, Lanhee J. Chen, Scott Gottlieb, Yuval Levin, Thomas P. Miller, Ramesh Ponnuru, Avik Roy, Gail R. Wilensky, and David Wilson. December 2015. <https://www.aei.org/wp-content/uploads/2015/12/Improving-Health-and-Health-Care-online.pdf>

^{xxiv} In an Interim Final Rule that CMS released May 6, 2016, the agency would require individuals who try to get coverage via SEPs due to a permanent move have to show prior coverage was in effect

^{xxv} <http://www.medicareinteractive.org/wp-content/uploads/2015/08/SEP-Chart.pdf>

^{xxvi} Oliver Wyman, Special Enrollment Periods and the Non-Group, ACA-Compliant Market. Chris Carlson and Kurt Giesa, February 24, 2016.

^{xxvii} Defined as any insurance that covers “medical care,” such as major medical, or other definitions of qualified coverage as determined in the state of purchase.

^{xxviii} Bronze Woes Raise Flags That Issuers Could Drop Entire Metal Tier. Inside Health Policy, May 3, 2016. “Stakeholders are mixed on whether CMS’ proposed risk assessment changes could avert the potential departure of bronze options. The consultant who asked to remain unnamed believes the proposed changes are largely useless and -- with the possible exception of adding drug use data -- won’t sway the market in a new direction.”

^{xxix} Starting with Medicare private policies (now called Medicare Advantage), CMS began using inpatient diagnostic information for risk adjustment in 2000, and then improved the precision of the risk-adjustment system with the addition of professional encounter data for chronically ill people in 2004. The ACA has now carried this approach forward to the individual and small-employer markets

^{xxx} What Risk Adjustment Does — The Perspective Of A Health Insurance Actuary Who Relies On It. John Bertko, Health Affairs, March 29, 2016 <http://healthaffairs.org/blog/2016/03/29/what-risk-adjustment-does-the-perspective-of-a-health-insurance-actuary-who-relies-on-it/>

Mr. PITTS. The chair thanks the gentleman.
I now recognize Mr. Roy, 5 minutes for your summary.

STATEMENT OF AVIK ROY

Mr. ROY. Chairman Pitts, Ranking Member Green, and members of the Health Subcommittee of the Energy and Commerce Committee, thanks for inviting me to speak with you today. My name is Avik Roy. I am a senior fellow at the Manhattan Institute where I conduct research on health care reform.

In my remarks, I will focus on two areas. First, I will discuss flaws in the design of the ACA's insurance exchanges. Second, I will describe the principles and policies that Congress should consider in order to achieve better reform.

The ACA has reduced the number of uninsured, but its premiums on the exchanges have been so high that enrollment in the exchanges has been poor. 2016 enrollment was around 11 million, far below the CBO's original 21 million estimate.

The exchanges were built on a theory called the three-legged stool. First, the law would impose a raft of regulations to transfer costs from the sick to the healthy. Second, it would impose an individual mandate in order to force the healthy to purchase this highly costly coverage. Third, it would lessen the burden of the mandate for the poor using subsidies.

The problem is that the legs of the three-legged stool in the ACA were poorly designed. The regulatory leg is too long, driving up the cost of nongroup coverage. The mandate leg is too short, allowing healthier individuals to avoid buying costly coverage. And the subsidy leg is too wobbly to correct the imbalances of the other two legs.

By far, the law's most damaging regulation is its age-based community rating, forcing insurers to charge their oldest customers no more than three times what they charge their youngest. This has more than doubled the cost of health insurance for younger individuals in most States. Because the individual mandate's fines are so small relative to the cost of this coverage, young people are staying out. For most Americans, the ACA's subsidies don't offset far higher premiums. As a result, exchange enrollment for people with incomes above 250 percent of the Federal poverty level is well below 20 percent.

Furthermore, the ACA's subsidy system has proven to be extremely convoluted. It requires people to estimate their future income on a rolling monthly basis and then pay the government back if the Treasury Department determines that they have overestimated their eligibility.

In 2014, MI published Transcending ObamaCare, a health reform plan that would cover more people than the ACA but with far less Federal intervention than either current or prior law. Here are some key concepts from that plan that Congress should consider.

The most important thing Congress can do is to repeal the ACA's three-to-one community rating age band, which makes coverage unaffordable for young people. This discriminatory policy is the single greatest driver of the exchange's poor performance. Repeal of the age band can be paired with transitional funding for the near-elderly such that current enrollees can keep their current plan.

If the age band is repealed, a reformed system can preserve guaranteed issue and prohibit medical underwriting. In other words, it can protect those with preexisting conditions without an individual mandate. The mandate can be replaced with late enrollment penalties, a shorter open enrollment period, and the option of insurance contracts of 2 to 5 years instead of only 1 year on the current ACA exchanges.

Congress should put patients back in charge of their own healthcare dollars wherever possible. It should maximize personal choice and improve the flexibility of health savings accounts. It should repeal the ACA's tax increases, especially those like the health insurance tax, the medical device tax, and the drug tax, that directly translate into higher premiums.

Finally, Congress should replace the ACA's convoluted subsidy system with transparent, means-tested, age-adjusted tax credits. Some have proposed a uniform tax credit in which the poor and the wealthy receive the same financial assistance. That approach is unwise in my view because it severely limits the amount of assistance we can provide to the poor.

In 2017, the average exchange subsidy per subsidized enrollee, according to CBO, will be \$4,550. By contrast, one uniform tax credit proposal that has been widely circulated would offer a subsidy of \$2,100 to those in middle age regardless of need. That difference would be highly disruptive to the poor and the sick and result in millions fewer insured.

Instead, an ACA replacement should preserve a sliding scale of means-tested tax credits but do so based on income from the previous tax year. That way the IRS has verified income data with which to base its tax credit calculations.

Based on our fiscal modeling, the reforms described above, combined with others, could reduce Federal spending by \$10 trillion over the next three decades and increase the number of individuals with health insurance by 12 million over and above current law, and they would reduce the cost of single health insurance policies by 18 percent by 2021.

The ACA's shortcomings should not discourage Congress from striving to achieve the law's stated goal, affordable health coverage for every American. That objective remains as important as ever.

Thanks again for having me. I look forward to your questions and of being of further assistance to this committee.

[The prepared statement of Mr. Roy follows:]

MANHATTAN
INSTITUTE

TESTIMONY BEFORE THE UNITED STATES CONGRESS

House Committee on Energy & Commerce

Subcommittee on Health

TRANSCENDING OBAMACARE

Achieving Truly Affordable, Patient-Centered,
Near-Universal Coverage

AVIK S. A. ROY

Manhattan Institute for Policy Research

May 11, 2016

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INTRODUCTION

There is no issue more important to the future of America than its long-term fiscal sustainability. And the long-term fiscal sustainability of the United States has been placed in jeopardy primarily by the structure and expense of America's federally sponsored health insurance programs.

In addition, one of the principal economic challenges faced by middle- and lower-income Americans is the expense and instability of American health insurance. Health insurance keeps getting more and more expensive, forcing many families to choose between paying health care bills and buying other essential goods and services.

These problems, rightly, remain at the center of our public policy debate.

THE ACA HAS DRAMATICALLY INCREASED THE COST OF INDIVIDUALLY-PURCHASED HEALTH INSURANCE

The Affordable Care Act, passed in 2010, sought to reduce the number of Americans without health insurance, primarily through two mechanisms: (1) expanding eligibility for Medicaid to all adults with incomes below 138% of the Federal Poverty Level; and (2) creating a network of health insurance exchanges, sometimes called "marketplaces," to deliver regulated and subsidized private insurance coverage to those with incomes between 100% and 400% of FPL.

While the ACA has reduced the number of Americans who are uninsured, it has fallen far short of the Congressional Budget Office's 2010 coverage projections, and has exacerbated several other long-standing problems with the U.S. health care system, most notably the high cost of American health insurance.

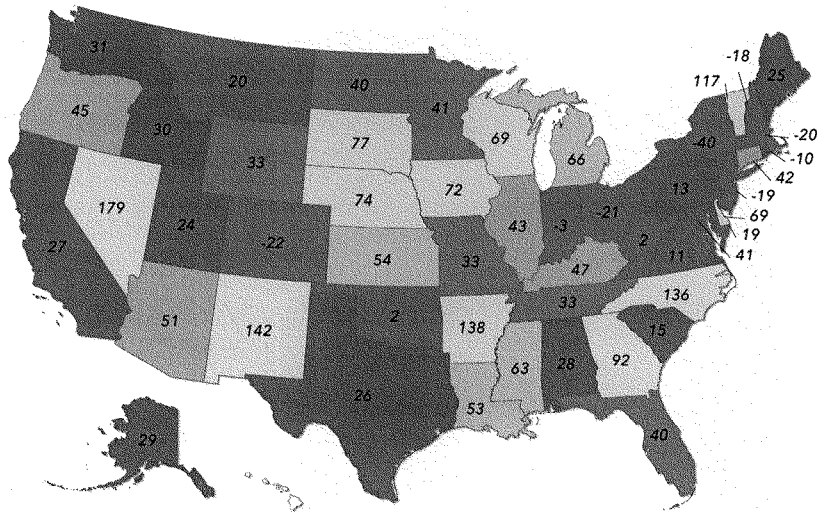
The ACA imposed significant regulatory changes upon the market for individually-purchased, or *non-group*, health insurance; i.e., those who do not obtain employer-sponsored or government-sponsored coverage, but purchase coverage on their own. These regulatory changes have dramatically increased non-group insurance premiums in most of the United States.

A Manhattan Institute study that I co-authored examined non-group health insurance premiums in 3,137 U.S. counties in 2013 (before the ACA's regulatory changes went into effect) and 2014 (after they went into effect). It found that in the average county, the ACA's regulatory changes increased non-group premiums by 49%. That 49% increase is adjusted to account for the ACA's requirement that insurers offer coverage to those with pre-existing conditions; i.e., for those without pre-existing conditions, the 2014 premium increase was significantly higher than 49%.¹ ACA exchange-based premiums increased by an additional

¹ Roy A, 3,137-County Analysis: Obamacare Increased 2014 Individual-Market Premiums By 49%. *Forbes*. 2014 Jun 18; <http://www.forbes.com/sites/theapothecary/2014/06/18/3137-county-analysis-obamacare-increased-2014-individual-market-premiums-by-average-of-49>.

5% in 2015² and 11% in 2016³, on average, with large double-digit increases common in specific jurisdictions.

Figure 1. Change in Individual-Market Premiums Under ACA, 2013-2014 (Percent)



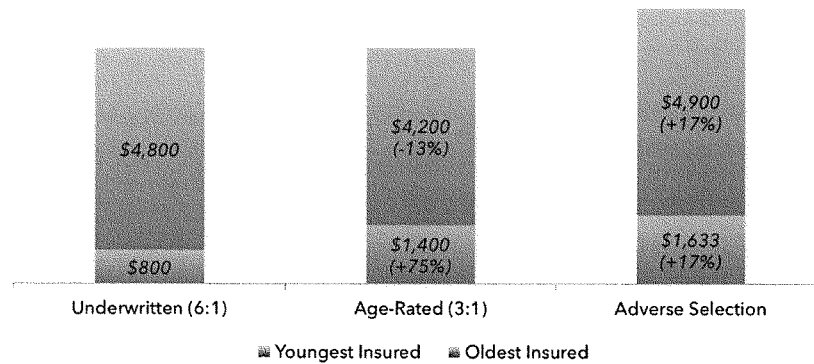
Rate shock in the non-group health insurance market. Prior to 2010, the market for health insurance purchased by individuals on their own was almost entirely regulated by states. The ACA added a new—and costly—layer of federal regulation upon this market. Many healthy individuals experienced rate increases of 100 to 200 percent. Even when taking into account those with pre-existing conditions, the ACA increased underlying rates in the average county by 49 percent. (Source: *Manhattan Institute*)

² Gonshorowski D, 2015 ACA-Exchange-Premiums Update: Premiums Still Rising. Heritage Foundation. 2015 Mar 20; http://thf_media.s3.amazonaws.com/2015/pdf/IB4366.pdf.

³ Manatt, Phelps & Phillips. HIX Compare 2015-2016 Datasets. 2016 May; <http://www.rwjf.org/en/library/research/2015/12/hix-compare-2015-2016-datasets.html>.

These rate increases were especially punitive for younger and healthier individuals. As a result, the ACA exchanges have largely failed to enroll these individuals, except in cases where their premiums were entirely, or nearly entirely, subsidized by federal premium assistance.

Figure 2. An Illustration of Age-Based Community Rating and Adverse Selection



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 forcing most young people to purchase government-certified insurance.

Because ACA-based premiums have been so high, enrollment in the exchanges has been significantly lower than expected. At the end of the 2016 enrollment period, the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation reported that 12.7 million individuals "selected, or were automatically

reenrolled into, a 2016 Marketplace plan.”⁴ If we assume a 15% attrition rate; i.e., those who select a plan but fail to pay the required premiums, we arrive at a 2016 enrollment of 10.8 million: a net increase of 1.7 million from 2015 levels, and far below the Congressional Budget Office’s 2010 projection that 21 million individuals would be enrolled in the exchanges in 2016.⁵

THE ACA’S FLAWED ‘THREE-LEGGED STOOL’ DESIGN

The high cost of ACA exchange-based coverage, and the resulting shortfall in exchange-based enrollment, was unsurprising to actuarial experts.

The ACA’s exchanges were built on a theory called the “three-legged stool.” First, a raft of federal regulations would be imposed on the non-group market, in order to redistribute premium costs from the sick to the healthy. Second, the ACA would impose an individual mandate, requiring most Americans to buy health insurance, in order to force healthy individuals to purchase coverage well in excess of their actuarial needs. Third, in order to mitigate the cost of mandated insurance coverage for low-income individuals, the ACA created a sliding scale of premium assistance and cost-sharing subsidies.

MIT economist Jonathan Gruber, in particular, has argued that each leg of the “three-legged stool” is essential to the proper functioning of the ACA’s insurance exchanges.⁶ However, the three-legged stool theory has not been entirely borne out by the performance of the exchanges.

The ACA dramatically increased the cost of non-group health insurance for people with a low probability of consuming costly health care services. By far, the most damaging ACA regulation in this regard is age-based community rating, whereby insurers must charge their oldest customers no more than three times what they charge their youngest customers. On average, 64-year-old Americans consume six times as much health care, in dollar value, as the average 21-year-old. If both young and old people remain in the insurance pool—i.e., there is no adverse selection—21-year-olds face a premium increase of 75%. If younger individuals drop out of the market, premiums can increase by more than 100%.

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.

Finally, for most Americans, the ACA’s sliding scale of subsidies do not fully offset the higher underlying cost of ACA-based coverage. For example, an individual whose premiums have increased by \$100 per month, and is eligible for a \$70 per month ACA premium subsidy, is still paying a net of \$30 per month more in health coverage, even without considering the adverse impact of higher government spending on insurance subsidies.

⁴ HHS Office of the Assistant Secretary for Planning and Evaluation, Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report. 2016 Mar 11; <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>.

⁵ Elmendorf D *et al.*, Letter to the Hon. Nancy Pelosi. 2010 Mar 20; <https://www.cbo.gov/publication/21351>.

⁶ Gruber J, Health Care Reform Is a “Three Legged Stool.” Center for American Progress. 2010 Aug 5; <https://www.americanprogress.org/issues/healthcare/report/2010/08/05/8226/health-care-reform-is-a-three-legged-stool>.

Our work at the Manhattan Institute, and the work of others, indicates that the uninsured are highly sensitive to their net premiums, inclusive of subsidies. In 2015, 76% of those with incomes between 100 and 150% of FPL eligible for exchange-based coverage enrolled; but only 41% of those with incomes between 151 and 200% of FPL did. 30%, 20%, 16%, and 2% enrolled in the income ranges of 201-250% FPL, 251-300% FPL, 301-400% FPL, and over 400% FPL, respectively.⁷

Furthermore, the ACA's system of means-tested subsidies has proven to be extremely difficult to administer, leading to a significant amount of waste, fraud, and abuse. It requires enrollees to estimate their future income on a rolling monthly basis, and then pay the government back if the Treasury department determines that they have underestimated that income (i.e., overestimated their eligibility for subsidies).

To extend the metaphor, the legs of the ACA's three-legged stool are of different lengths. The regulatory leg is too long, driving up the cost of exchange-based coverage. The mandate leg is too short, encouraging healthier individuals to avoid buying unaffordable coverage. And the subsidy leg is too wobbly to correct the imbalances of the other two legs.

PRINCIPLES OF NON-GROUP HEALTH INSURANCE REFORM

In contrast to the ACA, a robust non-group health insurance market will contain the following features, as discussed in the Manhattan Institute publication *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*.⁸

- *Put patients in control of their health care dollars.* Individuals should enjoy a wide range of choices in the way their health coverage is designed. For example, they should be able to choose from a wide variety of financial payout structures (i.e. actuarial value) and a wide range of covered health care services (i.e. essential health benefits). Patients should have the option to pay for more of their health care directly, through health savings accounts and other instruments, instead of being dependent upon health insurance companies.
- *Affordable premiums for young enrollees.* A well-functioning market will not require healthy and/or young enrollees to pay gross premiums (i.e., prior to the impact of subsidies) that are significantly out of line with their near-term consumption of health care services (i.e., their actuarial risk).
- *Voluntary participation.* No one should be forced by Congress to purchase health insurance against their will.
- *Affordable premiums and guaranteed coverage for sick enrollees and those with pre-existing conditions.* Direct, transparent premium and cost-sharing assistance can provide affordable coverage to those with higher actuarial risk, without driving out the healthy and the young.
- *Streamlined system of tax credits.* The ACA's convoluted system of direct and indirect subsidies should be replaced with a more transparent, tax credit-based system that reduces the incidence of waste, fraud, and abuse, while providing assistance to those in need.

⁷ Pearson C, Exchanges Struggle to Enroll Consumers as Income Increases. Avalere Health. 2015 Mar 25; <http://avalere.com/expertise/managed-care/insights/exchanges-struggle-to-enroll-consumers-as-income-increases>.

⁸ Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. Manhattan Institute. 2014 Aug 13; <http://www.manhattan-institute.org/html/transcending-obamacare-patient-centered-plan-near-universal-coverage-and-permanent-fiscal>.

- *Gradual transition to the reformed system.* Any replacement or reform of the ACA's exchanges should ensure that ACA enrollees face minimal disruption to their existing coverage arrangements.

TRANSITIONING TO A REFORMED SYSTEM

Congressional Republicans have repeatedly and consistently promised to repeal the ACA and replace it with a better system. A bill to replace the ACA that embodies the above reform principles should contain the following provisions:

- *Reduce premium costs and expand patient choice.* Congress should leave regulation of the design of non-group health insurance to the states wherever possible. It should allow for "copper plans" with a lower actuarial value, and offer other catastrophic coverage options. It should minimize the prescriptiveness of essential health benefits and cost-sharing limits, so as to encourage innovation in the design of affordable health insurance. It should improve the compatibility of exchange-based coverage with health savings accounts. It should repeal the ACA's tax increases, including those that directly increase ACA-based premiums, such as the health insurance premium tax, the medical device tax, and the pharmaceutical product tax.
- *Repeal the ACA's discrimination against young enrollees.* The ACA's 3:1 age band should be repealed; insurers should be free to charge prices that fully reflect the age of their enrollees, in order to make coverage affordable for the young.
- *Subsidized coverage for the sick and near-elderly.* A reformed system should allow for tax credits to increase as enrollees get older, in order to compensate for the repeal of age-based community rating. A reformed system can preserve guaranteed issue and the prohibition against medical underwriting (i.e., requiring insurers to cover those with pre-existing conditions and charge the same prices to those of similar age regardless of health status) without an individual mandate.
- *Repeal the ACA's individual mandate.* A well-functioning non-group insurance market does not require the constitutional injury of an individual mandate. The ACA's mandate can be replaced with late enrollment penalties, a more limited open enrollment period, and the option of insurance contracts of two to five years instead of only one year.
- *Means-tested, age-adjusted, tax-credit-based premium assistance.* It is important for an ACA replacement to means test its health insurance tax credits. Some scholars have proposed a flat, uniform tax credit in which the poor and the wealthy receive the same amount of financial assistance. Such an approach is unwise, because it severely limits the amount of assistance Congress can provide to those near the poverty line. According to the Congressional Budget Office, the average exchange subsidy per subsidized enrollee in 2017 will be \$4,550, and \$4,670 in 2018.⁹ By contrast, one widely circulated proposal to replace the ACA with a uniform tax credit would offer a subsidy of \$2,100 to those in middle age, regardless of need.¹⁰ Such an approach would be significantly disruptive to those with poor health status and/or low incomes, and would likely result in fewer people with health insurance relative to current law. Instead, a replacement for the ACA should preserve a sliding scale of means-tested tax credits, but do so based on income from the previous tax year. That way, the IRS has verified income data from which to base its tax credit calculations.

⁹ Hall K, *Federal Subsidies for Health Insurance Coverage for People Under Age 65: 2016 to 2026*. Congressional Budget Office. 2016 Mar 24; <https://www.cbo.gov/publication/51385>.

¹⁰ Anderson JH, *A Winning Alternative to Obamacare*. The 2017 Project. 2014 Feb; <http://2017project.org/site/wp-content/uploads/2014/02/An-Obamacare-Alternative-Full-Proposal.pdf>.

- *Transitional considerations.* Those who prefer to retain their existing exchange-based coverage, with existing subsidy levels, should be allowed to do so for several years, in order to minimize disruption to those on ACA-sponsored plans.

IMPACT OF REFORM ON FEDERAL SPENDING AND THE UNINSURANCE RATE

If Congress were to reform the non-group health insurance market along these lines, the likely result would be more affordable coverage, and a larger number of individuals with health insurance.

Based on CBO-style fiscal modeling conducted by the Stephen Parente of the University of Minnesota and the Manhattan Institute, the reforms described above could reduce federal spending by \$10 trillion over three decades. By 2025, it would increase the number of individuals with health insurance by 12.1 million, over and above current law. And it would reduce the cost of single health insurance policies by 18 percent over the same time frame.¹¹

Once Congress has replaced the ACA with a better system for non-group coverage, it should consider expanding access to that market to people currently enrolled in Medicaid. Medicaid's health outcomes are no better than those for individuals with no health insurance at all; access to a robust market for private coverage could significantly improve health outcomes for the poor, without increasing federal spending.^{12 13}

No one believes that the ACA's health insurance exchanges were perfectly designed. The evidence is mounting that they were in fact quite poorly designed. The ACA's shortcomings should not discourage Congress from striving to achieve the law's stated goal: affordable health coverage for every American. That objective remains as important as ever, and Congress has the ability to make that goal a reality.

¹¹ Roy A, *Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency*. Manhattan Institute. 2014 Aug 13; <http://www.manhattan-institute.org/html/transcending-obamacare-patient-centered-plan-near-universal-coverage-and-permanent-fiscal>.

¹² Roy A, Oregon Study: Medicaid 'Had No Significant Effect' On Health Outcomes vs. Being Uninsured. *Forbes*. 2013 May 2; <http://www.forbes.com/sites/theapothecary/2013/05/02/oregon-study-medicare-had-no-significant-effect-on-health-outcomes-vs-being-uninsured/#4829d92173aa>.

¹³ Roy A, *How Medicaid Fails the Poor*. Encounter Books. 2013.

Mr. PITTS. The chair thanks the gentleman.

Ms. Corlette, you are recognized for 5 minutes for your summary.

STATEMENT OF SABRINA CORLETTE

Ms. CORLETTE. Thank you, Chairman Pitts and Ranking Member Green. Thank you for the opportunity to testify today.

I am going to make two primary points. First, the Affordable Care Act has led to an unprecedented expansion in access to affordable comprehensive health insurance. And second, 6 years in, we have new opportunities to build on and strengthen the law in order to ensure its benefits can be truly universal.

The last time I sat before you, it was just after the launch of the ACA's health insurance marketplaces. Many were questioning whether the law would work. What a difference 2 years makes. Since the rollout of the ACA, we have strong evidence of improved access, the ACA has expanded health insurance coverage to 20 million people, and as a result, the number of uninsured Americans is at its lowest level in 5 decades with almost 90 percent of people now covered, an end of health status discrimination. Up to 122 million Americans with a preexisting condition now have peace of mind that if they leave work to care for a loved one, start a new business, or go back to school, they will no longer be denied access to affordable health insurance.

Improved quality of coverage. The ACA's reforms have improved not only access to coverage, but the quality. The vast majority of people newly enrolled are satisfied with their new health insurance plan and the doctors in it.

And bending the cost curve. The ACA has contributed to an unprecedented slowdown in healthcare cost growth. Further, several of the payment and delivery system reform experiments launched by the ACA are offering some hope that we can reduce waste, lower costs, and maintain the quality of care for patients.

To understand how far we have come, it is helpful to pause and remember where we were before the ACA. Back then, the individual insurance market suffered from a lack of access. As many as 40 percent of applicants were denied coverage because of a preexisting condition.

Inadequate coverage. Before the ACA, in most states insurers were permitted to permanently exclude any preexisting conditions, and many excluded maternity coverage, mental health, and prescription drugs as a matter of course. Deductibles of \$10,000 or more were not uncommon, and many policies came with lifetime or annual caps on benefits.

And coverage was often unaffordable. Before the ACA, 70 percent of people with health problems reported it very difficult or impossible to find an affordable plan.

At the same time, none of the nightmare scenarios that some ACA opponents predicted have come to pass. The ACA has not caused employers to drop coverage for their workers, nor has it resulted in reductions in employment. On the whole, coverage trends for ESI have remained stable.

No law is perfect, and the ACA is not perfect. Six years in, I encourage members of this subcommittee to consider some pragmatic improvements, including providing incentives to States to expand

Medicaid. In 19 states, families just below the poverty line are denied access to coverage because they don't make enough money to be eligible for the marketplace tax credits. Congress should adopt the President's proposal to allow any state that expands Medicaid to receive a 100 percent match for the first 3 years.

Fix the family glitch. Congress can and should clarify the law to ensure that working families are able to access the tax credits.

Improve affordability. Even with those tax credits and cost-sharing reductions, many low- and moderate-income Americans face very high costs when they purchase insurance. I encourage Congress to reduce the amount of income families are expected to contribute and to improve cost-sharing support.

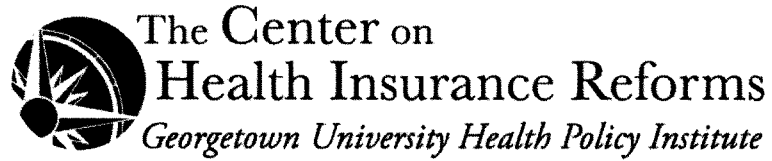
Support outreach and enrollment assistance. As many as 16 million Americans are eligible for but not enrolled in either Medicaid or subsidized marketplace insurance. Many just don't know about the availability of these coverage options and the financial help, and they need assistance through the enrollment process. A relatively small investment in funds could ensure that more people are enrolled in the coverage that is right for them.

And make the plan shopping experience as easy as possible. The marketplaces need a stronger infrastructure to support eligibility determinations and the plan shopping experience. This should include improved call centers and appeals processes, as well as better Web-based tools.

The ACA has ushered in much-needed reforms that have dramatically improved access to affordable, high-quality coverage. In just 2 short years, these changes have helped to reduce the percentage of uninsured to its lowest point in over a generation, and that is a huge accomplishment. However, we are also beginning to see areas in which we can build on and improve the law to make it work better for more people.

I look forward to the discussion of how best to achieve that. Thank you.

[The prepared statement of Ms. Corlette follows:]



**U.S. House of Representatives Committee on Energy and Commerce
Subcommittee on Health
Hearing: "Health Care Solutions: Increasing Patient Choice and Plan Innovation"
May 11, 2016**

**Statement of Sabrina Corlette, J.D.
Research Professor and Project Director
Center on Health Insurance Reforms
McCourt School of Public Policy
Georgetown University**

Chairman Pitts, Ranking Member Green, and members of this subcommittee: Thank you for the opportunity to participate in today's hearing about patient choice and health plan innovation. My name is Sabrina Corlette. I am a research professor at Georgetown University's Center on Health Insurance Reforms. However, the views I share here today are my own and do not represent those of the university, its faculty or staff.

Having affordable, adequate health insurance coverage is essential to the health and financial vitality of American families. People without health insurance are significantly less likely to receive necessary care, and a lack of meaningful coverage has resulted in medical debt being a primary cause of personal bankruptcies.¹

In my testimony today I'll make two primary points: (1) The Affordable Care Act (ACA) has led to an unprecedented expansion in access to affordable, comprehensive health insurance and (2) Six years in, we have new opportunities to build on and strengthen the law in order to ensure its benefits can reach all citizens.

The Affordable Care Act has expanded access to affordable, comprehensive coverage

The last time I sat before you, in November 2013, it was just after the launch of the ACA's health insurance marketplaces. Many were questioning whether the law's reforms would work.

What a difference two years makes. Since the roll out of the ACA's reforms and the marketplaces in January 2014, we have strong evidence of:

- *Improved access.* The ACA has expanded health coverage to 20 million people.² As a result, the number of uninsured Americans is at its lowest level in five decades, with almost 90 percent of people now covered.³ This has been an amazing success story, especially given that 19 states have not yet expanded Medicaid.⁴
- *End of health status discrimination.* Up to 122 million Americans with a "pre-existing condition" now have peace of mind that if they need to leave work to care for a loved one, start a new business, or go back to school, they will no longer be denied access to affordable health insurance.⁵
- *Improved quality of coverage.* The ACA's reforms have improved not only access to coverage, but the quality of that coverage. The vast majority (86 percent) of people newly enrolled in marketplace or Medicaid coverage are satisfied with their new health insurance plan. And 91 percent with marketplace or Medicaid coverage are satisfied with the doctors in their plan.⁶
- *Improved financial wellbeing.* The ACA is improving the financial wellbeing of low-income families. Recent research has shown that new Medicaid enrollees have been able to reduce their medical debt by approximately \$600 to \$1,000 each year.⁷
- *Improved economy.* The ACA has also been good for the economy. The health care sector is reporting record job growth, accounting for over 500,000 new jobs in the last year and ¼ of all new jobs in the Department of Labor's April jobs report.⁸

- *Bending the cost curve.* The ACA has contributed to an unprecedented slowdown in health care cost growth. Since the ACA was enacted, health care prices have grown at the slowest rate for any comparable period in the last half century.⁹ Further, several of the payment and delivery system reform experiments launched by the ACA are offering hope that we can reduce waste, lower costs *and* maintain the quality of care for patients.

To understand how far we have come, it's helpful to pause and remember where we were, before the ACA was enacted. As *Business Insider* magazine put it at the time, the insurance market was a "basket case."¹⁰ Until the ACA ushered in sweeping insurance reforms, the individual insurance market suffered from:

- *Lack of access to coverage because of health status discrimination.* Before the ACA, if you wanted health insurance, in most states you had to fill out a voluminous application that included detailed information about your health history and status.¹¹ As many as 40 percent of applicants were denied coverage because of a pre-existing condition.¹²
- *Inadequate coverage.* Before the ACA, the insurance coverage available to individuals buying on their own fell far short of the coverage available to people with employer-sponsored insurance. In most states, insurers were permitted to permanently exclude from coverage any pre-existing conditions, and many excluded from coverage maternity benefits, mental health services and prescription drugs as a matter of course.¹³

Deductibles of \$10,000 or more were not uncommon, and many policies came with annual or lifetime caps on benefits.¹⁴

- *Unaffordable coverage.* Before the ACA, coverage was the least affordable for people who needed it the most. Seventy percent of people with health problems reported it “very difficult” or “impossible” to find an affordable plan, compared with 45 percent of people in better health.¹⁵ A Kaiser Family Foundation study of rating practices found rate variation of more than nine-fold for the same policy based on age and health status.¹⁶

At the same time, none of the nightmare scenarios that some ACA opponents predicted have come to pass. The ACA has not caused employers to drop coverage for their workers, nor has it resulted in reductions in employment. On the contrary, the employment-to-population ratio in 2015 was higher than expected.¹⁷ Companies are also not shifting full-time workers to part-time status.¹⁸ And on the whole, coverage trends for employer-based plans have remained stable under the ACA.¹⁹

Building on and Strengthening the ACA

No law is perfect, and the ACA is not perfect. Six years in, I would encourage members of this Committee to consider some pragmatic improvements that could ensure the benefits of the law are extended to more people, particularly individuals of low- and moderate-income. My suggestions include:

- *Provide incentives to states to expand Medicaid.* In 19 states, families just below the poverty line are often denied access to coverage because they do not make enough money to be eligible for marketplace tax credits. Congress should adopt the President's proposal to allow any state that expands Medicaid to receive a 100 percent match for the first three years, consistent with the policy envisioned when the ACA was enacted.
- *Fix the family glitch.* Although I believe the Treasury Department has the authority to do this administratively, Congress can and should clarify the law to ensure that working families are able to access the marketplace tax credits. Doing so could help ensure that 4.7 million Americans have access to affordable coverage.
- *Improve affordability.* Even with the ACA's premium tax credits and cost-sharing reductions, many low- and moderate-income Americans face very high costs when they purchase insurance. For some, given their incomes, the marketplace subsidies are not sufficient to prompt them to enroll or to maintain coverage. I encourage Congress to consider proposals from the Urban Institute and others to reduce the amount of income families are expected to contribute to premiums, and to improve cost-sharing support.²⁰
- *Support outreach and enrollment assistance.* As many as 16 million Americans are eligible for but not enrolled in either Medicaid or subsidized marketplace insurance.²¹ Many lack information about the availability of coverage options and financial help and need assistance with the eligibility and enrollment process. A relatively small investment in funds could ensure that more people are enrolled in the coverage that's right for them.

- *Make the plan shopping experience as easy as possible.* The marketplaces need a stronger infrastructure to support eligibility determinations and the plan shopping experience. This should include improved call centers and appeals processes, as well as better web-based tools to support informed decision-making.

Conclusion

The ACA has ushered in much needed reforms that have dramatically improved access to affordable, high-quality coverage. In just two short years these changes have helped to reduce the percentage of uninsured to its lowest point in over a generation – a huge accomplishment. However, we are also beginning to see areas in which we can build on and improve the law to make it work better for more people. I look forward to the discussion of how best to achieve that. Thank you.

¹ Collins SR, Robertson R, Garber T, and Doty MM, "Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act," April 2013. Available from: http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

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Mr. PITTS. The chair thanks the gentlelady, thanks each of our witnesses for your testimony. You have each provided thoughtful testimony. And so we will now begin questioning. I will recognize myself for 5 minutes for that purpose.

Mr. Roy, we will begin with you. You have advised several high-level officials and candidates on health policy. Would you please describe some of the commonalities in the health reform plans offered by conservatives?

Mr. ROY. Yes. So I was also a co-author of the plan that Dr. Gottlieb mentioned that was published by the American Enterprise Institute. So to take that plan as an example and the plan that we published at the Manhattan Institute as two examples, both of them the common element is replacing the ACA with a system of tax credits in which patients control their own healthcare dollars.

The challenge with the ACA is twofold. One, a lot of discrimination against younger and healthy enrollees. And, two, the fact that there is very limited choice in the type of health insurance you can buy.

And so the key commonalities here are to offer tax credits that help the uninsured afford coverage, but to make sure that people have a much wider range of choices in how they purchase coverage and the type of coverage they buy, and also to make sure that they have the opportunity not simply to use insurance to pay for health care, but to use health savings accounts.

Mr. PITTS. Thank you.

Dr. Gottlieb, in addition to being a physician, you have counseled various healthcare companies and firms on Federal policy. Would you please talk about any of the components of previous or current alternatives to the Affordable Care Act that you are convinced will increase choice and competition?

Dr. GOTTLIEB. I will just touch on one. I think in terms of new health plan formation and new carriers entering the market, probably the single biggest obstacle has been the caps on the operating margins of plans, and I am talking here about the caps on the MLR. Because a new plan is going to have to spend a higher amount of its revenue on its overhead at the outset, and by capping the operating margin, you are discouraging capital formation, new carriers from entering the market.

If you look at what has happened since 2008, there has been no new net health plan formation, and by that I mean new carriers. So when we talk about new health plans entering the market, we are talking about existing insurers just entering exchanges with differently named products but not new health insurers.

And the analysis I am talking about actually goes back to last year, and it incorporated all the co-ops and the provider-sponsored plans. A lot of those—some of those have exited the market.

So I would submit that it is probably the case, that there has been a net formation of new healthcare carriers since 2008.

Mr. PITTS. Would the result or the effect of such components result in lower costs for patients?

Dr. GOTTLIEB. Well, I think the opportunity for new plans to enter the market is going to result in more competition between different insurers and ultimately is going to lead to lower costs. I think when we look at premium costs, in particular for individuals,

we have to look at it on a weighted basis, meaning that we look at the average premium increase, but we need to look at premium increases on the basis of where people are enrolling.

And it is the case that premiums are going up for the plans that have the highest enrollment because they are the ones facing the biggest losses in the market right now. I think by creating more competition between different plans, ultimately you are going to create more competition between premiums as well.

Mr. PITTS. Thank you.

Ms. Corlette, you mentioned that, "Even with the ACA's premium tax credits and cost-sharing reductions, many low- and moderate-income Americans face very high cost when they purchase insurance."

Absent more government mandates, more Federal spending, what would you propose that would help these patients receive care at a fair cost?

Ms. CORLETTE. Thank you, Mr. Chairman.

So one of the problems is that health insurance itself is an extremely expensive product. The average family premium for an employer-based plan is in the neighborhood of \$17,000 a year. So I think you are absolutely correct to point out, and as I pointed out and others have in their testimony, the Federal Government can't pick up that entire tab.

So the key is to get at what is driving that \$17,000 cost for a family policy, which is extremely expensive. And that, frankly, goes to the fact that we have an inefficient delivery system. We are spending 30 percent of healthcare DDP on wasteful and unnecessary care.

So, frankly, my proposals for getting at cost containment in health insurance would really target the delivery system and the way we pay for the delivery of those healthcare services.

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

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

Mr. GREEN. Thank you, Mr. Chairman.

Again, I want to thank our witnesses.

Mr. Roy, some of us were on the committee when we were drafting the Affordable Care Act in 2008 and 2009. I know it is something that somebody in academia may not understand, but we actually have to legislate, even when it is a majority of Democrats, just like a majority of Republicans.

The Affordable Care Act was built on our traditional insurance system that was started during World War II and continued, where in our country, unlike the countries we rebuilt in World War II that created some type of national care, whether it be Japan, Germany, France, Europe. And so we were building on that. So free enterprise was involved in it. And that is why the Affordable Care Act, it is not government—of course we regulate insurance, but it is based on that. And that was the decision made, that we would use this tried-and-true method, even though I think it is not as effective as other plans. But that is why we have this.

Of course my biggest issue in my home State of Texas is that Texas has not expanded Medicaid, leaving more than 1.2 million vulnerable low-income Texans without coverage. In fact, in our dis-

trict, I have 50,000 constituents in an urban district in Houston who would have Medicaid if the states expanded it. I hope that my state will expand it, and I am willing to work with them. I have said this for a number of years. For every one dollar my home state would pay in Medicaid expansion, it would earn back \$1.30 in new economic activity.

But the hearing today is about private insurance and ways to make it stable. It is clear that marketplaces are working, and the individual insurance market increased in size by 46 percent in the first year of enrollment alone. We need to continue to improve, however, and insurance markets function best when there is a large number of customers to spread the risk and keep costs down.

Before we consider revising or backtracking on the progress we have made, one important thing we can do to stabilize the individual insurance market is to grow it. The more people enrolled, the greater the risk pool, the more stability we will see. There are more than 10 million Americans who are uninsured and eligible for marketplace coverage. Seven million of those were eligible for tax credits to help them pay their premiums.

Ms. Corlette, initial research shows that Americans have a wide variation in knowledge of the options available on the ACA's exchanges and the assistance that can be made available. Could you discuss some of the harder-to-reach marketplace populations?

Ms. CORLETTE. Yes. Thank you.

So estimates are that we have between 29 and 31 million uninsured Americans, and many of them are uninsured because, as you pointed out, Congressman, they are in the Medicaid coverage gap.

Mr. GREEN. So that includes Medicaid?

Ms. CORLETTE. It does. But also some are just simply ineligible. They may be undocumented or they have other sources of coverage.

But among those who are eligible for the marketplaces and would benefit the most from the financial assistance that is available, a recent study found that many live in families receiving EITC or other public benefits, such as SNAP. Many also have a school-age child in the home. These are avenues that the Federal Government could take advantage of to do targeted outreach, to educate these individuals not only about the coverage that is available, but also the financial assistance that can help make that coverage affordable.

Mr. GREEN. OK. One of the issues I hear, and I heard it just this morning with a group of insurers, can you discuss the benefits of the medical loss ratio? Of course, let me explain my background. I managed a small business, and at one time it was hard to even get companies to offer us insurance for our small business.

But the medical loss ratio, the 80 percent of that premium has to go to health care. And, to me, most employers would say we are getting a return on our money. And could you talk about the importance of that benefit?

Ms. CORLETTE. Yes. Sure. The medical loss ratio basically says that of the premiums a health insurance company collects, 80 percent, or in the case of a large group 85 percent, has to go back towards the benefits that they are supposed to be covering. So it is an important consumer protection. Before this standard went into effect, you would see in the market companies with loss ratios of

50 percent, 60 percent. That means the company was pocketing close to half of the premium that they were collecting from the consumer or the small business. So the medical loss ratio is really just designed to bring more value to the purchaser.

Mr. GREEN. Thank you, Mr. Chairman. I will yield back my time.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the vice chair of the sub, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you.

And these questions are for Mr. Roy. We have instances of people purchasing health insurance under the ACA when they are sick, and it distorts the market for other people participating. Patients need to get access to care. That is important. But we also want patients to keep their coverage. There have been various ideas put forward about the best ways to help patients keep care and give market stability.

Medicare part D incentivizes participation by using late enrollment assessments. Patients are encouraged to join Medicare part D during their initial enrollment period because if they choose not to, their premium will be slightly higher. Do you believe this same model would be useful in the private health insurance market?

Mr. ROY. Yes, Mr. Guthrie, I think that that is one of the points I was making in my prepared remarks where I discussed the fact that we don't need an individual mandate to have a system that works to protect people who have preexisting conditions, expand access, and be nondiscriminatory towards the healthy, while also discouraging people from dropping in and out of the system just when they are sick.

If you have late enrollment penalties and other techniques, such as a tight open enrollment period, perhaps longer insurance contracts, those are all options on the table that help incentivize people voluntarily to be involved in their insurance continuously.

Mr. GUTHRIE. Similarly, and you have covered some of this, but according to CMS, the part D late enrollment assessment is 1 percent of the national base beneficiary premium times the number of full, uncovered months a beneficiary did not have part D or credible coverage.

I think we can agree that Medicare part D is one of the most successful Federal healthcare programs. Could this reasonable guard-rail also help improve private care programs?

Mr. ROY. Absolutely. So one of the reasons why that particular provision is useful is that it modulates the late enrollment penalty based on how far away you are from the open enrollment period. So that way if you are really trying to game the system or the economic equivalent of that, the penalty is larger in that way. The penalty is well calibrated to the severity of how much you are going in and out of the system. So it makes the penalty as light as it needs to be but as effective as it needs to be to discourage that dropping in and out of the system.

Mr. GUTHRIE. OK. And then another question. Another market lever to discourage people from only buying health care when they are sick is waiting periods. Let's say a patient gets a tough diagnosis and they rush to buy health care for the first time. Could a one-, two-, or three-month waiting period for a plan to become ac-

tive encourage people to enter private markets while they are healthy instead of waiting until they are sick?

Mr. ROY. Yes, it could. And, again, one thing that would tie in with that is longer insurance contracts. So if you have an open enrollment period every year, you still create a lot of incentive for adverse selection because people can change plans every year based on their health status. But if they have the option to, say, buy a 2-year health insurance plan or a 5-year health insurance plan at a discount relative to what buying five 1-year plans would cost, you can incentivize people again to stay in a long-term relationship with their insurer where the insurer then also has an economic incentive to work with that patient over time to do things like wellness and compliance.

Because the challenge is, if you have a 1-year insurance contract, then the insurer worries, well, if I invest a lot of time making this patient healthy, what if he signs up for somebody else's plan next year? Then I don't really get the benefit economically from having helped this patient.

So encouraging insurers to have long-term relationships with their patients and long-term contracts with their patients would do a lot to align the incentives of the patient and the insurer.

Mr. GUTHRIE. Thank you. I appreciate the answers to those questions.

And I yield back my time.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman, Dr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Thank you, Mr. Chairman.

I appreciate the panel. It is nice to be talking about something other than full repeal of the Affordable Care Act and thoughtful discussions out here. So I like that.

I guess the first opening question would be, I would be curious, actually the panel itself, Mr. Gottlieb in particular perhaps, I know the age thing has been talked about, we talked about that way back when we did the ACA, but what about lifestyle adjustment for premiums? That was something we considered very strongly early on. I know the President was interested in that. There is smoking, exercise, bunch of different variables. Sometimes hard to quantify, and we don't want to be discriminatory as we do that.

Now, that seems to me another thoughtful way, to be a good incentive, quality health care is a good result. Is there any discussion on that in the academic circles at this point?

Dr. GOTTLIEB. Yes, a lot of discussion. I think a lot of the approaches we are talking about here today aren't just, frankly, prohibited by the law, they are prohibited by the regulation.

The challenge isn't just some of the prescriptive regulation in the law itself, but, frankly, the way the regulations have been written by CMS I think have been overly prescriptive in areas that would deem certain things like what you are suggesting to be discriminatory.

Ultimately in the plan that we put forward with the American Enterprise Institute, we move towards a system where you could have subsidies based as a fixed percentage of the cost of the premiums, and you would ultimately cede back to the states more

flexibility to allow plans to adjust premiums on a whole host of things, such as age, geography, maybe even some measure of pre-existing condition. And then people, individuals, would get a subsidy that would be a fixed percentage component of that. And then you could go in if you wanted to as a matter of Federal law and increase the subsidies for certain individuals, including perhaps subsidizing certain kinds of risk in the marketplace and certain kinds of individuals with preexisting conditions.

But we would envision a more flexible framework that would allow for what you are suggesting. I will tell you I think the way the regulations have been written, in a very prescriptive manner, there is very little that wouldn't be deemed discriminatory.

Mr. SCHRADER. Ms. Corlette, comment on that?

Ms. CORLETTE. Yes. Sure.

So of course the Affordable Care Act already does include rating provisions that allow insurers to charge smokers or people who use tobacco up to 50 percent more than somebody who doesn't. It also allows employers to charge up to 30 percent more for people who don't meet certain wellness targets.

I would say that the research that is out there to date on that suggests that linking achievement of a certain health target or changing a behavior, linking that to an increase in premium or a higher deductible is actually not very effective in changing behavior. What researchers found is that people are much more responsive to sort of more discrete short-term incentives. You know, maybe it is a gift card or a discount at the gym or something like that. Those tend to be much more effective strategies for getting people to lose weight or change other behaviors.

We would be happy to discuss other alternatives with you.

Mr. SCHRADER. Mr. Roy, a comment?

Mr. ROY. Yes. I am less enamored of lifestyle-based health insurance pricing, and the reason why is that it is hard to enforce. Are you actually going to check and see, is the insurer supposed to check to see whether the patient is going to the gym one time a week versus three times a week, or smoking one pack a day versus half a pack a day?

I believe that those pricing mechanisms are very difficult to do in a rational way, and I think it is simpler to have a system where you have a means-tested schedule and an age-based schedule. You can publish it in a table, in a book, and people can know every year after they file their taxes exactly what tax credit they qualify for, and you make it very simple for people, very transparent for people, and that eliminates the waste, fraud, and abuse that we are seeing in the way the subsidies are administered now in the exchanges.

Mr. SCHRADER. Ms. Corlette, there has been a lot of discussion about the special enrollment periods and people taking advantage of that. CMS recently came out with some rules. Do you think those rules get to at least a bunch of what the concerns have been here recently?

Ms. CORLETTE. Yes, I think they do. Although I would just say I think the solution is not fewer people taking advantage of SEPs. It is actually we need more people taking advantage of SEPs. One

of the problems is that only 15 percent of people eligible for these special enrollment periods are actually taking advantage of them.

And there is nothing about the triggering events, right, that would suggest this should be a sicker population. It is people having a baby or getting married or leaving a job. That happens to healthy people. It happens to sick people. But it is the sicker people that are motivated, right, to find out about the opportunity.

So I do think that, coupled with documentation requirements, which I think are perfectly legitimate to ask people to verify what is going on in their lives, but we also need to be doing more aggressive outreach and education to all people who are eligible for SEPs.

Mr. SCHRADER. I yield back. Thank you, Mr. Chair.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. LONG. Thank you, Mr. Chairman.

Mr. Gottlieb, last week I had a manufacturing tour in my district back home and saw several manufacturing facilities, which is vital to my part of the country. And we had a little shoot-off with the Democrats yesterday, Republicans against Democrats shooting skeet and trap. And one of the things I saw was a clay pigeon mold that I have never seen before where a lot of those are made to mold the clay pigeons right in my district.

Another thing that I saw was DMP, Digital Monitoring Products Company, bank-monitoring products. It is a 41-year old company. A 41-year old company. They are adding 74,000 square feet and doubling the size of their engineering department. So manufacturing is really, really important in my area.

Another company that I went to see has done all of the work on the new African History Museum that they are putting up here on Washington, on the windows and all the structure there. They have also done all the work up here on the Native American Museum. They are doing one of the largest projects ever up in Manhattan right now. All the tall glass you will see on all those big new buildings going up in that section are coming out of my district.

So manufacturing is huge in my district. So I will preface my remarks with that.

Today large companies are able to use the size of their workforce to negotiate better rates with healthcare plans. Many healthcare thought leaders have suggested that individuals and small businesses should have the same benefit. In fact, before the enactment of the Affordable Care Act reforms, the Missouri Association of Manufacturers was able to operate two health consortiums providing quality health care to over 2,500 lives spread among 81 businesses, large and small, just as those that I described a minute ago on my tour last week.

On this issue of pooling, do you think that allowing individuals to join together to increase their purchasing authority would help lower costs?

Dr. GOTTLIEB. I think I would favor all kinds of pooling arrangements, including allowing small business to band together, including the concept of association health plans. There is nothing inherently wrong with pooling on the basis of state-based exchanges. I

wouldn't want to see a marketplace where that is the only way that people can pool together.

Just as an aside——

Mr. LONG. Now, what do you mean, the only way they can pool together?

Dr. GOTTLIEB. Well, right now, the way the law is trying to force the market, the only way you can pool individuals is either to self-insure or to go on the state-based exchanges. The kinds of construct you are talking about or the kinds of construct that the chairman introduced with respect to association health plans wouldn't be allowable in today's marketplace. There are really only two places to pool risk outside of government programs: it is on the state-based exchanges or if you self-insure.

There is now a secular shift toward self-insurance by small businesses who previously probably were too small to self-insure but are self-insuring to try to get out from some of the mandates and the regulation. I think one thing that should concern this committee and concern all of us is we are seeing efforts on the part of CMS now to apply more of their regulation to the self-insured businesses. And so you are seeing CMS regulation in certain instances potentially supplant ERISA law.

Mr. LONG. Well, when you say small companies can self-insure, pool, I guess they pool within themselves. But I am talking about all these manufacturers in Missouri were pooling among other manufacturers to come up with very good rates for their people.

Would the concept of individual health pools, or IHPs, make rates more competitive, in your opinion?

Dr. GOTTLIEB. Right. Absolutely. What it would do is it would allow small businesses to band together and negotiate for insurance contracts as self-insured businesses and put them on par with a large business. A large business that employs tens of thousands of people is getting better rates from the insurance companies who administer their products. It would allow self-insured small businesses to do the same thing.

Mr. LONG. So just like corporations and labor unions do, you think that they should be able to pool together?

Dr. GOTTLIEB. Yes. And just like small businesses are able to pool together to purchase office supplies in the marketplace and do other things like that, yes.

Mr. LONG. And finally, could these individual and association plans lead to more patients getting health care?

Mr. GOTTLIEB. I think that they would lead to more businesses being willing to self-insure. We are already seeing that in the marketplace, that businesses that are right on the cusp of having enough employees in order to reliably self-insure and take that actuarial risk are doing it. I think it would lead to more businesses being willing to do that.

We are also seeing innovation in companies that are forming to help very small businesses self-insure. So if you create the mechanism you are suggesting, it is going to just expand the ability of small businesses to do that.

Mr. LONG. OK. Thank you.

I think for the first time in 6 years I have time to yield back.

Mr. PITTS. The chair recognizes the gentlelady from California, Mrs. Capps, 5 minutes for questions.

Mrs. CAPPS. Thank you very much, Mr. Chairman. I appreciate our witnesses being here today for your testimony.

And I would like to just bring into this conversation more of the California experience with health reform. As we have seen time and time again, our healthcare markets hinge on the buy end and efforts at the State level. The network has a direct influence on the patient experience in finding and getting quality affordable health insurance.

As of June 2015, 1.3 million people in California are actively enrolled in health insurance, and our uninsured rate has been cut in half. In a time where there is a lot of rhetoric about how we must deregulate our health system, California has used smart regulation—this is my opinion, but they believe it too—to take a solutions-based approach to health reform. Our state exchange has required health insurance companies to build consumer tool that encourage participation and transparency, and such tools help with outreach by letting consumers compare plans in an apples-to-apples way by looking at out-of-pocket costs and quality.

So in using all the tools at our disposal to regulate the market and be active purchasers of health care, California has emerged as the leader in this space and has succeeded in providing important healthcare services to citizens.

Ms. Corlette, how do these state tools and others protect consumers?

Ms. CORLETTE. Yes, absolutely. So California is leading the way on many fronts, and I think is showing many of the other state-based marketplaces how to do things that can really help consumers have a better shopping experience.

So, for example, one thing California does is require the benefit designs to be standardized, and that is good for two reasons. One, it really helps consumers make apples-to-apples comparison among the plans, and allows them to focus on price and network and really important differentiators between the carriers. The second thing it does is it really limits the ability of the insurers to design discriminatory packages that can discourage enrollment by sicker people. So, for example, we saw in other States where insurers were putting all of the HIV-AIDS drugs on the very highest specialty tier, including generics. Well, that was clearly designed to try to discourage those individuals from enrolling.

So standardized designs are used pretty commonly in private exchanges, like Ayon and Mercer and Towers Watson, they require benefit designs to be standardized because it helps consumers make those comparisons. So California is doing that, and I think they have found it very useful.

Mrs. CAPPS. Not that we are doing everything perfect in California, that is for sure. But is there a way that we can—and I will put it this way—we need to learn in California from other states, and the successes that they are having. Are there ways other states could adopt these same practices for states who don't take these steps? What are their consumers faced with? And should the Federal exchange be doing anything about this? This is a lot to dump on you in one question, but if you don't mind.

Ms. CORLETTE. Yes, sure. So a number of other states are looking at, or have standardized benefit designs. They have also been implementing things like out-of-pocket costs calculators that not only tell you what your premium is going to be, but if you are high risk or low risk or medium risk what your total out-of-pocket spend might be during the year to come. And that is really important for consumers to be able to compare plans.

Another thing that the Federal marketplace is going to be bringing online, which I think could be useful, goes to the issue of network design and helping consumers discern whether or not a network is narrow, medium, or broad, because right now there is no easy way to tell. And many consumers are willing to make the trade-off between price and the narrow network, but you need to at least know what you are looking at, and so those kinds of tools can really help.

Mrs. CAPPS. I still have a minute. And that question is a little bit open-ended. Would either Mr. Roy or Dr. Gottlieb, would you like to respond to that particular question?

Mr. ROY. Sure, I am happy to. Thank you. I have a bit of a different view about the California experience. California actually had the most robust nongroup health insurance market in the country prior to the ACA, where individuals enjoyed a broad range of choices and diversity in the kinds of plans they could purchase. The reason why the uninsurance rate has gone down in California is not because of the regulations that have made health insurance in California cost more than double in many cases what it cost before. The reason is the subsidies, which, of course, help people afford these much higher premiums.

So I think it is great that there is financial assistance for the uninsured to purchase health insurance, but I think that the regulatory scheme that California imposes has actually dramatically increased the cost of health insurance. As an example, I can give you specifically, in Kaiser, a plan in Sacramento, that exactly the same plan with exactly the same network, exactly the same cost-sharing provision, exactly the same actuarial value, costs double as a result of the ACA's regulations than it did before. So that is a big problem in California. And, yes, people at below 200 percent of the Federal poverty level are getting a lot of financial assistance. But as you go up that income scale, the increased premiums are pricing a lot of people out of the market, and that is why enrollment in the exchanges nationally and in California has fallen well short of expectations.

Mrs. CAPPS. Well, I am going to have another round since I started that, Mr. Chairman. But I will yield back my time.

Mr. PITTS. The chair thanks the gentlelady and now recognize the gentlelady from North Carolina, Ms. Ellmers, for 5 minutes of questions.

Mr. ELLMERS. Thank you, Mr. Chairman.

And my questions are for you, Dr. Gottlieb. As you know, plans are starting to exit the Federal marketplace. Namely, one that has been highly publicized is United Health Group. United will be pulling out of 26 States because they project a \$650 million loss this year. Some supporters of the status quo have tried to downplay this, arguing that United was not a major player in the Federal ex-

changes. But their departure from the marketplace has the potential to significantly limit competition in some markets where patients may only have two, or maybe even one option for plans to purchase.

So my question is, should consumer advocates be concerned about this trend, or as this is happening in these markets, and will it limit choice based on what is left in the market?

Dr. GOTTLIEB. And so, I don't think United's exit was trivial, because United has the potential of dramatically expanding its footprint. They lost over, I think, \$1.2 billion over 2 years, and they exit the market, and it is not growing its footprint either. I think is what even more concerning is the Blues who have dominated the market to date are also experiencing losses, and we are seeing some signals that some of the Blues' plans may exit.

The observation that is worth making in my view is that as these plans do exit the market, the plans that are growing their footprint in the market, and actually offering the best price, and quite frankly, are the Medicaid plans. And I think that is because this is becoming a much more Medicaid-like benefit, where plans are competing on network design and formulated coverage alone and trying to cheapen the benefit, and the plans with the experience in the market of offering cheap benefits, cheap enough to offset the high costs of the regulation in this scheme are the Medicaid carriers, and they are, in fact, the ones that are growing their footprint quite dramatically. I think Molina doubled their footprint in the market. Centene came close to that this year, and they are also, frankly, making money, too. The few plans that are making money are the Medicaid plans.

Mr. ELLMERS. Thank you for—that is actually along my line of questioning. And you point out the Blue Cross, and that is going to be significant in North Carolina, where we do only have a couple of insurers participating. And Blue Cross has announced that they will be. I am very concerned about this, because we have got to do everything we can for these patients to get good healthcare coverage, and they are offering the coverage that they have been satisfied with. They may have had to have cancelled whatever plan they had before in order to get on it, but they have become accustomed to it, and now, even that is ending.

So that is my line of questioning here. Again, pointing out that Centene and their Medicaid-like plan said they would be likely turning a profit in the exchanges.

In fact, they say about 90 percent of Centene's exchange enrollees are subsidy eligible and have incomes at the level that leaves them moving in and out of Medicaid. So United, who is offering broader networks and better coverage, has dropped out of 26 States, while Centene, who offers narrower networks and higher deductibles, has projected that they will be profiting in the exchanges.

So there, again,—do you see this as a trend, or, in your opinion, is this a trend? And does this not demonstrate that basically, as I would put it, this current law is almost a race to the bottom for patient coverage?

Dr. GOTTLIEB. Well, I think it is a race to a Medicaid-like benefit. Not to oversimplify, but I think the issue is that all the traditional

tools—and I agree with—that it is a problem. All the traditional tools that insurers use to try to manage costs have largely been regulated away. Not all but many of them. And the only way that insurers can manage costs in this exchange market is to cheapen the benefit. The only way to cheapen the benefit is either you own the doctors and you try to regulate what they do very closely, or you network with very few doctors, very cheap doctors, doctors who don't see a lot of patients in the community, and you offer a closed formulary and you start tightening up your formulary design, and the plans with the experience doing that and the plans that have the cheap networks are the Medicaid carriers, and that is why we are going to see them continue to grow their footprint.

Mr. ELLMERS. I have only got a limited time left. So, basically, what this is going to do is limit care, limit access to care?

Dr. GOTTLIEB. And limit choice of plans, unfortunately. And I think the real thing that should concern individuals are when the Blues plans are experiencing losses and start pulling out of this market.

I raised this issue with folks in the administration about the Medicaid carriers growing their footprint, and the response was, well, they haven't really dominated the exchanges. It has been the Blues plans that have dominated the exchanges. And that is true, but we are seeing a lot of pain on the Blues plan as well. And when they start dropping out, I think that really is going to signal a downward spiral here.

Mr. ELLMERS. Thank you.

And I yield back the remainder of my time.

Mr. PITTS. The chair thanks the gentlelady.

I want to apologize to the gentlelady from California, Ms. Matsui. I missed you in the queue. You were here. You should have been recognized earlier.

The chair recognizes Ms. Matsui for 5 minutes for questioning.

Ms. MATSUI. Thank you, Mr. Chairman.

And I want to thank the witnesses for coming here today.

The passage of the Affordable Care Act eliminated exclusion of over 129 million Americans living with preexisting conditions from receiving affordable health insurance. These preexisting conditions include not only rare diseases, but also common diseases, like asthma or diabetes.

Ms. Corlette, can you talk about the experience of those with preexisting conditions attempting to purchase insurance in individual markets before the ACA?

Ms. CORLETTE. Sure. Absolutely. I will just say that the individual market was a very inhospitable place before the ACA. People with preexisting conditions were frequently denied access, up to 40 percent were denied outright a policy. It was frequently unaffordable, because rating factors related to their health status or gender or age, could sometimes be as much as nine times the amount of the unhealthy person. They found it often unaffordable to get a plan, and then that coverage was what we used to call Swiss cheese coverage; preexisting conditions were often excluded.

So, for example, a breast cancer survivor would be told that no oncology services would be covered under the plan. Or if you had incidences of asthma, you would be told that no upper respiratory

conditions would ever be covered under the plan. Those are the kinds of things that are now thankfully in the past.

Ms. MATSUI. Thank you. I also want to consider this, because protection against preexisting condition discrimination is important for the over 30 million individuals in this country who suffer from rare or serious chronic diseases, and they are in another situation too, which is even more difficult. These diseases can be debilitating, not only to the patient's health, but also to a family's financial stability, especially when diseases inhibit the ability of a patient to work. Patients sometimes need to rely on the goodwill of third-party nonprofit charity organizations to help them access the care they need. We need to preserve the ability of patients to rely on third-party payments from charities. And I am working with CMS to do that.

The ACA has been very good for millions and millions of Americans, and we are looking to see how we might improve that, too. And this is an area we are looking at because of the serious financial instability of the patient's family. So I do hope that we can work with you as we move forward on that. And thank you.

And I yield back the rest of my time.

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

Mr. LANCE. Thank you very much, and good morning to the panel.

I am concerned about the fact that exchange participants, based upon their 2015 plans, did not necessarily continue for 2016. A recent study, as I understand it, has found that only one-third of exchange participants kept their plan year to year. And I think this reveals significant market instability.

Could the panel comment on that?

Mr. ROY. Yes. So I would say it is not entirely about market instability. If you are going to have a 1-year insurance contract, people are free to shop year over year for the plan that is the best plan for their needs, and it might be that the prices have evolved in a different way. Just like you might not fly the same airline next week as you did last week, you might have a different plan next year than you did this year.

So much of this is quite natural. But I do think that instability is important insofar as, again, the insurance company does not reap the economic reward from making you healthy over the long term if you are switching plans year over year over year.

So maybe it is good for some people to have plans where they switch year over year, because that helps create the price discipline, that encourages insurers to compete for your business and be held accountability for the premiums they charge, but it would be nice for there to be an option in the individual market for people to shop for plans with longer time horizons so that, again, for a discount, perhaps those insurers would say, "Hey, if you sign up with me for 5 years, your insurance would cost 20 percent less, but we will be able to work together to make sure you stay healthy in the long run."

Mr. LANCE. Would anyone else in the panel like to discuss this? Yes, Ms. Corlette.

Ms. CORLETTE. Yes. Sure. I think the factor to keep in mind is historically the individual market was called the residual market, and that is simply because the primary source of coverage for most people under 65 is through their employer.

Mr. LANCE. Yes.

Ms. CORLETTE. And, certainly, for people of lower income, they may come in and out of Medicaid. So one of the reasons we are seeing a lot of transition in the marketplaces is because people might be gaining coverage because they get a job, or because they dip below the poverty line and so they are then eligible for Medicaid. So that is just an important factor to keep in mind when you think about these marketplaces.

Mr. LANCE. Thank you.

Doctor.

Dr. GOTTLIEB. I think your observation reflects the fact that the plans that experience the largest enrollment are the ones that increase their premiums the most in a subsequent year, because they are the ones that experience the biggest losses. And that is why when we are looking at the premium increases over the course of this year, we really should enrollment-adjust them, and think about the premium increases on enrollment adjustment basis, because it is going to be the case that the plans that take the biggest premium increases will be the ones that have the biggest enrollment, and then that is going to cause a subsequent churn that you are talking about in the subsequent years.

I think the other trend that is worth watching is that this is becoming a market that is increasingly narrow to a very narrow income demographic, and that is people who are eligible for the cost-sharing subsidies because of the high costs. We talk about the premiums and the subsidies for the premiums, but the out-of-pocket costs are very, very high in a lot of these plans.

And so, the only people for whom this is economically attractive, if you will, increasingly are going to be those who fall around 200 percent of Federal poverty level who qualify for the cost-sharing subsidies. And I think we talked at the outset about there hasn't been, sort of, the dumping, if you will, from the employer market into the exchanges. I think we are going to start to see that, start to see people who work for large employers who fall within that income range find themselves in the exchanges, and lose their employer-provided coverage, and it could, potentially, make the American health care less egalitarian overall.

Mr. LANCE. Thank you. And would anyone else on the panel like to comment on what the doctor has just said regarding the narrowed market?

Mr. ROY. Yes. One thing I might add, too, is that we have been talking a lot about preexisting conditions, and there's been an enormous amount of disruption of the individual market for health insurance because of the claim that we needed to do all the disruption to protect people against preexisting conditions. And that is not actually true. It turns out, actually, the CBO did a study where they asked the long-term uninsured why they didn't have coverage. Seventy-one percent said it was because the insurance cost too much, the premiums were too high. Only 3.5 percent said that be-

cause of a preexisting condition or other health status-related issues were denying them coverage.

We also have the evidence from the Affordable Care Act's own preexisting condition insurance program, a high-risk pool that was designed to be a bridge between the enactment of the ACA and 2014, when the guaranteed issued regulations came into effect. That provision allowed anyone who could demonstrate that they had been denied coverage by an insurer because of a preexisting condition, anyone, any person who could prove that could sign up for this program. Only 250,000 people in the entire country signed up for this program. And we disrupted health insurance for 300 million people, allegedly, because we needed to fix health insurance for these 250,000.

So it is really important to understand that we should address the problem of preexisting conditions, but there are a lot more efficient ways to do so that don't disrupt coverage for the people who had it under the old system.

Mr. LANCE. Thank you.

My time has expired.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. SARBANES. Thank you, Mr. Chairman. Thanks to the panel.

Just on that last point, there is a distinction between people that were being outright banned or denied coverage based on a preexisting condition, versus people whose premiums were being adjusted significantly or a lot higher based on the fact that they had a preexisting condition. So the observation by 90-something percent that it was the cost that was the barrier to them could still be linked to the preexisting condition situation, I would imagine, in a lot of cases.

The question I have, and I will start with you, Ms. Corlette, is I have heard some increasing discussion about the high-deductible plans and the impact that is having on the affordability, but also a discussion of how there is a wide variation in the kinds of benefits or services or products, for example, drugs, that are exempted from the deductible, and how that can affect affordability and behavior and access and so forth.

And I think, for example, California is an example—is a state where they have been pretty proactive in looking at that issue of where the exemption should be for certain kinds of services to try to make the coverage more affordable and more useful, frankly.

So could you start a discussion among the panel about that deductible issue, because I think it has implications potentially for some improvements that we could do with guidance in that area?

Ms. CORLETTE. Yes. I am so glad you asked that question. So two quick points about deductibles. One is I find it ironic that a lot of people who right now are complaining about the high deductibles on the marketplaces are the same people who have been calling for more high deductible health plans generally.

The second thing is, we have to think about where we were before and where we are today. Pre-ACA, deductibles were as high as \$10-, \$15,000 sometimes. So the financial protection that exists in the marketplace right now is way better than it was previous to the ACA.

But to your point, when you tell a lower income family that they have a \$5- or \$6,000 deductible, it doesn't matter, right? That is still a huge amount of money for them to lay out before they can get healthcare services.

There are a couple of things that are really helpful and important. Number one is, of course, the ACA provides first dollar coverage for preventive services and important screening. But, interestingly, California is a State that is doing this and other States are looking at it as well, is encouraging, or in some cases, requiring insurers to cover important primary care services, generic drugs, some urgent care before somebody has to pay up the deductible. So that allows a consumer to get more upfront value than they otherwise would, and I think that is an innovation that we should be looking at more broadly.

Mr. SARBANES. Anybody else?

Mr. LANCE. Yes. So, Ms. Corlette thought it was curious that people might critique the high deductible in the ACA. So let me try to explain why people do that.

The problem is that, in theory, high deductibles are good, because if you have the option of a low deductible and a higher premium and a high deductible and a lower premium, some people, naturally, might want a lower premium and a high deductible. If people are truly trying to seek protection from bankruptcy due to medical bills, the most affordable way to do that is through a high-deductible plan combined with a health savings account.

The problem with the ACA is the deductibles are higher, and the premiums are higher, too. So people are paying 50 percent more for their monthly premium and the deductible is 2,000, \$3,000 higher than it was before because of all the regulations and mandates in terms of how those insurance products have to be designed. And this is why the regulatory scheme of the ACA has been a major focus of criticism, because it is directly responsible for the fact that people are not only just paying higher deductibles, they are also paying higher premiums.

Dr. GOTTLIEB. So I will just comment. I think the idea of a high-deductible plan, some sort of a conservative theology, if you will, was that the high deductible was tied to a lot of consumer selection on the more routine care. And here you have a regulatory scheme that mandates a lot of first dollar coverage for ordinary, routine care, but still is coupled to a high deductible, and that is not really a high-deductible consumer-driven plan. And what is happening is because the insurers have to cover first dollar of a lot of the routine stuff, and they can't take premium increases; they can't offset those costs in other ways, they are offsetting it by, in my view, narrowing the coverage for the catastrophic fees. Exactly a place we want the most generous coverage. And that is being coupled—as you mentioned, drug formularies that is being coupled, for example, and it is manifesting in the form of closed drug formularies, where you have very narrow lists of drugs on formulary, and all the drugs that aren't on the formulary aren't covered at all. And what consumers spend out of pocket for those medicines doesn't count against your out-of-pocket maximums, so their deductibles are completely on their own.

And I would say, I think all the silver plans on the Affordable Care Act are closed drug formularies. I have gone through and I have looked at 30, 40 plans, and published this data, and they were all closed plans, and I just assume that it is almost all the silver plans are closed formularies. That is really a new development in the marketplace. We never saw closed formularies used so predominantly. The only place we really saw that was in Medicare Part D and Medicare Part D coupled it with a lot of regulations and modeled formulary protected classes.

And I will just sum up by saying I don't think the health plans are doing anything wrong. I think they are taking flexibility where they still have it. A lot of the flexibility that they have to or they have traditionally used to try to manage costs have been taken away from them, and the few places that it is left, they are exercising it.

Mr. SARBANES. Thank you.

Mr. PITTS. The chair thanks the gentleman, and recognize the gentleman, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman.

It is a sad thing to me when I look at, as we reflect on this committee, and also the subcommittee on Oversight and Investigations has looked over the last few years of the kind of spending we have had on the Affordable Care Act. We have had it for advertising, Web sites that didn't work. I think Oregon spent a couple of hundred million and finally, they decided since they didn't sign anybody up and it was filled with political corruption; it wasn't going to work. We have seen half the co-ops fail, administration costs. Secretary Sebelius went back to the insurance companies and said, Hey, we need some more money from you to donate to keep it going. And none of that money went for even a single Band-Aid. Nothing helped there. So we have got to find a different approach on how we are handling health care.

Now, one of the things I want to talk about are the high-risk pools, and particularly, invisible risk pools. I think, Mr. Roy, you have talked about these things. I want to see if you can elaborate. So are high-risk pools still today a fair pathway for helping to cover some of our sickest friends and neighbors?

Mr. ROY. They can be, but they face a lot of limitations. And I think that to the degree that we have talked about high-risk pools, we have to understand the risks of high-risk pools. So, for example, the AEI proposal proposes giving States funding for high-risk pools as a bridge for those who are very sick and don't get coverage for the traditional market. The challenge is that once States, State governments, just like State exchanges can be messed up, if State governments are running high-risk pools, they have incentives, an incentive to overpromise and underdeliver. They say, Oh, we are going to expand this high-risk pool to everyone because the politicians will have to pay the bill for that and the voters will have to pay for—

Mr. MURPHY. I understand.

Mr. ROY [continuing]. Or 20 years down the road. So—

Mr. MURPHY. So where would they pay that, on the back end, then.

Mr. ROY. Well, yes. So if you sign people up, but most of the health costs happen 10 years down the road as those patients age, and have higher medical costs as a natural combination of their aging and their health care. Once the government is actually determining the price of a risk, a lot of things can go wrong. I would argue it is actually simpler to preserve guaranteed issue, but get rid of the distorting and discriminatory regulations in the ACA exchanges that make guaranteed issue unaffordable. So you can actually preserve guaranteed issue in a very simple way that doesn't require the use of high-risk pools, have everyone in the same insurance market, and that way, the people who are high risk, the people with diabetes, people with chronic conditions, have a broader choice of health insurance plans than they would have on the high-risk pool.

Mr. MURPHY. Dr. Gottlieb, do you agree with that approach?

Dr. GOTTLIEB. I think we talk about high-risk pools as an interim step. My view is that I think with proper risk adjustment, that would be able to be done prospectively, and a subsidy structure, that you allow some adjustment for risk, you can achieve what you are aiming to achieve with high-risk pool and help underwrite the increased risk of certain individuals with chronic conditions much more effectively in a viable pool.

Mr. MURPHY. Let me ask this, too, then: As someone who has identified, so we know that people who are healthy are trying to avoid buying insurance, and then they start to get sick and they want to buy insurance, the same as people who have cars. They don't want to buy insurance until they get in an accident. But what happens here also is when you look at the incredible cost if these are not managed. So Medicaid, 55 percent of Medicaid spending goes to 5 percent of the population. And according to multiple reports, one of them Tom Insel, former head of NIMH, he said virtually all of them have mental illness. And yet, what happens is we maintain a system where medical records are kept separate but equal, which means you can't get information and know the higher risk, but the person who has a chronic illness and depression, for example, doubles, triples, quadruples the cost, if it is not treated. And so I am concerned about what we are talking about here is just a mechanism to pay for this, but not a mechanism to change this.

And how do we look upon this? If someone is identified then with a chronic illness, with a mental illness, they are really beginning to coordinate and integrate care, which I think is the absolute key to deal with it more cost effectively.

Mr. Roy, Dr. Gottlieb, and Ms. Corlette, if you could comment on that.

Mr. ROY. Yes, I mean, they are all related, because the reason why we don't have a patient-centered healthcare system in which hospitals and doctors and insurance companies would have the incentive to really cater to the patient's needs in those regards, is because the patient doesn't control the health care dollars. In every other sector of the economy, the consumer controls the dollars, and that is why businesses go out of their way to cater to the consumers' interests and the consumers' needs. In health care, the government controls the dollars.

Mr. MURPHY. But they are concerned about their own health. I think in these cases, if it is not explained to them that you really have to coordinate these services together and enforce the position that they would be talking to each other across boundaries.

Mr. ROY. Sure. But insurance companies and healthcare entrepreneurs, healthcare IT companies that integrate their patient records across providers, they can provide those services. And part of the challenge is that we have a culture in this country of patients who aren't engaged in their health care and the value of their health care because they are not paying for it directly. If they are paying for it directly, if they are choosing their own insurance plan and paying for care through, like, HSAs and able to shop, yes, you are not going to deal with the person who is like the schizophrenic who really doesn't have the necessary mental capacity and there, you need more of a role of the state to help navigate the healthcare system for those individuals, but a lot of the inefficiencies with those high utilizers is driven by the fact that they have zero economic incentive to save that money.

Mr. MURPHY. I agree to some extent. But I know I am out of time here. But I would also like to opine this, that you are right to some extent, but it is also an issue of if it is not managed by these companies, if there is no incentive for those companies to really manage and coordinate that person's care, then you end with increasing costs, the state or Federal Government is just going to pick up. And this is where I think we look at ways of financing this program inefficiently, but not really fixing it.

I know I am out of time, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. Now we are going to recognize the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes of questions.

Ms. SCHAKOWSKY. Mr. Roy, I don't even know. I am not going to spend my time disagreeing with you, because the idea that if only people had more control, that we would dramatically reduce. People can't afford the health care that they need, not that government is controlling it. But I am not even going there with you.

According to a 2014 study done by HHS, the rate review requirement included in ObamaCare saved consumers nearly \$1 billion on insurance premiums in 2013. However, currently, the Secretary of HHS only has the authority to review rate increases, not modify, approve, or deny them. Many states have taken the extra step of enacting legislation to provide their insurance department with the authority to deny or modify unreasonable health insurance premium rates.

Evidence shows that when insurance regulators have the authority to do so, consumers pay less. I am from a state that does not have that authority. In 2013, the Maryland Health Commission used such authority to modify the proposed rates for all nine carriers, who submitted plans for the Maryland health connector. The commissioner reduced the proposed rate increases of all existing plans, one by more than 66 percent. And that is why I have introduced the Health Insurance Rate Review Act, which grants the Secretary of Health and Human Services the authority to deny or modify unreasonable premium rate increases in the states where insurance regulators don't have the authority.

So, Ms. Corlette, here is the question: Would expanding rate review authority help to control the cost of premiums?

Ms. CORLETTE. Thank you, Congresswoman, for that question. So the evidence is really strong that having an independent reviewer of insurers' rates, proposed rates, the assumptions they are making, the claims they are making about trend and cost, et cetera, is a critical consumer protection, and it has saved consumers millions of dollars.

And it is a particularly critical function in areas that there is not a lot of competition among insurers. I would say that there are a number of states that are doing a really, really good job of this, but others where they either lack the authority or the resources to do it, and in that case, the Federal Government can be an important backstop.

Ms. SCHAKOWSKY. What states would you cite as examples of who is doing a good job?

Ms. CORLETTE. Who is doing a good job? I think that in Rhode Island and Oregon and Washington State, those are a few that come to mind immediately. Maine also has a good track record that are very proactive in how they are looking at insurers' claim.

Ms. SCHAKOWSKY. Let me also ask you this: I also strongly support creating a public option to be offered in the marketplace. We discussed this during the development of the Affordable Care Act, and we actually passed one in the House. A robust public option would increase marketplace competition, lower premiums for consumers, lower the Federal deficit, all this has been documented. It is estimated the consumers would save between 5 and 7 percent on their premiums through a public option health plan; moreover, the Congressional Budget Office previously estimated a public option would save \$158 billion in Federal spending over a 10-year period. I introduced legislation in the Public Option Deficit Reduction Act, which would create a publicly administered insurance plan that would be available in every marketplace, would be designed to include robust provider networks, and more affordable deductibles.

So, again, Ms. Corlette, would availability, in your opinion, of a public option provide consumers with a more affordable plan and help to create more competition in the marketplace?

Ms. CORLETTE. Yes, I think that the public option could really help keep costs lower, not only would it likely have lower administrative costs than a commercial insurance company, but it could also use its market power to ring lower prices out of providers. And also could be a really important backstop in rural or underserved areas where it is hard to get insurers to come in and compete. So for those reasons, I think it is definitely worth bringing back on the table.

Ms. SCHAKOWSKY. OK. And I yield back. Thank you.

Mr. PITTS. The chair thanks the gentlelady, now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. SHIMKUS. Thank you, Mr. Chairman. This has been a great panel, so I appreciate you all coming. I think people know that we have a system in place. Some people think it is the best thing since sliced bread, some people have concerns. I think everybody believes there are changes that could be made. So I think this is going to be a start of, hopefully, a lot of discussions.

There was a section of our citizens that got help, and that was the Medicaid expansion for people who didn't have access to care. But I am told all the time, it is never refuted, that people are paying more and getting less coverage now than they had before, if they had a standard policy beforehand. I acknowledge that Medicaid expansion did cover some uninsured. And even those who have it—and also the promise to hospitals who are part of the negotiations, was that they would save costs, and there would be less access to emergency rooms. Now they have more people going to emergency rooms, and it is because of these high deductible plans.

So there are a lot of problems and promises that were made that weren't kept on, what, \$2,400 a year savings for a family of four, premiums would go down, copays would go down. If you like your policy, you keep it. If you like your doctor, you keep it. All those were not satisfied.

So we are talking about tweaking and trying to fix—part of this is the cost sharing issue that we have been talking about, too, and how you incentivize. I am not a big supporter, and I am not a supporter of federally mandated plans without flexibility. But I do know that the cost sharing is based upon the silver and 60 percent amount.

Dr. Gottlieb, would it make sense to shift that bronze to a 50 percent, and not based upon the silver percentage? Would that help at all?

Dr. GOTTLIEB. Well, I note that people have also talked about creating a copper plan for younger healthier people. It is probably going to be the case that a lot of the bronze plans end up pulling out of the market and insurers ship more towards the silver plans this year for a variety of reasons, not the least of which is the bronze plans ends up having to pay back the most amount of money because they ended up attracting the healthiest individuals.

I think the problem stems from the rigid regulatory structure around the rating system and the fact that you can't vary the actuarial value more than 2 percent up or down from these metal tiers. I think what we should be thinking about doing is providing much more rating flexibility to the insurers so they can offer wider variety of different kinds of plans and offer different schemes, things like value-based insurance designs.

Right now what they do is they try to develop a plan to meet an actuarial target, rather than to develop a plan that sort of optimizes a set of circumstances.

Mr. SHIMKUS. And even in part of the value-based, or even the hospitals are going to be now incentivized to have quality care and quality care measures, which financially would be a value-based system. Would it not be?

Dr. GOTTLIEB. I think as providers take actuarial risk, we are moving toward that. And that is maybe one of the good benefits of the consolidation that is underway of the healthcare system. I have been critical of consolidation. With respect to the rating and the tiers and the metals, there was a view that by having discrete metals, it would make it easier for consumers to understand actuarial value. But, in fact, I think the evidence shows consumers don't necessarily understand actuarial value in relation to the metals. And we should think about conducting some real vigorous research

around whether or not consumers can be educated around just what the actuarial value means so we can provide number the number to the consumers, not just the metal. I think the Healthcare.Gov Web site is doing a better job of translating what actuarial value means in some practical settings. There are better tools to help people understand that. We can move towards a more flexible framework.

Mr. SHIMKUS. And let me end up with this statement saying to you, Dr. Gottlieb: This auto enrolling debate, helpful, harmful, or is there an incentive to, if you auto enroll, people are losing idea of cost and coverage by just letting it roll? If you auto enroll one policy down because they weren't engaged in making the decision, would that force a closer scrutiny of the policy?

Dr. GOTTLIEB. Well, we talk about auto enrolling in the plan we put out through AEI. What we do is we provide a minimum subsidy level that is going to be sufficient for states to be able to auto enroll individuals in a basic plan. We give the flexibility of states to do that.

Now, the reality is in our scheme, you are going to end up being auto enrolled into a basic healthcare plan that is only going to provide catastrophic coverage, so a lot of people are not going to like it. But we do talk about the concept in our plan.

Mr. SHIMKUS. I talk about catastrophic coverage all the time, and I think that is where we need to be.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentleman, and now recognizes the gentleman from New York, Mr. Engle, 5 minutes for questions.

Mr. ENGEL. Thank you, Mr. Chairman. I thank you and the ranking member for holding today's hearing.

Let me just say, you know, when you take a massive bill like the Affordable Care Act, of course, there are going to be problems with it. Major bills like this, whether it was Medicare or Medicaid or other large bills, you see how they work, and then you tweak them. You change things. You improve things. But, unfortunately, we haven't been able to do that. The majority seems to be more intent on trying to get us to repeal it 62 or 63 times, which really wastes everybody's time. We really should all put our heads together on both sides of the aisle and do some commonsense fixing. Not repeal it, because we really believe this Act is here to stay, and we believe that this is something that benefits people, because Ms. Corlette's testimony is a very apt reminder of the practices that were routinely employed prior to the passage of the Affordable Care Act.

Let's state them, again: Denying insurance for people with pre-existing conditions, forcing certain populations to pay exorbitant rates, applying lifetime limits to care. These practices, if you are under 26, you couldn't stay on your parents' plan. These practices were once commonplace in the individual insurance marketplace.

So we have made this point numerous times, and I think it is important to, again, remind ourselves what the status quo used to be and how it affected people, people like our constituents, our families, and our friends. And as Ms. Corlette mentioned, like any law, the ACA is not perfect. But it has made a world of difference for those millions of Americans who were once denied coverage or

couldn't afford it, and I think we need to keep working to ensure it continues to make a difference for millions more.

Ms. Corlette, you notice that the ACA has allowed states to implement new delivery systems reforms, a space which New York has been tremendously successful. New York's delivery system reform incentive payment program is laying the groundwork to ease payers' and providers' transitions from a fee-for-service system to one in which reimbursements are based on value, not volume. Through this program, often referred to as DSRIP, New York will be able to allocate more than \$7 billion in Medicaid savings towards improvements to its healthcare system over the next several years.

So would you talk a little more about the kinds of delivery system reforms that have been spurred by the ACA, and how those reforms might benefit the health system as a whole?

Ms. CORLETTE. Yes, absolutely. I mean, I talked earlier about how health insurance is such an expensive product. And one of the reasons health insurance is so expensive is because the delivery of care and the way we pay for care is often irrational. So some of the things that the Affordable Care Act did was really launch some experiments, primarily using Medicare, but also Medicaid, and I think Covered California is an example of how a state could maybe use its marketplace to also get at some of these payment and delivery system issues.

So some examples are encouraging expansion of patient centered medical homes, where care is truly coordinated and there is a real emphasis on primary care for people with chronic conditions, bundling payments for a particular medical procedure, so that, in some cases, providers are actually taking on some risk if they overdeliver services. That is another example. ACOs, accountable care organizations, again, where providers are taking on some risk; if they are over budget and not delivering quality of care, then they take a financial hit.

So those are just a few examples of some of the demonstration projects and other things that are being launched, and New York is a great example of a state that is taking it up and running with it.

Mr. ENGEL. Thank you.

Mr. Shimkus had asked a question to one of the other panelists about actuarial value. I am wondering if you would like to comment or respond to that question?

Ms. CORLETTE. Yes, sure. So the actuarial value targets are built around the bronze, silver, gold, platinum level plans. And, I mean, we talked a little bit earlier about how consumers are making trade-offs, right, between higher deductible, lower premium, higher premium, lower deductible. And that, it simply—these are signals for consumers to be able to help them make those trade-offs in a clear and understandable way. And as far as I can tell, they are working. Predominantly, people are enrolling in the silver level plans, but, you know, with 86 percent of people reporting satisfaction with their coverage in the marketplaces, it sounds like I think people are generally happy with their choices.

Mr. ENGEL. Thank you.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman. This has been a productive discussion today. I was a cardiovascular and thoracic surgeon before coming to Congress, so, obviously, it is near and dear to my heart. The one thing we are not talking about, though, is the cost of the product, itself, is too expensive. I mean, that is not what this is about. You addressed some of that.

The only way that we are going to get a handle on this is we are looking at ways to cover a product that continues to be too expensive itself, and so in some future hearings, hopefully we can address that. There is no price transparency in health care, very minimal from a consumer perspective, and it is third-party payer. The consumer doesn't care what things cost, essentially, because they are not paying the bill for the most part.

Quality transparency, which is improving. The Society of Thoracic Surgeons, my society, has had a database for almost 25 years that I participated in. The expansion of that is leading to some consumer-driven type health care, Healthy Indiana plan is the way we are covering our Medicaid population that is leading to decreased cost in that space, because consumers have a little bit of their own skin in the game. And we need to further incentivize preventive care by paying for it better because the people don't get sick, it doesn't cost you any money.

So that is my lead-in. I would also like to say some of the mentioned problems in the marketplace that were just mentioned were recognized by both sides of the political aisle. Everybody recognized preexisting conditions was the problem. Everybody—all of those—it is everything else that the ACA did that was the issue. We could have solved those problems in a different way, in my opinion.

The average Federal exchange premiums jumped 12.6 percent for bronze plans, and this is 2015; 11.3 percent for silver plans. Deductibles were up by \$500 in the silver plans. The reality is the people I talked to, healthcare costs are going up for everyone. And I think even though, in fairness, there are many people that are happy with their insurance coverage, there are also complaining about the costs.

The Gallup Poll recently said that healthcare costs are at the top of American families' financial concerns, number one.

So that said, a lot goes into rates: experience, trends, reinsurance, taxes, benefits, medical loss ratio, many of which are mandates in the ACA.

Ms. Corlette, in your testimony, you note Congress should approve affordability. I think we all would agree with that. You say that we can achieve that through premium cost-sharing arrangements. Can you identify—and this would be for the full panel, but I will start with you. One, government mandate that could be eased today that would alleviate costs? You may not be willing to mention, to say—

Ms. CORLETTE. Yes, I have to take a minute to think about that. But I would happily cede to my counterparts while I am thinking about it.

Mr. BUCSHON. Yes, I mean, I think since I am one of the last to ask questions, some of them have been answered, right? The 3–1 age premium limit is a big one, the MLR is a big one. Others?

Ms. CORLETTE. I would only point out that by expanding the age rating you would be lowering costs for younger people, but raising them for older people. So, there are winners and losers when you do that.

Mr. BUCSHON. Except for the fact that that is limiting the ability of younger people to enroll because the costs are too high for them to enroll in the plan in the first place. So—Mr. Roy.

Mr. ROY. Correct.

So in my written testimony, I provide a written illustration of this fact that, actually, the narrow age spans in the ACA end up increasing the cost of health insurance for older individuals as well, because the younger people don't enroll, which increases premiums for everyone in the end through adverse selection. So I definitely would highlight that, as you mentioned.

One thing I would bring up, since the goal is—you started in your question talking about, well, there are things in the ACA that we should change, and there are things that we should change, and there are things we should change to reform the way we pay for health care, and we absolutely do that as the core problem.

But one area that I would highlight that we haven't talked about today that is outside the scope of this today's hearing, but I would encourage you to consider is hospital consolidation. The fact that hospitals are consolidating and taking market power in a particular locality and using that market power to basically dictate prices to insurance companies, which insurance companies and Medicaid is simply forced to pass on in the form of higher premiums. That is a huge problem. There's a lot we could be doing to address the problem of hospital consolidation.

Mr. BUCSHON. I am running out of time.

Yes, and we are not even talking about the tax treatment of hospitals and the more complicated situation that we are in. Hospitals and insurance companies are building all the new glass buildings in every city that I visit, including my own. And it is getting harder and harder to justify to the constituents that their costs are going up, but yet, it appears that some of the providers of those things are doing quite well.

I am out of time. I yield back.

Mr. PITTS. The chair thanks the gentleman, now recognize the gentleman, Mr. Cárdenas, 5 minutes for questions.

Mr. CÁRDENAS. Thank you very much, Mr. Chairman. And I really appreciate the opportunity to have this hearing. I hope, and it appears to me that maybe we are starting to speak more about how we can legislate and improve on the environment that we have post-ACA instead of just talking about how we should go back to a world before ACA. But here we are. So thank you very much, Mr. Chairman and colleagues.

I am baffled that we would point out that healthcare costs keep rising, but it is my understanding—forget about my understanding. Could you answer the question, prior to the Affordable Care Act being passed, were healthcare costs going up in the United States

in overall consumption, overall GDP, et cetera, et cetera? Was it on the rise before the Affordable Care Act even got enacted?

Mr. ROY. Healthcare costs have risen every year since time immemorial, but one thing that is important, I think the question, sir, that you are trying to get at is, has the rate of growth in healthcare costs increased or decreased? And there's been, since 2003, a decline in the rate of growth in the increase of healthcare costs and healthcare spending that has continued with accelerated and exacerbated by the global recession. And so, now we are starting to see just in the last year, actually, the growth in healthcare spending and healthcare costs have turned up again. So there has been a significant increase in the growth rate of healthcare costs since the ACA's spending provisions went into effect.

Dr. GOTTLIEB. I would just add to that and echo that. When you look at the analyst reports being put out and what the healthcare companies are reporting right now, they are reporting clearly at the end of what we call an underwriting cycle, where healthcare costs declined as consumption, but yet, it declined during the recession and now you are seeing healthcare consumption go back up, and costs are going back up with it, and that is what the insurers are reporting. So that should be concerning. I think we are going to see an acceleration in healthcare inflation in the coming years.

Mr. CÁRDENAS. But weren't we seeing double digit year over year healthcare costs going up prior to the Affordable Care Act being enacted? Go ahead.

Ms. CORLETTE. Yes, sir. Before the Affordable Care Act was enacted, we were seeing double digit cost increases year over year, and since the ACA was enacted, we have seen lower costs growth year over year.

Mr. CÁRDENAS. And before the ACA was enacted, what would happen to somebody if they had a precondition? Say somebody had previously cancer, and it was in remission, and then all of a sudden they found themselves out of the insurance market? Say I want to get insurance. What would happen before the ACA was enacted? Would somebody likely, really, honestly, be able to get insurance with that precondition? Go ahead.

Ms. CORLETTE. Likely not. And I would point out, too, that there's been a lot of discussion today about how much more expensive these health insurance products are post-ACA. Well, one reason health insurance was cheaper before the ACA is they didn't cover sick people. So, yes, you can offer cheaper product if you don't allow any sick people—

Mr. CÁRDENAS. If you legally exclude sick people.

Ms. CORLETTE. Right. And if you don't cover benefits and if you don't cover mental health or prescription drugs, yes, the product will be cheaper. Will it provide the kind of financial protection that you and I and all of us with employer-based coverage are used to and expect? No.

Mr. CÁRDENAS. Also, let me ask you a follow-up. Prior to the Affordable Care Act passing, say somebody did get cancer and they wanted treatments and, thank God, they actually were cured, what was the likely deductible that that family or individual was likely going to be saddled with, with a full-fledged chemotherapy, maybe even some operations removing some tumors, et cetera, et cetera,

et cetera? What was the likelihood of that individual or family being saddled with their own portion of the costs, even if they had insurance?

Ms. CORLETTE. Financial stress is one of the biggest issues for cancer patients and their families, and not only can lead to medical bankruptcy and those kinds of things, but it also can really lead to worse health outcomes because of the trauma and stress of dealing with those financial costs.

Mr. CÁRDENAS. But what were the likely costs? Was it \$5,000, maybe \$10,000, \$20,000?

Ms. CORLETTE. No. If you have a cancer that it could be tens of thousands, hundreds of thousands of dollars depending on the kind of—

Mr. CÁRDENAS. Now, since the ACA has been passed, that same scenario, how much would that person be saddled with after all of that remediation and all of the treatments?

Ms. CORLETTE. I am really glad you mentioned that, because one thing we haven't discussed is that the ACA provides a critical financial protection in terms of an out-of-pocket maximum—

Mr. CÁRDENAS. We are running out of time. What is that?

Ms. CORLETTE. It is roughly \$7,000 a year that it would be maximum you would have to pay.

Mr. CÁRDENAS. Thank you. And also, look, I have a daughter. She is educated. She is a professional, so is her husband, both working. And when they had to go out and buy their own insurance, they were complaining. And when I asked them how much they were paying for this healthy couple, young couple, they were in their late 20s, they were complaining about the costs. And having been a former employer myself, I said, what are you complaining about? How much would it be? It was like a couple hundred bucks a months for them to get that coverage with a maximum deductible, \$7,000, et cetera, et cetera, et cetera.

And I was sitting there going, you know what, complaining about your health care cost is a matter of perspective, and some Americans are so dammed spoiled, including my own family, that they don't even get the fact that we are in such a better place today.

Thank you, I yield back.

Mr. PITTS. The chair thanks the gentleman. I now recognize the gentleman, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I appreciate it. Thank the panel for their testimony today as well.

Mr. Roy, in your testimony, you mentioned the convoluted tax credit system leading of incidents of waste, fraud, and abuse.

Today, we have more confusion during tax time as people need more tax forms. A means-tested tax credit that penalizes midyear pay raises, and as recently as January, the IT report that CMS can't, they cannot verify premiums paid before paying premium tax credits to insurance companies.

Can you elaborate on some of these problems, and what we should do? Is there a better alternative to the current tax credit based-premium assistance program, the system? Is there a better way?

Mr. ROY. Absolutely. And you correctly highlighted some of the examples of how problematic that system is.

One thing you often find is that people whose incomes are, say, 200 percent of the Federal poverty level, their incomes are volatile. They are often working odd jobs and being freelancers, so their income goes up and down.

So if they have to estimate what their income might be for the next month, and then it turns out they estimated that inaccurately and the subsidy they received is inaccurate because of that, theoretically, by law, the Treasury Department is supposed to go after them and recover what excess subsidies they received and vice versa.

That is an incredibly cumbersome system, and it also incentivizes people to underestimate their income in order to receive subsidies, knowing that the Treasury Department doesn't really enforce that clawback provision as often as they should.

So this is a serious problem, and the best way to deal with it is through a statutory change that, as I discussed in my written and oral testimony, would use the previous year's taxable income as the basis for whatever assistance you provided in the following year.

Now, that of course would not 100 percent match with your daily or monthly income, but that is the tradeoff for a system that is much more easily enforced where there would be very limited waste, fraud, and abuse, compared to the system we have today where there is enormous—as you mentioned, the OIG reports and other reports have estimated that there have been billions of dollars of misplaced subsidies and misallocated subsidies as a result of the very cumbersome, technocratic system that the ACA imposed.

Mr. BILIRAKIS. Dr. Gottlieb, do you have any thoughts on a better premium system, subsidy system?

Dr. GOTTLIEB. This is the reality of—look, we have never done this before. We have never tried to provide middle class consumers a subsidy based on income that changes as their income grows. And trying to create that framework is going to lead to very odd structures like the clawback, and people might underestimate their income just to get the float for the coming year, not to mention what Avik mentioned with respect to the fact that there isn't real enforcement in terms of clawing back that money, so you are getting a lot of wasteful spending.

This is why we advocate an age-based subsidy and a subsidy structure that allows the subsidies to be tied to a looser rate-setting environment where premiums can adjust based on risk. And I know there is a lot of criticism of an age-based subsidy because people who are in lower-income brackets might not get enough of a subsidy to be able to go into the market in as robust of a fashion as they are under the current scheme. These are the tradeoffs. I mean, an age-based subsidy and a risk-based subsidy will eliminate the need to have these really odd tax consequences that we have right now that I think aren't going to be fully enforceable.

Mr. BILIRAKIS. Thank you for those suggestions.

Dr. Gottlieb, you testified here in 2014 about the problems of narrow networks in the ACA. At the time, I used a very real example of the Moffitt Cancer Center, which is just outside my district—the only NCI-designated cancer center in Florida, by the way—only being available at that time in 1 out of 12 ACA plans in Florida.

It seems to me that the people most disadvantaged by the law may be the sick patients with serious, chronic, complex medical conditions. Unfortunately, the problem of narrow networks seems to be growing, unfortunately.

Can you talk about the growth of closed pharmacies, the continued narrow networks, and how we may build a system with more patient choices?

Dr. GOTTLIEB. The insurers are doing what they can to try to control costs in the marketplace that I think where the pool has ended up much more skewed than what people anticipated. So they are trying to cheapen the benefit, and they are doing that by continuing to narrow the networks and close drug formularies.

CMS is starting to apply more oversight on the networks and network adequacy right now. They are not applying as much oversight on the formularies. And so you are seeing very restrictive formularies. I went through and systematically looked at about 25 plans for the coverage around drugs for multiple sclerosis. I found that most plans excluded 6 or 7 of the 12 top drugs that you use to treat the disease, and that is a disease where you want to provide maximal flexibility to patients in treatment selection.

I think these are just the consequences of a very prescriptive regulatory scheme that takes away a lot of the other tools insurers might have to try to manage costs. They are going to manage costs through the only vehicles they have, and this is all that we have left them. And so I think you will continue to see increased ratcheting down to the extent that CMS is going to allow it under regulation.

Mr. BILIRAKIS. Mr. Roy, any thoughts?

Mr. ROY. Yes. So I think that it is part of a continuum of problems with when you have a cumbersome system and you don't have the right enforcement, what are you going to do? You basically have to go through various complicated—the IRS doesn't audit people's monthly income statements.

So, again, the simplest way to deal with this is, if you go by the previous tax year's income, and then you have an age-adjusted subsidy along with it, then what you can do is—it is very transparent. People can know ahead of time, OK, here is my age, here is my income in the previous tax year, here is the assistance I am going to get.

And then you pair that with a regulatory system that gives people the flexibility so that insurers have the freedom to offer young people and healthy people plans that are affordable to them that accurately represent the expected healthcare consumption they might have in a given year.

Mr. PITTS. The gentleman's time has expired. Thank you.

That concludes the questions of the members present. We will have some additional questions from members. We will submit them to you in writing. I ask that you please respond.

Terrific panel today. Thank you so much.

Members have 10 business days to submit questions for the record. That will be close of business on Wednesday, May 25.

Without objection, the hearing is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2927
Minority (202) 225-3641

June 17, 2016

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

Dear Dr. Gottlieb:


Thank you for appearing before the Subcommittee on Health on May 11, 2016, to testify at the hearing entitled "Health Care Solutions: Increasing Patient Choice and Plan Innovation."

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

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on July 1, 2016. Your responses should be mailed to Graham Pittman, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, DC 20515 and e-mailed in Word format to graham.pittman@mail.house.gov.

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

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record

The Honorable Chris Collins

Major insurers are dropping out of insurance marketplaces all over the country, and beneficiaries are being left with fewer choices and increasing costs. Your written testimony states that we should focus our reform efforts around, “increasing choice and competition as a way to give consumers more options, and more opportunities to access affordable coverage.”

1. Do you think that removing the current government monopoly on operating health insurance exchanges and allowing subsidy portability could help these efforts?
2. Do you think it would make sense to create a new portal for plan shopping that would allow private entities to take on more functions and compete for consumers, provide consumers with greater flexibility, and at the same time, allow the government to outsource activities that the private sector excels in?

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WASHINGTON, DC 20515-6115
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Minority (202) 225-3641

June 17, 2016

Ms. Sabrina Corlette, J.D.
Research Professor
Center on Health Insurance Reforms
Georgetown University
3300 Whitehaven Street, N.W.
Washington, DC 20057

Dear Ms. Corlette:


Thank you for appearing before the Subcommittee on Health on May 11, 2016, to testify at the hearing entitled "Health Care Solutions: Increasing Patient Choice and Plan Innovation."

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

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

Sincerely,


Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Gene Green, Ranking Member, Subcommittee on Health

Attachment

Attachment — Additional Questions for the Record**The Honorable Chris Collins**

In your series of recommendations you highlighted the fact that many eligible consumers are not being reached by current exchange structures and suggested that the shopping experience should be made easier. While you focused on increasing the government's role and spending for these activities, I'm curious as to whether you have considered the fact that many private entities would be interested in investing heavily in this space to target populations that are being missed and compete for their business. Many private websites have experience targeting consumers and helping them with plan selection through "smart shopping tools." All of this is being done without additional government funds.

1. Should we consider removing restrictions on the private sector to providing these benefits to aid consumers?

While there are state licensing and marketing requirements with which private exchanges and insurance brokers must comply, I am aware of no federal restrictions on the ability of private exchanges or brokers to sell legal health insurance products directly to consumers or employers, either online, over the phone, or in person.

You may be suggesting that consumers should be able to access the federal premium tax credits and cost-sharing reductions for qualified health plans through private exchanges or online brokers. This is currently available to consumers, but some web brokers have raised concerns about continued barriers to a seamless enrollment. HHS/CMS is currently working on this. See the preamble to the 2017 Notice of Benefit and Payment Parameters, available here: <https://www.gpo.gov/fdsys/pkg/FR-2016-03-08/pdf/2016-04439.pdf> and 45 CFR 155.220(c). My personal view is that insurers and brokers may have greater incentives to invest in marketing, outreach and web-based decision support tools if consumers are more easily able to buy directly from them. However, it will be important to maintain strong consumer protections to ensure that (1) consumers are able to see all available plans, not just those for which the broker or exchange receives a commission and (2) to limit potential fraud and abuse related to the federal subsidies.

The Honorable Lois Capps

As of June 2015, 1.3 million people in California are actively enrolled in health insurance, and our uninsured rate has been cut in half. Our state exchange has required health insurance companies to build consumer tools that encourage participation and transparency. In using all the tools at our disposal to regulate the market, and be active purchasers of health care, California has emerged as a leader in this space and has succeeded in providing important health care services to citizens.

1. Ms. Corlette, how do these state tools and others protect consumers? Should other states adopt these practices? For states who don't take these steps, what are consumers faced with? And further, should the federal exchange be doing anything like this?

California and its health insurance marketplace, Covered California, have engaged in a range of activities to deliver greater value in health insurance to consumers. They include, for example: selectively contracting with insurers, negotiating premiums, standardizing benefit designs, and requiring insurers to engage in efforts to improve the quality and efficiency of health care delivery. In addition, I would argue that the state's decision to prohibit the so-called transitional or "grandmothered" plans in 2014 led to a better marketplace risk pool than has been seen in other states.

These activities and policy decisions have helped consumers in the following ways: First, and importantly, premium rates in California's marketplace are likely lower than they otherwise would be (although it is extremely difficult to demonstrate this conclusively). Second, by standardizing benefit designs, the marketplace improves consumers' ability to compare plans and ultimately select the one that best meets their health and financial needs. Third, by pushing insurers to do more to improve the quality and efficiency of the delivery system, the marketplace is helping consumers get more value for their premium dollar.

While the Affordable Care Act provides all marketplaces with the authority to be "active purchasers," not all state-based marketplaces (SBMs) are exercising that authority. By some estimates, 10 SBMs are engaged in one or more activities that could be considered active purchasing, but none have embraced the authority to the extent that California has. For example, while 7 states require participating insurers to offer standardized benefit designs, California is the only state that requires all plans to be standardized. In the other 6 states, insurers are also allowed to offer non-standardized plans. To the extent that the goal of such a policy is to enable consumers to make apples-to-apples plan comparisons, allowing standardized and non-standardized plans to be marketed side-by-side limits consumers' ability to do so.

The federally facilitated marketplace (FFM) has signaled an intent to engage in more active purchasing activities, such as by encouraging (but not requiring) insurers to offer standardized benefit designs in 2017. Standardized plans may be required in future years. However, there are limits to the FFM's ability to be an active purchaser in the way that an SBM can. First, the FFM must adopt policies that apply across 34 states, each with different market dynamics and characteristics. For example, a policy that might work well in a state with 10 or more competing insurers might not work as well in a state with only one or two. Second, the FFM has limited capacity to engage directly with insurers in the way that a SBM can do on a local level. Covered California executives speak of "jawboning" premiums down in negotiations with insurers. This would be much more difficult to replicate at the federal level.