

OBAMACARE'S IMPACT ON PREMIUMS AND PROVIDER NETWORKS

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM

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Wednesday, December 12, 2013,

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
WASHINGTON, D.C.

The committee met, pursuant to call, at 9:30 a.m., in Room 2154, Rayburn House Office Building, Hon. Darrell E. Issa [chairman of the committee] presiding.

Present: Representatives Issa, Mica, Turner, Duncan, Jordan, Chaffetz, Walberg, Lankford, Gosar, DesJarlais, Farenthold, Woodall, Collins, Meadows, Bentivolio, DeSantis, Cummings, Maloney, Tierney, Clay, Lynch, Connolly, Speier, Cartwright, Duckworth, Davis, Cardenas, Horsford, Lujan Grisham, and Kelly.

Staff Present: Brian Blase, Majority Senior Professional Staff Member; Molly Boyd, Majority Deputy General Counsel and Parliamentarian; Lawrence J. Brady, Majority Staff Director; Sharon Casey, Majority Senior Assistant Clerk; John Cuaderes, Majority Deputy Staff Director; Brian Daner, Majority Counsel; Adam P. Fromm, Majority Director of Member Services and Committee Operations; Linda Good, Majority Chief Clerk; Frederick Hill, Majority Deputy Staff Director of Communications and Strategy; Christopher Hixon, Majority Chief Counsel for Oversight; Mark D. Marin, Majority Deputy Staff Director for Oversight; Matthew Tallmer, Majority Investigator; Sharon Meredith Utz, Majority Professional Staff Member; Rebecca Watkins, Majority Communications Director; Krista Boyd, Minority Deputy Director of Legislation/Counsel; Courtney Cochran, Minority Press Secretary; Jimmy Fremgen, Minority Policy Advisor; Susanne Sachsman Grooms, Minority Deputy Staff Director/Chief Counsel; Jennifer Hoffman, Minority Communications Director; Chris Knauer, Minority Senior Investigator; Una Lee, Minority Counsel; Juan McCullum, Minority Clerk; Jason Powell, Minority Senior Counsel; Dave Rapallo, Minority Staff Director; Daniel Roberts, Minority Staff Assistant/Legislative Correspondent.

Chairman ISSA. The committee will come to order.

The Oversight Committee exists to secure two fundamental principles: first, Americans have a right to know that the money Washington takes from them is well spent and, second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold Government accountable to taxpayers, because taxpayers have a right to know what they get from their Government. It is our job to work

tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy.

Today, as we view a continued rollout of the Affordable Care Act, we deal with the Administration's selling technique. The Administration sold the health law to the American people with a simple, clear promise: if you like your plan, you can keep your plan; if you like your doctor, you can keep your doctor.

After millions of Americans received notices that their plans were being canceled, the President was forced to acknowledge just how misleading he had been. The President apologized for people who were misled by his claim and found themselves in difficult circumstances. The quote is: "I am sorry that they are finding themselves in this situation based on assurances they got from me. We've got to work hard to make sure that they know we hear them and we are going to do everything we can to deal with folks who find themselves in tough positions as a consequence of this."

Now there is mounting evidence that the President's second promise is also untrue. Americans cannot keep the plan they like, they cannot keep the doctor they like, and it is increasingly clear that more needs to be done to keep the President's assurance that we will do for folks everything we can.

Americans deserve to hear the truth. The Administration has been stringing them along with promises that every day are being broken. Many of these promises were predictable; many of these occurrences cannot be reversed. But to the extent that we can bring the American people the truth of what is happening and reverse, in any case we can, the lowering of access to care, we must do it.

Initially, in Minnesota, for example, the Mayo Clinic was only going to be open to people virtually within walking distance. Now it is open, because of the backlash, to at least people in Minnesota. But as a Californian, the ability to get reimbursed, if I am a California exchange, for the Mayo Clinic does not exist; and this is true throughout the Country.

Just last month, thousands of doctors were terminated from Medicare Advantage plan networks, including 2250 in Connecticut alone. Thousands of seniors are facing the loss of physicians they relied and trust on.

In Florida there are areas of Southwest Florida in which no oncologist exists for patients who currently have life-threatening cancer.

Many Americans who are shopping for plans on the Obamacare or Affordable Care exchanges have found that they offer extremely limited provider networks that exclude their preferred physicians, physicians who they have built relationships with. Many parents are finding out that their child's pediatrician is no longer covered by their insurance plan.

We now know that exchange plans exclude our Nation's best hospitals, hospitals like Seattle's Children and Sloan-Kettering, MD Anderson Cancer Center, and the like. Unfortunately, millions of Americans are likely to find out early next year that their new health insurance plan doesn't cover the doctors who they most value and trust. Such limited plans demand that we ask the question: What quality of care will Obamacare actually provide?

The access shock has prompted many Americans to ask: Didn't the President promise me that I could keep my doctor, period?

On November 19th, the White House press secretary explained that the President meant by that "you can keep your doctor" was that, if you want coverage from your doctor, you can look and see if there's a plan in which your doctor participates. Clearly, in the case of Federal and State exchanges, it is unlikely that the best, and perhaps most expensive, physicians will ever be available.

Just this past Sunday a key architect of the law explained if you like your doctor, you can pay more for that doctor. Before the Affordable Care Act was passed, you had that right, and you had the right to pick a plan that suited you and paid for that doctor.

In essence, the public is now being told, if you like your doctor, then you can try to find a plan that carries them, and then you can pay more for that plan. But you are already paying more for plans that include items you don't want, items you didn't need and likely will not need. This is so unacceptable to the American people that there is no question, both through public polls and, if you will, even by Democrats no longer touting the main benefit of the Affordable Care Act being the improvement of affordability of healthcare, there is no doubt at all that if you could pass this bill again, you couldn't pass it in this Congress. Even if you had not read it and you knew what was going to happen, you would not vote for it.

When our Government, including the Congress, passed this law, we have a solemn duty to honestly inform the American people of what is going to happen. In this case, clearly the American people were misled. This duty is no more solemn when it affects Americans' relationships with their physicians. That is a sacred trust; it is the most important thing in the life or death situation to many Americans, and it is a trust that has been broken.

Today we will hear testimony from experts at think tanks and institutions. They will be on our second panel. We have concluded that the first panel should include three doctors who have actual life experience practicing with patients and realizing what can or cannot be done, what should or should not be done, and direct experience of what is happening under the Affordable Care Act not just to their practices, which are businesses, but to their patients, who are human beings in need of their care. Today the testimony from these physicians will describe in the most candid and personal terms exactly how the Affordable Care Act, or Obamacare, has affected these patients in their practices.

I am sure these doctors will agree that there were problems in the healthcare system that needed to be reformed. The fact is America had an imperfect system developed with a number of public and private forms of money, tremendous Federal taxes, insurance companies that were often difficult to work with, and the like. But a broken system that is repaired by crashing it into a wall is not, in fact, a fixed system.

With that, I would recognize the gentleman from Maryland for his opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, and thank you for calling this hearing. This week I had the tremendous honor and privilege of traveling to South Africa as part of our Nation's delegation to honor the life of the late President Nelson Mandela.

It was an inspirational trip, a life-altering trip because I had the opportunity to reflect on the amazing changes that one individual, working with determination over a lifetime, can bring to millions of others.

There will always be forces aligned against progress, against equality, and against basic human dignity. But Nelson Mandela's life reminds us that our mission on Earth is to transcend these destructive forces and always pursue the betterment of our fellow man.

As I traveled back yesterday on the 20-hour flight home, I began thinking about today's hearing, and I was amazed again at the significance of what our Nation accomplished with the Affordable Care Act. Before we passed this landmark law, millions of our own citizens could not obtain health insurance because they had pre-existing conditions, and we allowed insurance companies to discriminate against them. They charged exorbitant premiums that were prohibitively expensive, they attached riders that excluded care for these illnesses, and in many cases they did not access the health insurance altogether. Think about this: Before we passed the Affordable Care Act, there were about 50 million people in the United States without health insurance. Fifty million. That is almost exactly the population of the entire country of South Africa. Before the Affordable Care Act, we had an entire Nation within a nation of people without coverage; no insurance for doctors' visits, cancer treatments, prescription drugs, or hospital care. That was a shameful and immoral legacy for a Nation as prosperous as ours.

Three years ago, after decades of inaction, Congress and the President passed the Affordable Care Act. We finally banned insurance companies from discriminating against people with pre-existing conditions. We prohibited insurance companies from charging higher prices for women than for men. We eliminated junk plans that collected premiums, but then did not pay hospital bills when the people got sick. The result today is that tens of millions of people now have something they did not have before we passed this law: the opportunity and the ability to afford and obtain quality health insurance that will safeguard their financial security and recognize their dignity as human beings.

Congress understood, when we passed the Affordable Care Act, that these changes would tend to increase premiums for a subset of people who already had insurance under the old discriminatory rules. So we put in place several measures to lower prices and control costs, including subsidies to help people buy insurance, a requirement that insurance companies spend at least 80 percent of premiums on healthcare services or offer rebates to consumers, and reviews of proposals by insurance companies to raise their rates by more than 10 percent in a year.

The good news is that the actual premium rates have now been submitted by insurance companies, and they have come in much lower than expected. In September, the Department of Health and Human Services issued a report explaining that actual premium rates now being offered under the Affordable Care Act are 16 percent lower than projected. Based on this actual premium data, the Center for American Progress issued a report in October showing that these lower premiums will save the Federal Government \$190

billion over the next 10 years, meaning 700,000 additional people will be able to obtain coverage.

More broadly, the Centers for Medicare and Medicaid Services issued a report finding that national health spending has slowed to only 3.9 percent in the last three years, which is the lowest rate since the Government began keeping these statistics in 1960.

I understand that we will consider two studies today that assert that premiums are increasing for the majority of people in the exchanges. Both reports have significant, very significant flaws. First, the Heritage report completely disregards the subsidies provided by the Affordable Care Act. Completely. As a result, it inaccurately inflates the actual cost of coverage for consumers across the Country. Second, although the Manhattan Institute study is better because it includes subsidies, it still compares “apples to avocados,” as one commenter explained. It compares five plans under the Affordable Care Act with the five cheapest plans offered before the law passed. The obvious problem is that the old cheap plans offered vastly inferior coverage. To me, the most significant problem with comparing premiums before and after the Affordable Care Act is that it disregards the 50 million people who could not get insurance. If someone could not afford a policy that covered a pre-existing condition, the price of that prohibitively expensive plan is not considered.

Let me close by offering a final thought. One of the things that Nelson Mandela will always be remembered for is his push for reconciliation. I respect the viewpoints of my colleagues on this committee, as well as those of our witnesses, and I understand that the Affordable Care Act is not perfect. I have said that many times. In that spirit, I hope that we can work together in a bipartisan way to improve the Affordable Care Act, rather than continuing to fight over its very existence.

One of the things that the late President Mandela said, and I have thought about this a lot because it is so true, he said it always seems impossible until it is done. It always seems impossible until it is done. We can no longer disregard the experiences of 50 million members of our population. We can no longer ignore the pain, the frustration, and the fundamental inequality of this Nation within a nation.

And with that, Mr. Chairman, I yield back.

Chairman ISSA. I thank the gentleman.

Members may have seven days to submit opening statements and other extraneous material for the record.

We now welcome our first panel of witnesses. Dr. Patricia McLaughlin, M.D., is an ophthalmologist in a private practice in New York City. Dr. Eric Novack, M.D., is an orthopaedic surgeon with the OrthoArizona practice in Phoenix, Arizona.

And I would like to recognize the gentleman from Georgia, Mr. Woodall, to introduce his constituent, Dr. English.

Mr. WOODALL. Thank you, Mr. Chairman. I appreciate that courtesy. We do have the great pleasure having Dr. Jeffrey English with us today. He has been a tremendous resource to the Georgia delegation, not just to me and Mr. Collins on the committee, but to the entire delegation. I want to tell you just a little bit about his background.

He earned his bachelor of arts in psychology at Boston College in 1991 and then graduated from Dartmouth Medical School in 1995; served relatively close by here as chief resident in neurology at the University of Maryland in 1999; and to the great pleasure of all Georgians has chosen to call Norcross home, where he is now the Director of Clinical Research at the Multiple Sclerosis Center in Atlanta and President of the Georgia Chapter of Docs for Patient Care.

It is with great pleasure that I welcome you today, Dr. English, and thank you so much for what you do for us not just on the committee, but for us back home.

Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

Pursuant to the committee rules, I would ask all three of our witnesses to rise to take the oath. And please raise your right hands.

Do you solemnly swear or affirm the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

Chairman ISSA. Please be seated.

Let the record reflect that all witnesses answered in the affirmative.

Dr. English, do you have time in your practice to watch C-SPAN?

Dr. ENGLISH. [Nonverbal response.]

Chairman ISSA. Well, then for all of you, I will give you a brief. First of all, with unanimous consent, all of your opening statements in their entirety will be placed in the record. In addition, any pertinent or even extraneous material you would like to submit now or for the next seven days will be included in the record. That leaves you free to use the entire five minutes on the clocks in front of you to say anything you would like to say, but I would ask that, as that runs down, you try to wrap up.

Dr. English.

WITNESS STATEMENTS

STATEMENT OF JEFFREY ENGLISH, M.D.

Dr. ENGLISH. Mr. Chairman and members of the committee, I want to thank you for inviting me to talk about how the Affordable Care Act is going to affect my patients.

Practicing physicians who see real patients like myself, members on the panel, and the Group of Docs for Patient Care, who have read the law and understand the law have already predicted some of these outcomes that you mentioned earlier. None of what you are seeing and are about to see is unforeseen. The Affordable Care Act's problem is not a computer site. It would be common sense to me that a program that is designed in Washington, D.C. by people who don't take care of patients, that is supposed to affect people from Maine to Oregon in a sort of a top-down fashion, with patients being so variable, is going to have a lot of unintended consequences, as you mentioned before. Unfortunately, those unintended consequences are the patients that we are going to talk about, and they are also your constituents and our fellow Americans.

I am a private practice doctor, but half of what I do is in a salaried position at the MS Center of Atlanta, which is a nonprofit for the treatment of patients with MS. What I am going to talk about is not isolated to MS, certainly.

MS is a disease of the brain and spinal cord, and can be very disabling; affects about half a million Americans. Most of the patients are female and it affects them at a young age, twenties and forties. In the 1990s we had no medications; now we have ten. They are highly variable; patients' response is highly variable and they can have life-threatening side effects. So the MS patients require twice the number of staff and twice the amount of time to take care of. So these people can present as young teachers, working mothers who all of a sudden can't walk, a typical presentation.

MS doctors must be able to identify risk factors and start to move very quickly to therapy. It takes a lot of experience to know how to do that, which is why we have about 5,000 patients that come from 28 States and 118 of our 159 counties in Georgia, and they look at us as their primary care providers because they see us so often.

We are now set up with a healthcare plan where we are looking at things like metrics that different physicians will be weighed against, and I think my colleagues will probably touch on this too. The metrics, again, are set up by people, mostly in Washington, D.C., who don't take care of patients. If you comply with these metrics, there are bonuses; if you don't, there are penalties. And section 302 and 307 of the healthcare law actually states some of those penalties include removing physicians from Government-approved insurance.

So I want to give you a couple of stories, and hopefully I can finish them in five minutes.

Number one was a report by CMS, or Centers of Medicare-Medicaid Services, February of 2012, and it said that I was an over-utilizer of MRIs, compared to my peers. MRIs are what we use to look at brain injury. They are a routine protocol for MS. Not to do so can lead to disability, so we obviously don't want to not do the MRIs. So I called CMS and I said, first of all, who are my peers, were they other MS doctors? They said no. My other peers also included orthopaedic surgeons. And I also said are you aware that I am an MS doctor and that these are routine protocols, and I got nos to that as well. They did tell me on the report, though, that this information would be on the Medicare website in the future, and people would look and they would see that I did not meet their standards. Again, that will be on their website.

I heard earlier in the opening testimonies about United Healthcare. Many of you have read United Healthcare dropped quite a few providers, and according to The Wall Street Journal article, it mentions that this was in part due to managing its network using Medicare's new five star rating system that ties bonus payments that meet certain measures on cost and quality.

Well, you are looking at now a downgraded physician. I am not off United Healthcare, but I am downgraded because of, again, in compared to my peers, which are fellow neurologists, general neurologists, they looked at cost and quality. And I want you to know that my quality was literally off the chart. There was a bell-shaped

curve. We were over here, thanks to my wonderful staff. However, because of cost, I was also too high, so that was what downgraded me. And the two areas of cost were, guess what, MRI, which we talked about, and the other was drug cost. MS drugs are expensive and I have absolutely no control over that. And, again, my peers are neurologists who send me their most complicated patients that require these therapies.

So I actually reached out to CMS a few years ago with a question, and I want to ask United Healthcare, but besides a December 2nd deadline to appeal, after three weeks of calling we still, now four weeks out, have not gotten through to United Healthcare to appeal after the deadline. So what I want to know, as a provider, am I supposed to not take care of MS patients, or do I just take care of them, but I don't do what is required, and limit my MRIs and my medications in order to meet metrics. And I think, again, this is just an example. I think physicians will be stuck with, the way the law is written now, that we will be penalized for taking care of these more complicated patients.

I will close by saying that I have submitted testimony on the State exchanges. They are going to have as equal a difficult time as far as access to medications and to providers who know how to care for certain types of patients like I do myself.

With that, I will close and again I thank you for this opportunity.
[Prepared statement of Dr. English follows:]

**Dr. Jeffrey English, M.D.
Neurologist
The Multiple Sclerosis Center of Atlanta**

Mr. Chairman, members of the committee, and my fellow Americans, I want to express deep gratitude for inviting me to discuss how the Affordable Care Act will affect patients and the ability of healthcare providers to care for them.

Physicians such as myself and those in the organization I represent, Docs 4 Patient Care, are dedicated to patient care. We have spent the time to read and understand the law, plus its almost daily addition of regulations, and have already predicted how harmful this law would be. None of what is happening now and will happen over the next months and years is unforeseen. Health care is a very personal interaction between an individual patient and their doctor in an exam room. Unfortunately, the doctor and the patient were completely left out of discussions when the law was written. The Affordable Care Act's biggest problem is not its website which will be fixed some day. Common sense will tell you that a top down program run by bureaucrats in Washington, DC, with a one size fits all system for patients from Maine to Oregon, will be filled with unintended consequences. Unfortunately, those unintended consequences are my patients, my fellow Americans, and your constituents.

I could talk for days about how patients will be hurt by this law. Because of time constraints, I will focus on several poignant examples.

I am a private practice physician. I spend half of my time in a salaried position at the MS Center of Atlanta, a non-profit organization dedicated to the treatment of patients with multiple sclerosis. What I am about to discuss is not unique to patients with MS but will serve as a great example of the damage to come.

MS is a disease of the brain and spinal cord that affects over half a million Americans and is a potentially disabling disease. The majority of patients are female and the disease presents when people are in the prime of their lives, 20's and 40's. Until the mid 1990's, there were no treatments for this disease. We now have 10 medications to use. Prior to these treatments, over half of patients would have progressive disability within 10 years.

My patients present as young teachers paralyzed due to spinal cord disease. They present as working mothers, previously providing for their families, with the sudden inability to walk or talk. An MS doctor must identify warning signs of progressive disease and must move quickly to change treatment to prevent permanent disability. This ability only comes through years of experience. Many neurologists and all primary care physicians will never attain that experience. This is why most of the 4,500 patients that come to our Center look at us as their primary care provider, as is the case with all MS doctors. We see patients from 28 States and 118/159 counties in Georgia for the same reason.

To understand what it is like to live with MS, a patient once told me to try to function normally in my house for a few hours with a flipper on one foot, a 10 pound ankle weight on the other, while keeping one hand in my pocket. The medications are aimed at preventing this type of disability or worse.

As stated, all patients are different. Their presentations and situations are never the same, nor is the response to treatment. For MS, the treatments given can be very different from one another (injections, infusions, pills) and some are associated with life threatening side effects. This is why MS patients require twice the number of staff and twice the time to care for them. Therapy must be personalized and often altered quickly as failure to do so can be catastrophic. One size fits all "treatment protocols" will harm patients.

Despite the dedication of providers and staff at centers like ours, the ACA will punish us because we take care of the most vulnerable patients that only we are equipped to care for. Metrics are being set up by bureaucrats that have never taken care of a single patient. CMS (Centers for Medicare and Medicaid Services) will evaluate providers based on their compliance with these metrics. Failure to meet these arbitrary metrics will lead to penalties. The law actually states that failure to comply with these metrics can lead to removal of providers from government approved insurance plans. (See sections 3002-3007 of the ACA.)

I am here today to tell you those punishments have begun.

In February, 2012, I received a report from CMS. The report mentioned a metric where I was an over-utilizer of MRI's (or brain imaging) "compared to my peers." MRI's are the best way of evaluating brain injury. It is standard protocol that MS patients on treatment be evaluated by MRI every 1-2 years. Failure to do so can lead to undetected, irreversible progression of their disease. I contacted CMS and asked if they knew that a large majority of my patients had MS and MRI's were standard protocol. I asked them if my "peers" were other MS doctors. They said that they did not know which patients I cared for and that my "peer group" included general neurologists and even orthopedic surgeons. The report warned me that when patients looked up my rating on the CMS website in the future, it would include data that showed that I over used MRI's and did not meet their standards.

Many of you recently may have read that United Healthcare dropped physicians from their Medicare Advantage plans. They stated this was due to "managing its network, in part, to provide more value for their members, particularly given Medicare's new five star rating system that ties bonus payments for insurers that meet certain measures on cost and quality." (Melinda Beck, The Wall Street Journal)

Keeping that in mind, here is another example of unintended consequences that will affect real people. I recently was downgraded by United Healthcare to "non-preferred" status. It turns out that a significant number of MS specialists within and outside of my practice were also downgraded. The United Healthcare report looked at 2 metrics. One was quality of care. You will be happy to know that I received "off the chart" positive

results. The second was cost metrics. Unfortunately, my costs were above “my peers,” which lead to my downgrade. At least this time my peers were fellow neurologists, but not neurologists that care for MS patients. The driving factors for my higher costs were MRI and drug costs. MS drugs are very expensive, about \$50,000 per year, but that is beyond my control. United Healthcare’s website states that patients will have to pay more to see “non preferred doctors.”

So, I will ask members of Congress the same question I asked CMS and the same question I have been trying to ask United Healthcare for over 3 weeks. (We haven’t been able to get through to United Healthcare.) Do you want me to stop taking care of patients with MS or just stop taking good care of them and withhold their medications in order to meet metrics? Should my fellow physicians take care of only people who are young and healthy in order to meet metrics?

In summary, neurologists in 28 States are referring their most complex patients for me to take care of because they trust my experience, experience they don’t have. These patients require medications and monitoring that is costly due to their complexity and these factors are beyond my control. In reward for my passion to prevent real people from becoming disabled, CMS and insurance companies like United Healthcare are going to post negative grades in my name. They will financially penalize me, or the institution I work for, as I am trying to practice quality care to some of our most vulnerable patients.

I would like to quickly shift gears before I finish and discuss the state exchanges. Remember that therapies are vastly different and delay in getting a patient on appropriate therapy, or switching to another therapy, can lead to permanent disability. In my state, insurance products sold in the exchanges only need to provide 4 of the 10 therapies. As you all have heard, insurance products sold in the exchanges will have extremely restricted physician networks. In every state, there is not simply one exchange, but numerous, each with its own products and restrictions. Just weeks before these products are supposed to take effect, patients have no idea if they will be able to see a doctor trained in treating their disease, nor if their medication will be covered. Patients like my previously paralyzed schoolteacher are afraid as the medication that has kept them functioning may be taken away leading to disability. What started a few years ago as uneasy laughter about what was in the ACA has turned into fear and even crying. I am used to tears when dealing with very ill patients, not when dealing with ones who are doing well.

No one in America will argue that the healthcare system did not need reform. The ACA took a bureaucratic, top down approach and the unintended consequences will be devastating. This is fact. Simply having an insurance card that does not guarantee access to providers nor medications is useless.

I know I speak for the staff, the nurse practitioners, and the physicians at the MS Center of Atlanta when I say I owe gratitude to every patient who has trusted their lives in our dedication and care. I will continue to fight for them with passion inside and outside of the exam room where healthcare decisions are supposed to occur.

Chairman ISSA. Thank you, Dr. English.
Dr. McLaughlin.

STATEMENT OF PATRICIA MCLAUGHLIN, M.D.

Dr. MCLAUGHLIN. Good morning, Mr. Chairman and members of the committee. I want to thank you for the invitation to be here, and I welcome that opportunity. I have submitted testimony which I hope you will all take the time to read; it is packed with details about the nuances of how these plans were designed and architecture with perhaps improper thoughts of the privates in the battlefield, and that being the patient and the doctor.

You are all generals, and we respect the hard work that you have done to get this law passed. And as Mr. Cummings said, even in my own family I can personally attest the fear that came when my father passed away and my mother, at the age of 61, with a terrible medical history, lost her insurance because it was company-based with my father's company, and for four years she was essentially uninsured. So I have walked that road and I understand where you are coming from, and the President, in wanting to do something for the citizens of this Nation who had such fears as well.

However, in taking care of that, unintentionally there were horrific events that are only starting to come to light, which is the part that concerns me so much. In my State society in ophthalmology, I serve as the third-party liaison, and I look at all things that insurances do as a patterned behavior and I report on them, and then we take appropriate action, as necessary; and most times, with good negotiations, we can sometimes make great strides. So I am an optimist at heart and I believe that everything can be fixed.

My former training in college and my graduate work was an aerospace engineer, and I had hoped to become an astronaut, but, because of my mother's health, my life took a vast change. And I must tell you a little divergent comment. The pay-for-performance structure that we have now in Medicare for bonus pay, to most physician colleagues, I think we can honestly say should be scrapped. We are trained to give our best to our patients. We are paid, supposedly, to give our best to patients. We shouldn't be doing metrics that have no bearing on the field that we do. In my field of ophthalmology, some of the pay-for-performance measures could include something as ridiculous as being a body mass index. What does that have to do with the health of the eye or what the eye says about other conditions in the body? Nothing.

So you are spending Medicare money for ridiculous measures, taking our time in clinical practice to document this for someone who is a statistician who wants to run numbers. This is not what the doctor-patient relationship is about, and that is the only thing that this is about.

My comments have no bearing on politics or what brought us to this point. We are now at T minus 20 days and counting. The doctors and the patients are going to be having extreme difficulties in accessing care.

And yes, Mr. Cummings, I agree with you it is nice to carry a plastic insurance card to say you are insured. It is quite another thing to access the care.

Whoever allowed the insurance companies to devise the current plans and how they are structured on the Affordable Care Act and, I might say, affecting small businesses, as well, outside or off the Affordable Care Act, leaves a lot to be desired. And I am glad that I was put in the middle of this, because for everything bad something good comes of it, and that is why I am here today. As a small business, I insured my family and my two employees, and I had wonderful insurance. I was pleased with it. It was a small business plan. And I might tell you a little fact now that you will find surprising. In 2008, just as you said, those premiums raised ridiculous amounts every year. One year it was 26 percent for this great insurance plan. I was in sticker shock. It got to the point, in 2008 dollars, that each individual in my small business plan, to have a fully comprehensive plan, would have cost \$859. These are 2008 dollars. I did the math and I said I can't possibly afford this, so I contacted my insurance broker, I said what are my options, and he mentioned the consumer-driven health plans. Not very familiar with it, a little bit leery about a new concept, I explored it. It took me two years to sign on, however.

What that did in those 2008 dollars, without the Affordable Care Act legislation, the insurance company took my premium of \$859 and dropped it down to \$300 for the same plan. So why? It did that because we had to assume a \$2,000 first-pay deductible expense. That is where the risk got put. The insurance company lowered the premium by increasing the deductible. We didn't have a deductible before for in-network coverage. We had a very modest deductible of \$500 to go out of network. And I was blessed, yes, with an out-of-network plan. I continued this plan for all those years and I was pleased.

I was not pleased when I received a letter dated September 21st that my plan was going to be canceled, that it was not in compliance, it said, with the ACA. I am no one to judge that; I have not read that 2,000-page document. I am assuming the insurance company is telling me the truth. They said that plan would be replaced by something comparable, and I trusted them for that. I have been with this company for years. I was a participating provider with them for years. Just like patients have trust in their doctors, patients have trust, sometimes, in their insurance company too, and I was one of them.

The new plan rolled out. It took away my out-of-network benefits, which I might say I might be able to live with because, under the high deductible plan, the in-network deductible was \$2,000 for an individual, but the out-of-pocket was \$3500. I was less likely, I must say, even in my position, and certainly my staff, to go to an out-of-network physician because those first dollar amounts would be ours to bear and, being a responsible individual, you should take care of your bills.

The new plan does not give out-of-network benefits; not just to me, but to all small businesses. The Affordable Care Act insurances do not allow for individuals out-of-network benefits.

What I also noted with my new plan that was developed was a very crafted letter that implied that even though I was going to have an in-network plan, presumably of the same level as my current day plan, but only in-network, it would now be called an EPO. The EPO plan was not going to have the same network of physicians that my current plan did. Both EPO and PPOs had the same network. The HMO physicians were a smaller, different network. So some doctors, by their contract, had the ability to be in one or the other network, but by some contracts they had to be in all products.

So what happened now was there was this term about I needed to be careful, as the administrator, and I needed to inform my employees that they needed to check to be sure that all of their doctors that they currently saw in-network—now, mind you, the same insurance company makes this a bit difficult, because you would assume if your doctor was in-network before, why wouldn't your doctor be in-network afterwards? But that was where the catch was.

The new network was given a fancy name, it was called Pathway, with variations; Pathway X, Pathway X Enhanced, or just simply Pathway. I didn't understand that. I am a participating physician. I never heard Pathway before. I just knew that I took care of the EPO and PPO levels, I took care of the HMOs and the point of services. But I didn't understand Pathway. I went to their website and I looked this up, and what I saw was that actually these pathways were very restricted. So we have now an inability to refer patients. As an ophthalmologist, I will need a neurologist, but if that neurologist is not in that network, how am I going to give the patient with optic neuritis and sudden loss of their sight the ability to see a fine physician that I have sitting on my right?

We have to fix this, and we have to fix this now. We have no time to play with this. Patients lives are at stake. Acute care situations need a specific doctor to refer the patient to; it is not enough to send them to an emergency room. And, by the way, many hospitals are not in these networks either.

I thank you so much for your time and I hope I can count on you to fix this. Thank you, sirs.

[Prepared statement of Dr. McLaughlin follows:]

TESTIMONY OF PATRICIA A. McLAUGHLIN, M.D.
AT A HEARING OF
THE US HOUSE OF REPRESENTATIVES
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
DECEMBER 12, 2013

My name is Dr. Patricia A. McLaughlin, M.D. and I am an ophthalmologist in a solo practice in New York City. I sincerely appreciate the opportunity to share, with the Committee, the difficulties I am experiencing with the implementation of health care reform and, more importantly, the impact this will have for my patients and my employees and my business operations. My comments and concerns will be made outside the political debates, as these ultimately have no business in the doctor-patient relationship. My concerns are, first and foremost, for those that need and seek medical care. My responsibility is to take the knowledge handed down through years of supervised training, and ethically and morally deliver the best that I have to offer, to a patient seeking help to prevent or treat an illness or accident.

Regardless of a physician's individual perspective of the new health care law, physicians are only beginning to recognize the sudden and massive upheaval to business, as usual that is to come as of the first of January, 2014. Health insurance companies have been rather late in the game in announcing their creation of new limited networks, which will offer only in-network benefits. This, shockingly, is affecting long-standing health insurance plans with excellent benefits that served Small Business groups, such as mine, as well as plans offered to individuals through various State Exchanges and the Healthcare.gov site.

My personal story unfolded in late September, 2013. I received written notice from Empire BCBS that the health insurance plan, I provide myself and my employees would not be renewed on the anniversary date of 1/1/14. The reason given was that there were components that did not comply with the Affordable Care Act (ACA). I was reassured, as the Administrator of my small business group coverage that the insurance company was preparing to roll out a new plan, which would be similar to my existing plan, and would be in compliance with the ACA requirements. In the interim, I was further advised to consider researching other offerings for Individuals and Small Businesses on the NY Exchange Marketplace. All of this was surprising to me, as my plan was quite comprehensive and included both in and out-of-network benefits.

Near the end of October, the new plan was described. Two major differences were noted immediately: the first was that this was to have only in-network coverage, an EPO plan, and the already high deductible of \$2000.00 per individual, was about to increase to \$2500.00 annually. Cost sharing, co-insurance would remain the same at 80/20. While the deductible increased \$500.00, the out-of-pocket cost was to decrease by the same amount. The new premium was slightly decreased, less than \$20.00 a month. On the surface, this did not sound so disturbing, but the extra deductible was going to cause a definite hardship for all concerned.

Re-reading this introductory letter several times raised more serious concerns. The insurance company was stressing the need to check with current doctors, who had been in-network with the terminated plan, to see if they would be participating in the new "Pathway" network. In spite of my familiarity with this insurance company, myself a participating physician with them since going into practice in 1993, I found it odd that a "new" EPO plan would be having a different and apparently far more limited network of participating physicians from the current EPO/PPO networks for present day insurance plans. Yet that is the reality. In addition, the approved formulary drug list, in the new EPO Small Business plan was also going to be more restricted than the plan phasing out for my group on 12/31/13. These points were certainly missed by me, on the first pass, and I am quite familiar with this type of information. I am concerned that other Small Business Administrators, in non-medical businesses, may not appreciate the significance of the limited network.

As if this wasn't enough, I then received notice last month from the same insurance company addressed to me as a participating physician, that due to the terms of my contract, I would not be extended participating status on the new insurance plans covering the Individuals on and off the Exchange or for the new HMO/EPO Small Business plans beginning on 1/1/14, all using the "Pathway" network. No reason was given, other than there was no need for them to offer participation at this time. However, they still will consider me to be a participating physician in their other BCBS plans off the Exchange that essentially cover large businesses, government workers, and Small Business plans yet to reach their anniversary date until later on in 2014.

At that point, I decided to investigate the Web site for the Empire BCBS Pathway network, listing those doctors that would be the ones my employees would need to use if I decided to take on this new EPO group plan. Amazingly, all of us would lose our primary care physician, unless we elected to see him on a completely non-covered private arrangement. Since our new plan is only to have in-network benefits, these costs would not go toward satisfying either the deductible or the out of pocket maximum. My employees also see specialists, and again, none of their current specialists were in the new "Pathway" network. This is alarming. No patient should have to give up all the doctors that they trust and with whom they have had long-standing doctor-patient relationships over many years. We all cherish our freedom of choice, but to maintain the doctor-patient relationship, while insured, with all out-of-pocket

costs coming from the patient, seems to have been an unintended consequence of an attempt to pass a law to cover individuals without insurance and/or pre-existing conditions in an affordable manner. This instead has turned into a house of cards about to fall affecting the lives of millions and severing doctor-patient relationships over and over again.

All insurance participating physician offices will need to be on high alert booking appointments after 1/1/14 to question the patient about changes in insurance coverage that could affect their ability to remain in the practice if they only wanted to use in-network benefits. If we found this out only when the patient presents to the office, the patient would naturally be disappointed and perhaps angry. They may not be in a financial position to pay for services without any reimbursement from insurance, if only to satisfy the deductible, which this situation clearly would not permit with all in-network plan offerings.

Exacerbating this problem is that almost all health insurance plans to be offered, completely eliminate out-of-network coverage altogether. For the limited few plans that offer an out-of-network benefit, some insurance company quotes that I have been reviewing are now lowering that benefit to a fixed amount, equal to 110% of the already low Medicare allowed fees, which in the New York City area can often only be a small fraction of usual charges. The balance of the doctor or facility bill then becomes the patient's responsibility. With such limited out-of-network payouts from insurance companies to the member, how can this be "too expensive to offer?" Clearly, the almost extinct Indemnity Plans of years gone by paid out using geographically determined reasonable and customary fees with 90/10, 80/20, or some other cost-sharing amount. The newer method comes in far lower and, again, puts a greater responsibility on the patient that chooses or needs to go to a physician or facility out-of-network. So why were all these Healthcare.gov and Exchange Marketplace insurance plans made to have such limited networks and no out-of-network benefits? In my opinion, this will slow down health care spending, simply because the patients will have to wait weeks or possibly longer to access a physician or facility that is in-network. These in-network physicians are already seeing a maximum number of patients per session. How are they going to take on so much more responsibility? Moreover, this gives so much more ability to control care by the insurance company, and takes away clinical control from the physicians who are able to be in these networks.

I estimate that I could easily lose 20% or more of my current patients that currently are insured through Healthy New York and other Individual contracts, both of which were eliminated with the roll-out of the health care reform law. Where will they be able to seek care? My doors will always be open for them and I shall do everything possible to see to it that my patients will receive the care they need. After all, physicians care about their patients. There should be no imposed barriers to access care. The patient's life may depend on a timely response to treatment. This must be fixed immediately. "There for the grace of God, go I." Even, I, as a physician, may require urgent care one day.

The other part of the problem I see from reviewing the NY Exchange Marketplace insurance offerings, applicable to all new ACA plans across the Nation, is the shockingly high deductibles. Yes, certain, individuals of lower income will qualify for government subsidy to offset the monthly premiums and the deductibles. However, many middle class people, living and working near my office, will not qualify for a subsidy, and are paying rents for studio apartments greater than \$2000.00 per month. These hard working individuals can ill afford a first dollar expense associated with the Bronze level plans calling for a \$3000.00 deductible before there is any insurance cost sharing. To add to this, the Bronze level plans seem to also expect the patients to pay 40-50% co-insurance on the allowed in-network amount. The only information out there for the public to hear is that these plans are so inexpensive. Many individuals, who never had insurance, do not even understand the concept of a "deductible" and "co-insurance." Insurance law compels the in-network participating physician to bill the patient for deductibles and co-insurance. These bills are going to come as sticker shock to patients since they have no prior experiences. They will be hard-pressed to meet this financial responsibility. In clinical practice today, we have seen such behavior with the use of consumer driven health plans when the employee and/or employer did not set up an HSA or HRA account to offset the high deductible expense. Ultimately, this will significantly drive up collection costs, potentially threatening physician practice viability, but perhaps more significantly, it discourages patients from availing themselves of getting needed care because of these potential out of pocket costs.

It is very important to understand that expenses to run medical offices have skyrocketed. The monthly maintenance for my office has doubled from \$2900.00 per month to \$5700.00 per month in 13 years. Every invoice related to the operation of my business has seen a double-digit increase in the past two years. New York State physicians pay among the highest liability premiums in the country. Ironically, due to the flawed SGR formula affecting Medicare payments to doctors, income for physicians has actually decreased. The insurance companies have also decided to use the Medicare fee schedule as the point of reference for all 'negotiated' participating fees. Thus, what happens to Medicare actually directly affects all the commercial fee schedules. We are seeing many physicians, especially, primary care physicians, closing their private practices and joining faculty practices in hospitals or large physician groups. They are doing this because the days of joy in a solo practice are now filled with concern over the ever increasing overhead costs. Our employees are a dedicated team but are facing long hauls of no salary increases because we simply are struggling to keep the lights on so we can continue to deliver the care. We have stuck with this to be there for the patients.

The doctors enrolled on the Exchange plans are telling grave tales of FAR lower reimbursement from the very same insurance network 'ON' the Exchange from 'OFF' the Exchange in the current commercial networks. Most of these doctors have found themselves listed as participating without even written notification from the insurance company. This is largely due to an 'all products clause' in a contract signed, many years ago. Others find themselves listed in newly created insurance companies utilizing 'rental networks' such as entities known as MagnaCare or MultiPlan. The fees being proposed simply

cannot allow the physician's business to remain solvent. Again, what good could come of this to society, if another physician is forced to close the office doors forever?

The 90-Day "Grace Period" authorized by CMS will also be a huge problem, and we ask that it be addressed. We are very sympathetic to the problem the Administration was trying to address. Everyone has fallen behind in a bill. Grace periods are a wonderful cushion for such a circumstance. However, the law will create great confusion and potentially unnecessary anger at the physician delivering the care. Once a physician sees a patient and provides the necessary care, the insurance claim is filed. We would then be informed that that patient's insurance is cancelled. Collecting, after the fact, is never easy. It is imperative that the physicians providing services receive the same real-time adjudication offered by the insurance companies to the pharmacies. Without such protection, the account receivables will soar. This will become a great problem trying to meet expenses.

The confluence of all these factors place small practice physicians in an ever-tightening financial vise that threatens to shutter many private physician offices, and with them, an estimated 330,000 jobs in New York State, according to a study from the Medical Society of the State of New York. Undoubtedly, more and more physicians will be forced to close their practices and join large hospital systems in order to continue to deliver care, which will reduce patient choice, reduce competition, and drive up the cost of health care and health insurance. Worse still, many experienced but frustrated physicians have indicated they may simply retire and close their practices, further exacerbating the discussed access to care issues. Again, who will be there to deliver the care for our patients?

New York senior citizens, enrolled in Medicare Advantage Plans recently received notices that their doctors, previously in-network, would now be considered non-participating or out-of-network, even before these same doctors, themselves, were notified of the change by the insurance company. Roughly 2100 physicians were dismissed from Oxford/UHC networks affecting approximately 8,000 Medicare patients. Our seniors deserve better. The insurance companies claim to be reacting to decreased reimbursement from CMS. As physicians, we are urging CMS and Congress to investigate this development. From the insurance industry standpoint, this may be sound for business, but destroyed doctor-patient relationships and the subsequent disruption of the bond the patient feels for their doctor can take a toll on that individual's health and well-being. In fact, one federal court in Connecticut recently imposed a preliminary injunction against United Healthcare from imposing this mass termination.

In closing, by far my greatest concern for the doctor-patient relationship is the limited networks and greater numbers of insured lives. Patients with acute conditions together with their primary care

physicians will lose precious time attempting to locate a qualified specialist and hospital to treat the condition expediently. I thank you, again for the opportunity to present testimony today, and am happy to answer any questions you may have for me.

Chairman ISSA. Thank you, doctor.
Dr. Novack.

STATEMENT OF ERIC N. NOVACK, M.D.

Dr. NOVACK. Mr. Chairman, members of the committee, thank you for having me back again.

When President Obama made the case in 2009 that the U.S. needed to lower cost and improve access to healthcare, I agreed with him. On June 23rd, 2009, I told the House Subcommittee on Health that “The system within which you are allowed to provide care is as important to the delivery as the people providing it. So if we are not willing to put the same level of attention to detail into designing the system, it is doomed to fail.”

During that same hearing, Congressman Dingell announced that he “would never presume to tell somebody how to take out an appendix or to replace a knee,” but he does know a little bit about drafting law; he’s been doing it for 50 years.

Since then, the healthcare law has failed to deliver on nearly every promise, including if you like your doctor, you can keep her, and if you like your healthcare, you can keep it.

The problems and failings certainly extend to Medicaid.

In February 2013, the Obama Administration made clear their position about access to care for Medicaid patients in a court filing in the 9th Circuit: “There is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs.”

As Children’s Defense Fund President Marian Wright-Edelman said at that same hearing in June 2009, talking about a child on Medicaid who died, “His mother couldn’t get the dentist to take him because of low Medicaid reimbursement rates.”

In addition, Obamacare architect Jonathan Gruber’s research and Austin Frakt’s research suggests that between 50 to 80 percent of all new Medicaid enrollees will actually lose private insurance as it is crowded out by Medicaid.

And in Arizona, according to a 2013 Milliman report, most hospitals receive 70 percent of Medicare rates from Medicaid, which is unsustainable.

While some will benefit from the expansion, the losers will far outnumber the winners. To respond to Congressman Dingell, he may not be saying how the surgery gets done, but he is certainly impacting who will get it and when.

But the access problems do not end with Medicaid. As I wrote in August 2010, the healthcare exchanges are really just a variation of Arizona’s 100 percent Medicaid managed care system, which, the last time it was expanded, has actually cost over four times what was predicted by the supporters.

The policies available through the exchanges, even with subsidies, are, for many, far more expensive than Democrats and the President promised, and many have higher deductibles, copays, and coinsurance, and very narrow provider networks.

OrthoArizona, the group of over 70 musculoskeletal providers I am in, does not have a single exchange contract by choice. One reason is the required 90-day grace period for policies. This means we can provide two months of care, thinking the patient has coverage, and then we are on the hook for payment, and the insurers have

no responsibility. And OrthoArizona is not alone. At least one major Phoenix area hospital system does not yet have a single exchange contract, in large part because the rates being offered are at or near Medicaid rates.

I recently spoke with a retired professor from an esteemed New York medical school. She feels Obamacare is morally right. But she notes that none of her personal doctors take Medicare, let alone Medicaid. Unwilling to make a moral stand and not go to those doctors, the professor is blaming the doctors and seeks to have Government force them and hospitals accept whatever payment the Government decides, even if they go out of business doing so. And I strongly suspect we will be hearing some variation of this very soon from the Administration.

Those who do not wish to defend the failures of the law are quick to say, well, what is your solution? I know this hearing is not focused on alternatives, but I want to quickly mention three areas that should contribute to the many larger proposals that do exist.

This year, Arizona passed a first in the Nation price transparency law. I would add, with significant bipartisan support. The law extends already “only in the Nation” State constitutional rights to spend your own resources for legal healthcare services, but it also ends direct pay price discrimination based upon insurance status. This law goes into effect on January 1st.

OrthoArizona, since its inception in 1994, has focused on quality, utilization, and cost. We have shown repeatedly with payers that local, same specialty physician accountability is a reproducible and effective way to lower healthcare costs while maintaining high-quality orthopaedic care.

Intelligent InSites, a software company with whom I work, is a company that provides a platform that takes automatically collected data and provide analytics on that data combined with other sources of information. Getting better, more accurate, unbiased information in the hands of everyone from transporters in the hospital to doctors to healthcare system CEOs to you, the policy-makers in the Country, has never been more needed.

Ultimately, we must move to policies that ensure patients and families maintain control of their healthcare decisions, and that includes access to quality physicians.

[Prepared statement of Dr. Novack follows:]

Oral Testimony to House Oversight and Government Reform
Committee

12 December 2013

Eric Novack, MD

Mr. Chairman, members of the committee, thank you for having me back again. When President Obama made the case in 2009 that the US needed to lower costs and improve access to healthcare, I agreed with him. On June 23, 2009, I told the House Subcommittee on Health that, “the system within which you are allowed to provide care is as important to the delivery as the people providing it. So if we are not willing to put the same level of attention and same level of attention to detail... into designing the system, it is doomed to fail.”¹

During that same hearing, Congressman Dingell announced that he “would never presume to tell somebody how to take out an appendix or to replace a knee, but [he does] know a little bit about drafting law. [He has] been doing it for about 50 years...”²

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In February 2013, the Obama administration made clear their position about access to care for Medicaid patients in a court filing in the 9th Circuit— “there is no general mandate under Medicaid to reimburse providers for all or substantially all of their costs.”³ As Children’s Defense Fund President Marian Wright Edelman said at the June 23, 2009 hearing, talking about a child on Medicaid who died, “his mother... couldn’t get them [the dentists] to take him because of the low Medicaid... reimbursement rates.”⁴

In addition, Obamacare architect Jonathan Gruber’s research⁵ and left economist Austin Frakt’s research⁶ suggest between 50%-80% of all new

¹ <http://democrats.energycommerce.house.gov/sites/default/files/documents/Final-Transcript-Health-Comprehensive-Health-Care-Reform-Discussion-Draft-2009-6-23.pdf> (page 193 of pdf, page 183 of testimony)

² *Ibid* (page 186 of pdf, page 176 of testimony)

³ http://www.nytimes.com/2013/02/26/us/politics/states-can-cut-back-on-medicaid-payments-administration-says.html?_r=0

⁴ <http://democrats.energycommerce.house.gov/sites/default/files/documents/Final-Transcript-Health-Comprehensive-Health-Care-Reform-Discussion-Draft-2009-6-23.pdf> (page 192 of pdf, page 182 of testimony)

⁵ <http://www.nber.org/papers/w12858>

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Medicaid enrollees will lose private insurance as it is crowded out by Medicaid.

And in Arizona, according to a 2013 Milliman report⁷, most hospitals receive 70% of Medicare rates for Medicaid—which is unsustainable.

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As I wrote in August 2010, the health care exchanges are really just a variation of Arizona's 100% Medicaid managed care system⁸, which, the last time it was expanded, has actually cost over 4 times what was predicted by supporters.⁹

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⁶ http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1782210

⁷ <http://www.azahcccs.gov/commercial/Downloads/rates/MillmanAHCCCSReport20120628.pdf>

⁸ <http://www.washingtontimes.com/news/2010/aug/4/the-arizona-experiment/>

⁹ <http://goldwaterinstitute.org/10-reasons-to-decline-medicaid-expansion>

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Eric Novack, MD

Ultimately, we must move to policies that ensure patients and families maintain control over their health care decisions, and that includes access to quality physicians.

Chairman ISSA. Thank you. I thank all three of you. I will recognize myself for a first round of questions.

Dr. English, you said very well in five minutes a position. I just want to make sure I ask a question that makes it clear to all of us. Under the Affordable Care Act, what was often called rationed care is occurring simply because you are being told that if you take an expensive practice, you could be locked out, while a doctor who sends off, casts off the kinds of people you deal with, in other words, a doctor, a neurologist who says, look, anyone gets MS, I am going to dump them onto Dr. English because Dr. English costs more, and I am going to keep my costs down by not having those patients; he or she wins, you lose under this rating system. Is that pretty much a wrap-up of what you are dealing with?

Dr. ENGLISH. Correct. That is my interpretation.

Chairman ISSA. But you can fix that. You simply provide marginal care and do less MRIs and so on, and then you will be okay, is that right?

Dr. ENGLISH. Or I stop working for the MS Center of Atlanta and just do general neurology, correct.

Chairman ISSA. So you cannot take these difficult patients. And the same with an oncologist who says I am going to go into a practice where I only deal with people up until the time they have a serious cancer event, but after that I am going to dump that person. So the really sick, under the current system, unless we change it, find themselves undesirable either to get full care, which costs more, or, quite frankly, to get to the doctor at all. That is what you are dealing with unless we make these changes.

Dr. ENGLISH. Yes.

Chairman ISSA. Dr. Novack, transparency is a good thing, and certainly the person who walks in and writes a check or hands out cash for the service should not be disadvantaged. What happens, though, if—and I support that. I really, from the bottom of my heart, find it hard to believe that your cash customer pays more, as they do in almost every State and every hospital in America, and they don't even know they are paying more because there is no transparency. But what would happen to the hospital system if everybody walked in and paid the Medicaid reimbursement, if that is the lowest rate?

Dr. NOVACK. Mr. Chairman, in my conversations with a variety of hospital system C suite folks over the last few months, for the most part they feel that they need to be able to be profitable at Medicare rates, which, talking to, again, major hospital systems, meaning they need to actually cut their operating costs by 30 percent. So I can speak to Arizona, where the average hospital Medicaid reimbursement is 70 percent of Medicare. So, for example, for a total knee replacement, the average commercial payment is \$24,000. Medicare pays 14; Medicaid pays 8. So were that to be extended further, there is simply no way that basically any of the hospitals, certainly in the Phoenix area, and I guess the bulk of the ones around the Country, would stay open.

I would add, by the way, that that isn't that unique a statement, because if you look at the Medicare actuary report that came out, there is an expectation that up to 25 percent of the hospitals won't be able to survive this decade, anyway.

Chairman ISSA. So one of the things that we have to do is figure out how to stop cost-shifting. In other words, anyone, including the Federal Government, mandating a rate less than what it takes for an entity to stay in business, unless we are willing to work with that entity to make sure they can in fact live with that rate.

Dr. NOVACK. That is correct. It is important to know, on the issue of transparency, as a very brief aside, remember that over 100 million Americans get their insurance through a self-funded payer. So in the same example of transparency, what we found out was that, again, in Arizona, using hospital association data, that the commercial payment was \$24,000. In Arizona, if you pay cash for a total knee replacement, it was \$19,000. So as one of the executives of a privately held large company in the State said to me, in exchange for doing everything right for our employees and their spouses, we are paying \$5,000 extra, or 20 percent more, for that knee replacement.

So when we look at what the healthcare price transparency law has done in Arizona, is in effect it creates a mechanism where not only can we protect the uninsured, but ultimately we are going to protect the folks who are insured by hopefully lowering the difference between what they are going to pay.

Chairman ISSA. One quick question. And I am going to respect the five minute clock very exactly today. The fact is that you are all seeing something else, I believe, and I would just like a yes or no if you have observed it. Federal reimbursement for a particular event at a clinic or a doctor's hospital is almost always less than in a hospital, right?

Dr. NOVACK. Correct.

Chairman ISSA. So one of the interesting things is if a doctor's hospital is more efficient than a hospital, a doctor's office is more efficient than a hospital, we don't say we are going to try to get people to the most efficient rate by paying a fair rate to the doctor; instead, we simply pay less to the doctor, more to the hospital, and it is causing hospitals to buy up doctors' practices, which means we are paying more. Is that correct in all of your experience?

Dr. NOVACK. Yes.

Chairman ISSA. Thank you.

The gentleman from Maryland, Mr. Cummings.

Mr. CUMMINGS. Thank you very much, all of you, for your testimony. I appreciate your passion and what you do, and I want you to be effective and efficient in what you do. It is so important.

Dr. English, you talked about the work that you do with multiple sclerosis patients. I am very familiar with that whole area. Johns Hopkins is smack dab in the middle of my district, so we spend a lot of time dealing with that issue. You also discussed the costs associated with it as being about \$50,000 per year, is that right?

Dr. ENGLISH. [Nonverbal response.]

Mr. CUMMINGS. That is a hefty price tag. Dr. English, MS is, of course, a troubled disease and I sincerely appreciate the work that you do to treat those patients afflicted with it. And I know you have concerns about the Affordable Care Act, but I have serious concerns about what happens to the 20-year-old woman or the 40-year-old woman who is diagnosed with MS but does not have insurance. So do you agree with the Affordable Care Act's prohibition on

discriminating against people with preexisting conditions? Do you agree with that? I can't hear you, I am sorry.

Dr. ENGLISH. Yes. Again, as we opened up, everyone agrees, I think, with the majority of your opening statement about the need to fix the healthcare system and preexisting conditions, so sure.

Mr. CUMMINGS. Do you agree that if an uninsured person with MS were seeking healthcare coverage in the individual market prior to the ACA, that person would have been very unlikely to have gotten insurance? Would you agree?

Dr. ENGLISH. No. In my experience, at least in my State, the majority of my patients had very good access to care. Those who were uninsured, there were methods of getting them care. Again, as Congressman Issa mentioned, I am cheap. The cost of seeing me is cheap. The medications are expensive, and those are usually subsidized.

Mr. CUMMINGS. So prior to the ACA, insurance companies were allowed to discriminate against patients with preexisting conditions and exclude them from coverage, and that is a fact. But do you think that people with MS would have been able to get health insurance, or would it have been so cost-prohibitive that they wouldn't have been able to afford it?

Dr. ENGLISH. Well, again, I would agree with your original statement that we need to handle preexisting conditions. What I am seeing here is that patients are getting, again, as Dr. McLaughlin said, a card that gives them access to nothing. So I want to solve the problem that you exactly stated. I am on board with you 100 percent, especially since at the time it was the University of Maryland that was the MS center. Now Hopkins has taken over, you are right. But at the University of Maryland, again, I was—

Mr. CUMMINGS. That is right, you graduated from Maryland?

Dr. ENGLISH. From Maryland.

Mr. CUMMINGS. Oh, wonderful.

Dr. ENGLISH. I have two children born in your district. My wife got an MBA at Loyola.

Mr. CUMMINGS. Fantastic. I am a Maryland graduate too.

Dr. ENGLISH. Good.

Mr. CUMMINGS. Go ahead.

Dr. ENGLISH. So, yes, so we needed to solve that problem. I don't think this, in my opinion, my experience, and what you have heard here, this didn't solve that problem, and we are going to see these unintended consequences in the very near future and you are going to hear it from your constituents.

Mr. CUMMINGS. Thank you.

Dr. McLaughlin, I just couldn't help but think about the things that you said about your mother not having insurance for a short period of time. A member of my immediate family had a, they found some precancerous cells with regard to the breast and could not get insurance, could not get it for four or five years; and this was a young woman. Couldn't get it. As I listened to you, I can see that you all seem to understand the problem here. On the one hand, we want to make sure that treatment that is provided is the appropriate treatment and it does not—because we hear all these complaints about, and I know you have heard them, doctors giving too many tests and all this kind of thing, and at the same time we

want to get the results so that people can stay well or get well, if they are sick, because if they have to keep coming back it is only going to cost the system even more.

The last thing you said, and this is written in the DNA of every cell of my brain. You said I want you to fix it. That is what you said, didn't you?

Dr. McLAUGHLIN. Yes, sir.

Mr. CUMMINGS. And I want to fix it. What suggestions do you have, based upon the things that you talked about today, that you would suggest to us about fixing it?

Dr. McLAUGHLIN. Well, I am glad you asked. Thank you so much. You see, the real problem with this, too, besides these networks being set up that are so restrictive, I also got a letter dismissing me as a participating provider from the insurance that would cover patients on the ACA. No one here intended that to happen, I am sure, but that is what is happening to us as physicians. Or we are being put on these panels without knowledge that we are because of contracts we signed 10 years ago that had all products clauses. And you might assume, as someone who owns a business, that if you were paid X number of dollars by the insurance company as a participating provider currently with them, wouldn't you be offered the same fee just simply because you were taking care of the new Government law? Well, that is not the case. They are coming in with fees that are sometimes 50 percent of Medicare and, as businesses, we can't survive.

So back to your question, the other problem here is these deductibles, sir, is their subsidy, but that is for people who qualify for it. And maybe this is not universal across the Nation, but in a large city like New York City, a studio apartment is \$2,000 a month. How is a person earning \$50,000, which by most standards across this Country is not a terribly small amount of money, but someone earning \$50,000 in New York City, paying \$2,000 rent for a hole in the wall, cannot afford a \$3,000 deductible for a plan that is being advertised as affordable because they take the bronze plan. The bronze plan in New York State, for something like Emblem, has a 50 percent coinsurance after that patient reaches that \$3,000 deductible.

What we have found, when we went back to that 2008 level, is that just simply having these high deductible plans slowed down healthcare utilization because patients were afraid that they would have to pay that first deductible amount. Other patients saw good physicians, went to the hospitals, and then are in collections. We can't have a whole Nation of patients in collection and we can't have a whole Nation of physicians' offices and hospitals fighting the system to get paid. And this isn't fair to the patients.

So when we talk or there is rumor about a single payer system, I think, in my heart, the quickest answer to help us in the next 20 days is eliminate these networks. Let everybody who signed up stay in those plans, and those insurance companies must be made also to be transparent about what they will pay, which, by the way, up until this point they haven't. I have colleagues that have no idea that they are even on these panels and they have no idea what they are going to be paid. So let the insurance companies, so not to hurt their business operations, because we all want them to

stay in business too for the rest of us, let them pay that same dollar amount as the access reference point, and then allow a negotiated fee between the patient and any doctor they want for a value for that service. Who is hurt by that? You will then establish a competition between physicians to keep prices controlled, unless you want to have one of those often spoken about concierge practices that charge enrollment fees of \$24,000 for a certain one percent of this Nation. But everyone else will keep their prices in check with this negotiated amount. The doctors will be able to remain in private practice, keeping them out of the facilities that are going to cost everyone more money, and the patients will have the ability to see someone for a modest fee, if that is available, or they can negotiate some other fee. That is the only fix right now. But get rid of, please, those networks and allow the doctors to stay in business at the same time.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

I now ask unanimous consent that the article today in The Wall Street Journal, or actually yesterday in The Wall Street Journal, entitled Juking the Obamacare Stats, be placed in the record. Without objection, so ordered.

Chairman ISSA. I now recognize the gentleman from Florida, Mr. Mica.

Mr. MICA. Thank you, Mr. Chairman. Perfect lead-in, putting that into the record.

The title of the hearing is Obamacare Impact on Premiums and Provider Networks. Let's first talk generally about the impact on premiums and the people who have been affected so far that we know about. So far, the chairman just put this in, The Wall Street Journal said yesterday that between 4 million and 5.5 million people have had their plans liquidated. Isn't it your observation that most of these people are now going to face a higher premium, Dr. English? Actually, a higher premium and lower deductibility. I mean higher deductibility and higher premiums, both. Would that be your guesstimate?

Dr. ENGLISH. Well, I think there is so much variability, I think, as we have talked about. We want people to have——

Mr. MICA. But these people who had existing plans now have been notified that they are not getting them, with the new mandates in that. For example, I have been forced onto Obamacare. My deductibles are doubled or tripled, and my premiums are up, and I think that is what 4 million to 5.5 million have seen. What do you think, doctor?

Dr. ENGLISH. I would answer that. I am reading what you are reading. I just can't give you personal experience with my patients.

Mr. MICA. Okay.

Dr. ENGLISH. Some of them even don't know yet; they don't know what they are having.

Mr. MICA. Well, again, with more mandates, the cost, the premiums are more. So they have shafted as many as 5.5 million in their premiums.

Dr. Novack, any comment here?

Dr. NOVACK. No. Clearly, we are seeing that it is highly likely that the number of net losers are going to substantially outweigh the number of—

Mr. MICA. And they have signed up a whopping 364,682.

Dr. NOVACK. And we don't know if those are—since the Country is starting out with a 5.5 million negative number, so we don't know who those people are. Are the 300,000 people or so just the people who previously had insurance but lost it? So we don't know who those numbers are, let alone whether or not they paid for it.

Mr. MICA. Let's jump to the impact. Again, the title is Impact on Provider Networks. Here is another article from The Wall Street Journal about what the chairman talked about in his opening statement. In my State, which has many, many senior citizens residing in Southwest Florida, their primary oncologist provider was the Moffitt Hospital. That has been dropped. Thousands of seniors now do not have access to this critical care. Is that the kind of impact you are seeing? Again, this is on our seniors. This doesn't involve Obamacare coverage, this is an existing Medicare Advantage, of which 28 percent, I guess, of all the Medicare people are on. This is an indirect result of Obamacare and what is going on in the marketplace.

Is that correct, Dr. English?

Dr. ENGLISH. Yes. I think Congressman Issa mentioned, again, the drafter of the law who was on the talk shows talked about paying more to see doctors on those plans. The State exchanges are set up, there are different exchanges in the State, so your providers, if they are in a different area, you can't even move out of that exchange to see those people.

Mr. MICA. What we are seeing is absolute turmoil in the marketplace. Seniors, they are the most vulnerable in our society and probably need the most medical coverage. Instead of getting coverage, they are searching for a doctor to serve them, as doctors have been thrown out in the cold.

Dr. McLaughlin?

Dr. MCLAUGHLIN. Well, absolutely, sir. I can tell you, in New York State, we are such a large State and, really, the behavior of the insurance companies has been quite different upstate New York as opposed to downstate New York. In the downstate area, 2100 physicians were dismissed from Oxford United managed medical—

Mr. MICA. So it is not just Florida.

Dr. MCLAUGHLIN. Absolutely no.

Mr. MICA. We are seeing it across the Nation.

Dr. MCLAUGHLIN. And there is a reason for that and there is a link to the ACA, because the CMS budget to these managed care companies was decreased from 17 percent to I believe the figure is about 8 percent to manage the Medicare beneficiaries. Now, with all due respect to the business operations of an insurance company, when they have a cut like that in their payments from the Government to manage these patients, as a business, they have to do something to cut their costs. Morally and ethically, none of us in here are happy with that, but I can understand where that came about.

Mr. MICA. Doctor, you had mentioned the panels that are being set up and I hear from seniors these rumors that certain ages, certain types of care is going to be cut off. Do you envision that happening? I heard rumor 73 you don't get cancer treatment or there is a possibility of not getting transplants and things like that. What do you see—

Chairman ISSA. The gentleman's time has expired. The gentlelady may answer, doctor.

Dr. MCLAUGHLIN. May I answer?

Chairman ISSA. Of course.

Dr. MCLAUGHLIN. Okay. You know, a lot of that could be hearsay at this point. We heard rumors about death panels and things like that, but clearly rationing care is something that has to be part of this to make it work. It is not the appropriate answer, however. So I am not quite sure what the facts are about at what age some procedures will be limited, but I would not dare think that that may not come.

Mr. MICA. Thank you.

Chairman ISSA. If I could ask unanimous consent just to follow up for 30 seconds on this, because when the word death panel is used, Dr. Boustany and others who are serving in Congress have a real problem with it.

Dr. McLaughlin, you do agree, I believe all of you, that medically sensible decisions about whether to use extreme healthcare options or not, in other words, decisions that are not always to do the most expensive and thorough do change with age, and that medical doctors need to make those decisions. So the term death panel hopefully does not mean that doctors don't make a decision that extraordinary measures sometimes are not appropriate for the elderly. And I want to ask that because I think both Republicans and Democrats found that word to divide us, rather than unite us, on your making decisions about what is best. So just a yes or no, if you can.

Dr. MCLAUGHLIN. The simple answer is most of us who are physicians will have a talk with the family and advise them what we feel is medically appropriate at the time and will do everything possible to sustain life where there is life and to allow the family to make a just decision. We hope most people will do advance beneficiary notices so that the individual has that choice and takes that burden away from the family. And if there is anything we can do as a society, we should be pushing individuals to make that decision. Thank you.

Chairman ISSA. I appreciate that. I didn't want that to divide this panel, because I think we are united on the need to fix healthcare.

The gentlelady from Illinois, Ms. Duckworth.

Ms. DUCKWORTH. Thank you, Mr. Chairman. Thank you for that comment. As someone who was accused of being involved in death panels at the VA, where they certainly use outcomes-based to deem what is appropriate for veterans, that is a very sensitive statement, so thank you very much for bringing that up, Mr. Chairman.

Dr. English, I just wanted to follow up with you a little bit. You know, the goal of giving Americans access to affordable, quality, life-saving healthcare is critical. It is not only the moral thing to

do, to make sure that getting sick in America doesn't lead families to bankruptcies, but, as far as I am concerned, it is common sense for our Country's economic competitiveness and our Government's fiscal health. I personally think that the Affordable Care Act made big steps in that right direction, but, as you have mentioned, there have been some real problems with it that need to be fixed. You spoke a little bit about the issues with CMS, for example, and how they rated your use of MRIs and incorrectly compared your use to others. I, myself, understand how different types of therapies will differ and associated diagnostic equipment that you need to do to treat that.

Are you saying in your testimony that the CMS decisions on how you are evaluated with your use to this is specifically to the Affordable Care Act, or are you saying this is just part of their trying to improve the Medicare-Medicaid system?

Dr. ENGLISH. I believe that outcomes measures are a major part of the Affordable Care Act, and they are using models like that. Some of those things were predated with the stimulus package, some of that started ahead of the Affordable Care Act, but that is big portion when we look at the Medicare cuts for the future. How will we evaluate outcomes and physicians and bonuses versus penalties, that is part of the Affordable Care Act. So it is a combination.

Ms. DUCKWORTH. Do you support outcomes based on decision-making in medicine in terms of aggregate treatment and outcomes of those treatments for your patients, this particular procedure works better than others? I know you come from a very cutting-edge institution that is, according to your web page, very progressive and aggressive in treatment which, if I had MS, that is what I would want, but do you support looking at outcomes?

Dr. ENGLISH. I do. I think when they come from as far away from where the actual patient care is occurring, the more mistakes are made, and I think the ACA really approaches this coming from D.C., which was the wrong way. I really wish specialty societies were encouraged to come up with metrics, given a few years to say what is appropriate care in MS, what is appropriate care in knee surgery, etcetera. That would have been a better way, in my opinion.

Ms. DUCKWORTH. So what I am hearing is not so much that looking at outcomes is a bad thing, but that the way CMS is going about it, using accountants to look at it versus relying on the healthcare practitioners to be the ones who inform that process of developing what those guidelines are, so that if they are going to evaluate the outcomes, if they are going to use outcomes, base evaluation of physicians who deal with MS, they should probably have some MS physicians who would inform that process of developing those guidelines so that your use of MRI would be perfectly in keeping with other physicians who treat MS in an institution like in your setting, right?

Dr. ENGLISH. Yes. As I stated, I think the Affordable Care Act, again, is going to have all of these unintended consequences because it is built from the top down, not from the ground up. So whether you like the law or not, I want you to understand these

things, these unintended consequences, are going to happen and they are not unforeseen.

Ms. DUCKWORTH. Well, I happen to agree with you that we need to fix these unintended consequences, and I would love to be able to continue to focus on that. I don't know that repealing the law or unfunding it or defunding it is the way to go, but I do agree with you that there are many problems that need to be fixed. But there are good things with it. I have a preexisting condition. I would assume that someone with MS would be considered to have a preexisting condition if they were to enter the marketplace or try to find their health insurance now. Have you had experience with MS patients on reaching lifetime caps from insurance companies for their treatment?

Dr. ENGLISH. Well, first of all, I would say everybody in this room has a preexisting condition, it is just that some of us don't know it yet.

Ms. DUCKWORTH. Good point.

Dr. ENGLISH. So you need to have an insurance that actually will follow you once that happens. If everybody owned their own insurance, then once they got sick there is no such thing as preexisting conditions.

So in my practice the answer is no, I have never, to date, 13 years in Atlanta at our center, not been able to get the care to my patients through one way or another. Even with gaps there have been ways to do that.

Ms. DUCKWORTH. Let me fix that. I am talking about caps from insurance companies. I think your institution does a fantastic job of raising alternate funds as a charity, to provide charity dollars in order to cover patients who have lost the coverage from their own insurance companies. That is very different. I am glad that you can get the care to the patient. But the fact of the matter is you are using other techniques. And I would think it would be better if the patient had insurance that stayed with them and would cover so that they did not have to rely on charity.

I am out of time. Thank you.

Chairman ISSA. I thank you all.

We now go to the gentleman from Michigan for his questions.

Mr. WALBERG. Thank you, Mr. Chairman, and thanks to the panelists for being here. Thanks for the work you do, as well.

Dr. Novack, let me go back to some questioning beforehand, and specifically what are your views on the Independent Payment Advisory Board, or IPAD?

Dr. NOVACK. Sure. Thank you for that question. Obviously, the IPAD, which is supposed to be in existence, but no one has been nominated yet, to my knowledge, they say that it is not going to be involved and it doesn't have the power to determine what care can or cannot be given, but as I believe not only are the people on the panel with me saying, but I think in the comments of the members implies, that what the IPAD can do is determine effectively how much you get paid for it. And if the payment for something drops to a point where you cannot stay in business or keep your doors open if you continue to provide it, less of it is going to be available.

So I think it is a bit of semantics and I think some of the words can cause division, but the ultimate reality and the ultimate goal of the Independent Payment Advisory Board, if Medicare expenditures go up faster than inflation, or 1 percent above inflation, is to reduce those costs, and they are going to go where the money is. So they are going to go to the expensive patients with MS and say we are just going to pay a lot less because we think that means that centers like Dr. English's will just not make services available, and that is how they are going to lower the cost.

Mr. WALBERG. So it takes away decisions from the patient and the healthcare provider.

Dr. NOVACK. Correct.

Mr. WALBERG. To a great degree.

Dr. NOVACK. Correct.

Mr. WALBERG. I would assume that that is, from what you say, a negative to the healthcare system.

Dr. NOVACK. Well, I think that ultimately the question is how do we get the best healthcare to the mom who brings in their child to me after they fall at the park.

Mr. WALBERG. The best healthcare, what we deserve.

Dr. NOVACK. And the ultimate answer is trying to get patients and families involved on multiple levels to help try to make the best decision for them, because certainly in my world, taking care of a number of fractures and acute injuries, I don't have the luxury of longstanding experiences with patients and families, so you need to be able to get data so that families can make the best decisions.

Mr. WALBERG. Do you have any evidence, doctor, that competition and choice is a better way to increase value and reduce cost than Government bureaucracies and their expertise?

Dr. NOVACK. Sure. Obviously, you have examples in certain parts of medicine where that does exist, but I think we can look, for example, in California more recently with what WellPoint has done with reference pricing for joint replacements, and by changing the structure, they have lowered the cost of joint replacements by 20 percent in, I think, less than two years. So the idea of creating transparency and really giving the opportunity to create new creative ways where you bundle your services together, you can actually provide high-quality care at a lower cost that ultimately results in better patient satisfaction.

Mr. WALBERG. Okay. Thank you.

Dr. English, just to make sure it is clear where you stand, will Obamacare limit your patients' treatments?

Dr. ENGLISH. Yes.

Mr. WALBERG. In your testimony you mentioned 10 medications for MS patients. A Washington Post article from two days ago said one-way insurance plans under Obamacare are keeping costs low by not covering widely used MS drugs and requiring doctors to prescribe drugs in a certain order, which would compel patients to take drugs more toxic to them, potentially. Have you found that to be the case?

Dr. ENGLISH. This is our major concern, because I can't impress upon you enough how variable patients are and the drugs that they need, and without the ability to move quickly to one and switch to

another. If I can't do that anymore, that is what will get me out of medicine, not the reimbursement stuff.

Mr. WALBERG. What does that do to your patients?

Dr. ENGLISH. It is my teacher who is paralyzed, who I know I can do something for, but I can't, and I have to watch her stay paralyzed. That is my concern.

Mr. WALBERG. And puts them at risk, at the very least—

Dr. ENGLISH. Correct.

Mr. WALBERG.—to take drugs that don't impact them positively, let alone produce the change that is necessary.

Dr. ENGLISH. Correct.

Mr. WALBERG. You stated Obamacare punishes you because you care for the most vulnerable patients. How does it do that?

Dr. ENGLISH. Well, let's look at that. I think Congressman Issa had mentioned, too, or it might have been Congressman Cummings, about if our center closed down and I was looking for a job at a hospital, and 5,000 expensive patients were coming that was going to bankrupt my hospital, which ones do you think would sign up to take me on? I want to work, like University of Maryland, the trauma center, I learned there. That was incredible, taking care of the sickest of the sickest. But I loved doing that. And I don't see how, under these payment models, that any hospital system is incentivized by taking care of the sickest patients; they would be disincentivized based on incomes.

Mr. WALBERG. So what we are looking at is a two-tier, those that can afford it for specialized treatment, have the money to do that, and then all of the rest of us.

Dr. ENGLISH. Correct.

Chairman ISSA. I thank the gentleman.

We now go to the gentlelady from New York, Mrs. Maloney.

Mrs. MALONEY. Thank you, Mr. Chairman and ranking member for calling this hearing, and I thank all of the panelists for their testimony and participation, particularly Dr. McLaughlin, who is from the great State of New York, which I have the privilege of representing a portion of it.

I do believe that you have raised some important concerns, but I truly do believe that the Affordable Care Act really is important legislation; and it is by no means perfect, but it really addresses some of the massive deficiencies in our Nation's healthcare system, such as covering preexisting conditions and providing coverage to over 30 million Americans that did not previously have coverage. And while I do want to get to your concerns and understand them in a deeper way, I would like to take a moment to highlight some of the successes of the marketplace in my home State of New York.

Earlier this week, the New York State of Health reported that over 314,000 New Yorkers had completed their applications for insurance and over 100,000 New Yorkers have enrolled for coverage starting on January 1st, 2014. And I understand that 70,000 selected a private insurance plan and one report stated that New York has the second highest raw enrollment numbers of any State. So there are some successes, but I do want to acknowledge that there is always room for improvement. And any massive new change in something as complicated as healthcare is going to have to face many improvements and we need to be willing to work to-

gether on both sides of the aisle to correct deficiencies and challenges that we see during this implementation process.

But, Dr. McLaughlin, I would like to understand the concerns that you raised today, and I want to make sure that I understand completely your situation. You stated that you received notice last month from an insurance company stating that you would not be extended participating status on the new insurance plans in the Pathway network. Is that correct?

Dr. McLAUGHLIN. Yes, councilwoman, that is correct.

Mrs. MALONEY. And what about other insurers, did you get similar letters from other insurers?

Dr. McLAUGHLIN. Well, the way this works is the insurance companies can only approach those physicians that happen to be already networked with them, under contract to them. So, for instance, I am not in the Emblem system, so they cannot approach me or do anything to me involuntarily. And that is important to understand.

Mrs. MALONEY. But can you approach them, another insurance company? Would you be willing to participate in any plan on the exchange? Can you approach another plan?

Dr. McLAUGHLIN. I am assuming that that door may be open; however, what is clearly evident by the plans that I am already under contract to, BlueCross for the main one, they made a decision, for whatever reason, that they had enough participating physicians to form this Pathway network, which I might add, by just looking at the ophthalmologists serving Manhattan in that list, came to less than 150 names, of which most of them were in solo practices with no affiliation to large group contracting forces. So these physicians happen to be under contract to that company for the lowest fee reimbursement for the same service that another physician who is part of a faculty practice or a large group practice would get. And as insane as that sounds for doing the same work, physicians are paid differently in the current system depending on how large a group you belong to and what negotiating power comes with those numbers.

Mrs. MALONEY. Well, have you appealed the decision? I know that they are trying to save money. In fact, the New York State testified or released a report saying that the people that had enrolled, 100,000, were seeing premium rates that are as much as 53 percent lower than the rates in effect in 2013 for comparable coverage. So that is great news for them, but they are looking for services that are more affordable. But you can appeal these decisions, as you know, and, as you know, particularly in New York State, that is being run by the State, and State insurance is regulated by the State, and you can appeal to the New York State Insurance Commissioner, and I would be happy to work with you in setting up such meetings if you would be so interested. But have you appealed the decision?

Dr. McLAUGHLIN. There was not an opportunity mentioned in that letter for appeal, it was a unilateral decision. There was no notice in there that I even had a right to appeal. I must say also that I had an amended contract to my United Healthcare participating status, and that also said that because I was not in an Oxford Liberty current network, I would not be put onto the Afford-

able Care Act insurances. So that was an automatic opt-out. Not an automatic opt-out; I wouldn't be in it. And for those doctors who were in the Oxford Liberty current plan, once they see their fee schedule, they could then opt-out.

Mrs. MALONEY. And you can also get a navigator to help you or broker to determine what plan would be best and to help you with your appeal, but I would be delighted to help you with an appeal if you are so interested.

Chairman ISSA. I thank the gentlelady.

We now go to the gentleman from Oklahoma, the head of our Energy and Healthcare Subcommittee, Mr. Lankford.

Mr. LANKFORD. Thank you, Mr. Chairman.

Thank you all for what you do and the way you are taking care of patients. You are going through a lot of paperwork and a lot of process right now that I can imagine the incredible amount of frustration that every day you are getting a new regulation, a new rule, or a new something that is coming out at you while you are trying to just take care of people and patients, what you love to do. So I want you to know from us we appreciate what you are doing and how you are trying to focus on taking care of people.

The problems are very, very real you all are experiencing on the ground. We hear about them in our offices all the time. The numbers are out. For the first two months of enrollment in the Affordable Care Act in my State, in Oklahoma, they are now up to just over 1,600 people have been able to sign up in my entire State. To give you a point of reference, 1400 companies got a letter two months ago that their insurance was canceled because they were in a small business group just in Oklahoma City. So just in one town in my district 1400 companies received a letter all in the same day that they had all been canceled because their association is no longer legal and they are out looking. And now we have had 1600 people total in the entire State have been able to sign up.

One of those was a small car dealership in Oklahoma City with 14 employees. They now are having to select a different insurance policy, a different company, and as the owner of the car lots told me, we can either select a plan that is much more expensive than what we had last year, but keep our doctors, or pay the same as what we had last year, but we all have to switch doctors. But we can't do both. We can't both keep our plan and keep our doctors or keep the price and keep our doctors; we have to choose on it. And it has been a very difficult process for them as a small business, as it is facing a lot of small businesses across our area.

Dr. McLaughlin, you mentioned that even with your own practice. That is becoming a big issue. It is one of those many things that is out there.

So let me just ask a couple questions about processing. By one count, this law creates about 159 new boards or agencies. We asked the Congressional Research Service to try to determine how many boards or agencies are created by this. They said it is not knowable at this point exactly how many.

Dr. English, you mentioned multiple times the difficulty of decisions being made in Washington, D.C. and getting passed on to you, and I have direct family members that have MS, and I am very familiar with the process and the drugs and what is going on.

So I am trying to process through 159 different agencies that are all setting these different rules and you get instructions about how to take care of your patients. What does that do for you day-to-day?

Dr. ENGLISH. Well, let me give you an example. I have, for the first time in my career, had patients who are healthy previously not walking, etcetera, on a medication doing great who are crying in my office. People are really afraid, as you are seeing as well. They don't know whether their medication is going to be covered. I am filling out forms. Patients who are stable on medications, but they are not on the list anymore of the restricted provider list.

Mr. LANKFORD. So we are talking about people that are currently under medication doing better, stabilized in the process, that instructions are coming down to them to say we may have to switch the regimen for treatment to a different drug or a different treatment regimen when they are currently stabilized right now.

Dr. ENGLISH. Correct.

Mr. LANKFORD. That sounds like someone in Washington telling you how to take care of a patient that is doing well with their treatments, and saying we are going to experiment with a different way to do this with your patients.

Dr. ENGLISH. And in the Georgia State exchange we have no idea what medications are going to be available to those patients and then, again, we are less than a month away from patients coming to my office on those insurance plans.

Mr. LANKFORD. And the current system, as it has been set up, is there a discouragement to take the more complicated patients. So the more complex the case is, the more that that is discouraged financially and in every other way from the Federal Government and from the system, is that correct?

Dr. ENGLISH. The current system in the ACA, the current system before—

Mr. LANKFORD. The current system, ACA, that is coming at us.

Dr. ENGLISH. As we discussed in my testimony, there are many things that will be discouraging me to take care of the sickest patients, yes.

Mr. LANKFORD. Dr. Novack, you mentioned before all the issues with Medicaid that are out there based on the reimbursement rates and the number of physicians that do that. Half of the people that have now signed up for insurance nationwide are not signing up for private insurance, they are in State Medicaid programs. While they have access to care on that, what are the issues that they are going to face in the days ahead?

Dr. NOVACK. Well, I think the first issue, again, I think the crowd-out issue is something we really can't discount. Jonathan Gruber, who was really the architect of Romneycare and he was really an architect of the Affordable Care Act, his own research that he did originally in the 1990s and then repeated in 2007 showed half the people who ended up on the Government program lost private care. Again, the more recent study from Austin Frakt, I believe from one of the Boston area universities, showed that up to 80 percent of the people who will end up on expanded Medicaid will lose their private health insurance.

When you look at the smaller networks, when you look at the lower payment rates that discourage people to accept it or create

long waiting lists to get access to it, I think, again, there will be a few winners, but ultimately the number of losers is going to be a lot greater. And we see in orthopaedics in Arizona that access to certain kinds of durable medical equipment, access to getting physical therapy after an injury in terms of limits, access to certain medications, all of those are severely restricted under Medicaid relative to what was existing in the commercial market.

Mr. LANKFORD. There is a tremendous difference between the hope of what this would be and the reality of what it actually is on the ground.

Dr. NOVACK. Yes.

Mr. LANKFORD. With that, I yield back.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Pennsylvania, Mr. Cartwright.

Mr. CARTWRIGHT. Thank you, Mr. Chairman, and thank you for all the witnesses appearing today. I believe the Affordable Care Act is a landmark law. It is obviously, by no means, perfect, it needs a lot of work, but all of us need to roll up our sleeves and work together and make it better.

I had planned to ask all of the witnesses questions about provider networks, including Dr. Feder, but, unfortunately, the Majority didn't inform us they decided to change the panel structure today. They didn't inform Dr. Feder, either. Dr. Feder was here and ready to testify at 9:30. I would say that the fact that she is here and waiting for the second panel, while we are not including her now, is disappointing.

But, Dr. McLaughlin, I was interested in your testimony and your comments, and I would like to follow up on some of the things that Congresswoman Maloney covered with you. It is my understanding that—well, a large part of your testimony has surrounded the fact that you got dropped by Empire BlueCross and BlueShield, right?

Dr. McLAUGHLIN. As a participating provider in the new plans that they are developing for small businesses off the Affordable Care Act exchange, as well as those serving the ACA.

Mr. CARTWRIGHT. All right. And not to put too fine a point on it, you are still waiting to hear about the larger employers, whether you will be included in that coverage.

Dr. McLAUGHLIN. No, I am completely in that.

Mr. CARTWRIGHT. You are in that.

Dr. McLAUGHLIN. For now, yes.

Mr. CARTWRIGHT. Okay. So we want to look into why these things happen. You got less than a full explanation from Empire BlueCross and BlueShield, am I correct in that?

Dr. McLAUGHLIN. Yes. And everyone who is on my associated hospital staff had the same letter. This is not an isolated letter, this is clear across the board.

Mr. CARTWRIGHT. Right. So if I am not mistaken, you got the Empire BlueCross Blue Shield letter on October 29th of this year, am I correct in that?

Dr. McLAUGHLIN. Yes.

Mr. CARTWRIGHT. Okay, so I want to talk about what efforts you have made in the couple of months since then to go over what the situation is and see what light you can help us shed on the situa-

tion. So I think you said you saw about 150 names of ophthalmologists who are included in the system, is that correct?

Dr. McLAUGHLIN. That is correct.

Mr. CARTWRIGHT. Did you make an effort to compare different sets of facts, for example, compare your own credentials with those of the other ophthalmologists who made the list? I assume you are board certified, for example.

Dr. McLAUGHLIN. It is not based on that. We are all equal. What the basis clearly is is the original fee schedule of the networks that the doctors are in. And, as I said, if you are a complete solo practitioner, not part of a large group who negotiates a fee schedule with the insurance companies, you get what is called the standard rack rate from the insurance company, and those preferentially are those doctors that are on this network, they are the lowest paid of the physicians, and that is clearly what the decision is.

Mr. CARTWRIGHT. I don't mean to belabor the point, but are you saying you haven't really engaged in a comparison of your own credentials with those of the 150?

Dr. McLAUGHLIN. There is nothing to compare. This is across the board. Everyone who is at my hospital was not offered the status. We are all of equal rankings, do the same work, the same exams. That is not what this is about.

Mr. CARTWRIGHT. So you think it is more about pricing, it is about money.

Dr. McLAUGHLIN. It is clearly about money.

Mr. CARTWRIGHT. All right. Well, let's take that, then. Have you compared the pricing? Have you compared how much it costs people to get treated by you and the other people who got dropped versus the people who got accepted into the system?

Dr. McLAUGHLIN. Well, first of all, I would have no way to compare that. There are quite a bit of regulations on us, also, as far as fee schedules. We have antitrust regulations and we are not allowed to collectively negotiate, so, in honesty, I would have no idea to know pure facts as to what someone is being paid compared to myself.

Mr. CARTWRIGHT. Well, obviously somebody engaged in that comparison; that is why some people made the list and some people didn't.

Dr. McLAUGHLIN. That is right. That is maybe for you to find out.

Mr. CARTWRIGHT. Thank you.

Dr. McLAUGHLIN. You are welcome.

Mr. CARTWRIGHT. But another thing you mentioned was this idea, and I had heard it before, that if you want to protect yourself as a physician, you want to join groups, and the bigger the group you are in, the more protection you have as we enter the new age. You are a solo practitioner, am I correct in that?

Dr. McLAUGHLIN. That is correct.

Mr. CARTWRIGHT. So intertwined with that thinking, you have the least protection of anybody entering the new age, and I want to ask you hadn't you heard this, hadn't you heard what I had heard, that you were going to protect yourself by joining medical groups?

Chairman ISSA. The gentleman's time has expired. The doctor may answer.

Dr. McLAUGHLIN. Well, let me just share this with you. I had been, for eight years, a full-time faculty member at a major hospital in New York and enjoyed my time there. But I also saw the benefit of being able to be a physician, to make choices for the patient care in a way that I see fit, and the best care that I see fit for the patient that works for me and my patients. I don't want to give up that freedom by joining a larger group that has a non-physician administrator telling me how fast I have to see a patient and what I can or cannot do for them. That is a choice that I have in this Country, thank God, and I want to keep it for my patients' sake.

Chairman ISSA. I thank you.

We now go to somebody who knows about patients' care, first on the list, Dr. Gosar.

Mr. GOSAR. Thank you, chairman.

Dr. Novack, can you discuss for me the confusion your patients are feeling about Obamacare, your services, and then also touch a little bit about urban and rural? You know, we are from Arizona, so there is definitely a dichotomy going on here.

Dr. NOVACK. Sure. I think that if there is one term, regardless of your political party preference, that describes whether it is providers or patients or administrators or staff, it is confusion, because no one really knows. And I have 100 patients a week coming through, the bulk of whom will actually ask that question, because they know I am involved in different policy issues, and my answer is we just don't know. They don't know what plans are going to be available. They don't know what services are going to be available. They don't know what medications are going to be covered. They don't know which hospitals they are going to be allowed to go to.

So the issue here is basically abject confusion, and no one knows what is going to happen January 1st. And to say that that was an unforced error because of political realities, the great tragedy are really the tens of millions of Americans and hardworking American families that have been suffering emotionally because of the uncertainty that the law has created, because of work that was not done, the lack of transparency, the unwillingness to release regulations.

I have patients who work for insurance companies, and I was hearing from them throughout the summer that they didn't even know the requirements that they were going to be forced to put into the software that they had to write. We are hearing that they are being required to be responsible for the data on these servers, but they are not allowed to get access to the servers to be able to test the integrity of the data that they are being held responsible for.

So at every single level, unfortunately, the claims that were made to pass the law are not the reality, and the losers—this is not about the three of us up here, it is not about the dentists, it is about the fact that we do need to do something about preexisting conditions, but that was a small part of the population. The same amount of people basically that folks have recently been saying that, oh, it is a small number, don't worry about them that are getting their policies canceled, it was really only 10 to 15 million peo-

ple that had these chronic conditions, and we could have addressed that. Instead, we have totally uprooted essentially everybody.

Real quickly about the Medicare Advantage issue. There is nothing tangential to the changes in Medicare Advantage as it regards the Affordable Care Act. Remember that the Affordable Care Act cuts between \$130 and \$150 billion out of Medicare Advantage this decade, and that is why you are seeing these cuts to Medicare Advantage networks.

Mr. GOSAR. So when you are talking about preexisting conditions, I am going to ask you and Dr. English, we just exchanged, as the ranking member talked about, a prejudice to preexisting conditions, we just traded one prejudice for another. Would you agree with that?

Dr. NOVACK. Correct.

Mr. GOSAR. Dr. English, would you agree with that?

Dr. ENGLISH. Correct. You haven't, in my opinion, increased care, you shifted care, and that is quite obvious.

Mr. GOSAR. Well, I want to get to that and I really want to applaud you. I have family members and dear friends that have MS, so thank you very, very much. But there is prejudice now because we are talking about acute care versus chronic conditions, right, Dr. English?

Dr. ENGLISH. Correct.

Mr. GOSAR. So you are handicapped when we are talking about chronic care, are we not?

Dr. ENGLISH. Correct.

Mr. GOSAR. And so we are asking you to decrease time, reduce reimbursement, reduce the possibility of drugs, reduce your opportunity to individualize individual treatment modalities. But I have a question for you. Did you see any tort reform in this bill?

Dr. ENGLISH. No, sir.

Mr. GOSAR. Dr. Novack, did you see tort reform in this bill?

Dr. NOVACK. No.

Mr. GOSAR. Dr. McLaughlin, how about you?

Dr. McLAUGHLIN. Absolutely no.

Mr. GOSAR. Have you ever heard of solving a problem without putting everything on the table, Dr. English?

Dr. ENGLISH. Say that again, please?

Mr. GOSAR. Have you ever heard of solving a problem, but not putting everything on the table?

Dr. ENGLISH. No.

Mr. GOSAR. It is foreign to me.

Dr. NOVACK. And the law did actually approve the opportunity for some demonstration programs for medical liability reform, but in the law, the plain language of the law says you may not do any demonstration program that includes any limits on non-economic damages. So the constraints were fairly significant.

Mr. GOSAR. Dr. McLaughlin, I want to go back to this. Reducing time for physicians to see their patients, we are reducing the reimbursement rates, we are reducing the panels, all choreographing hurting the patient. Would you agree?

Dr. McLAUGHLIN. Absolutely.

Mr. GOSAR. You made the comment that you want to practice medicine your way. You want to individualize, take your time, how you see fit, individualize the treatments, right?

Dr. MCLAUGHLIN. Yes, sir.

Mr. GOSAR. How do you feel most patients would like it, would they appreciate your thoughtfulness?

Dr. MCLAUGHLIN. Absolutely, because over and over again I will have patients returning to me, perhaps even out of network, as they go to some of these larger group practices where physician extenders are employed to process patients literally through a quicker assembly line so that that facility can reap more benefits, cost-wise, out of the poorer reimbursements, but they may actually only have two to three minutes of face-to-face physician time in that. And most people are often told to bring a companion with them, because when you are the one that is seeking care, you are only observing half of the response from that physician, and you are losing the other half, which is why most of us actually face umpteen phone calls after the fact, because there is something they forgot to ask or something they didn't understand. So you can only imagine how that problem is magnified with only two minutes of face-to-face time with the doctor. Patients are generally nervous under those conditions.

Chairman ISSA. I thank the gentlelady.

Dr. Novack, I just want to make sure the record is clear. When you were talking about what wasn't in the Act in tort reform, you were talking prohibition on MICRA, like they have had in California since the 1970s, limitations on things over and above full compensation for actual loss, is that correct?

Dr. NOVACK. Correct. I think there is a little bit of money for demonstration projects in the States, but in the law it actually says those demonstration projects may not include any demonstrations that include any limits on non-economic damages.

Chairman ISSA. Thank you.

The gentleman from Nevada, Mr. Horsford.

Mr. HORSFORD. Thank you, Mr. Chairman. The title of this hearing is Obamacare's Impact on Premiums and Provider Networks, but the majority of the opening testimony has largely focused on inadequate reimbursement from Medicare and Medicaid rates, which private insurance companies use, in large part, to set their own rates. So weren't the issues related to reimbursement rates under Medicare and Medicaid issues for the provider community before Obamacare and the Affordable Care Act were even law? Yes or no?

Dr. NOVACK. There is no question, but I think, and I will speak a little bit, is that if the title is about provider and provider networks, we need to look at this is not about us, right, it is about how do we get the maximum number of people the best personalized healthcare we possibly can. And the practical reality is our large group employs nearly 500 people—

Mr. HORSFORD. With all due respect, my question was are Medicare and Medicaid reimbursement issues issues that the provider community were dealing with prior to the Obamacare, Affordable Care Act ever becoming law, yes or no?

Dr. NOVACK. Yes.

Mr. HORSFORD. The rest of the panel?

Dr. McLAUGHLIN. Yes.

Dr. ENGLISH. Yes.

Mr. HORSFORD. So isn't the real issue that you all, as the provider community, want this Congress to focus on, as many of the doctors in my district in Nevada have talked to me about, is the need to reform the reimbursement rates under Medicare, specifically the SGR? Isn't that the focus that would help to address a large part of this problem?

Dr. NOVACK. I will speak for myself, and I would say, Congressman, I don't think so. This isn't about creating a new Washington system to have to figure out how to pay people to provide care. This is much more broadly about how do we establish policies to allow patients and families to remain in control of their healthcare and healthcare decisions. So—

Mr. HORSFORD. So why did you guys bring up the reimbursement rates under Medicare and Medicaid as one of the reasons why there is this lack of adequacy of network providers within some of the plans?

Dr. NOVACK. I would say it is one of the reasons, so it makes an impact.

Mr. HORSFORD. So if the Congress could help address the reimbursement rates and reform SGR, would that help or hurt the process?

Dr. NOVACK. I think it all depends upon how it is done. And again I would refer you back to the position of the Obama Administration, who said in a court filing this year that there is no general mandate under Medicaid to reimburse providers, including hospitals and that, for all or substantially all of their costs. So the position of the Administration seems to be—

Mr. HORSFORD. But SGR is focused on Medicare.

Dr. NOVACK. But I am just saying that the position is—

Mr. HORSFORD. It is not the same thing. You are giving me a reference that is not my question. My question is on the SGR, which is largely the basis for how reimbursement rates to doctors are established by the private insurance companies.

Dr. NOVACK. I think that things would be improved if there was not an annual uncertainty every year for us to say that on January 1st, 2014, we are getting a 25 percent cut, so we tell our patients that under those conditions we cannot continue to see you, so we have to decide if we are going to be willing to see Medicare patients until Congress chooses to fix the problem every year.

Mr. HORSFORD. So if the Congress worked to fix the problem with the lack of reimbursement to cover the cost to the providers providing care under Medicare and Medicaid, that would help, not hurt, correct?

Dr. NOVACK. I think it would—depending upon how it was done, it might help, but there is always the possibility that new policies could not be helpful.

Mr. HORSFORD. Okay. Well, later today we will be voting on a budget deal that includes a rule on the SGR extension for another three months. Not reforming it, not increasing the reimbursement rates like doctors in my State of Nevada want us to do because they are not covering their costs, it is just extending it for another

three months. So I would just hope that at some point in the Government reform part of this committee we would work to bring forward those bills. I have signed letters with my colleagues on the other side in favor of these reforms. I am prepared to work on legislation to bring these needed reforms forward.

But instead we are having kind of these dog and pony kind of show hearings that don't get at any of the real reforms to make the law work better, or to address other issues that are unrelated to the law. Medicare and Medicaid reimbursement issues for doctors were a problem before Obamacare, before the Affordable Care Act was put into place, so to somehow suggest that it is because of the Obamacare that these issues are happening is to fail to recognize the history of the problems in the healthcare system to begin with.

Chairman ISSA. Would the gentleman yield?

Mr. HORSFORD. No, Mr. Chairman, I just want to conclude my—

Chairman ISSA. The gentleman's time has expired.

We now recognize the gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman. I would be happy to yield a minute to you to finish your thought.

Chairman ISSA. Thank you.

I was only going to say that I wasn't here in 1997, when they scored a big savings based on a theoretical reduction in the cost of doing business. You weren't here. It is something that I agree with the gentleman, we need to realize that simply paying doctors less, and then renegeing on agreeing to pay them less when the real cost-savings didn't occur because we never legislated or did anything to help drive down the cost of delivery, is in fact a very good point, and I agree with the gentleman that that fundamental change, which was scored before you and I got here, is not about just paying doctors more, because we did say we are going to find ways to be more efficient in what drives their cost up. So I look forward to working with the gentleman on that. It won't come to our committee, but I would certainly be happy to work with the gentleman to try to drive down the cost of doctors delivering quality healthcare.

And I thank the gentleman for yielding.

Mr. DESJARLAIS. Certainly. Reclaiming my time. I will also add that we just had a Doctors Caucus meeting this morning. As you know, there are markups pending in Ways and Means and Energy and Commerce dealing with an SGR replacement. There is going to be a three-month patch, but we are working with the 15 members of our GOP Doctors Caucus, as well as our dentists and our nurses, and we are going to try to find something that has a sensible approach to reimbursing physicians, unlike the SGR, which over the past 15 years has yielded nothing, I think, but a 1.9 percent increase; and I think most industries would have a hard time making that work with rising costs in other areas.

I wanted to put up a video, if we could.

[Video shown.]

Mr. DESJARLAIS. Okay, I am sure this is probably something most everyone in this room has seen or heard, maybe everyone across America, and practicing primary care medicine for the 20 years before coming to Congress, I know that a lot of my patients

who had insurance probably believed the President. If you had an insurance plan that you liked and you had a doctor you liked, and you were given that clear assurance over and over again, right up through 2012, right before the election, I am sure a lot of your patients were secure that maybe this healthcare law wasn't going to impact them. Well, now they are finding out that that is simply not the case.

So I would ask you—we can just go down the line—what are your patients finding and feeling when they, all of a sudden, realize they have been duped?

Dr. ENGLISH. Well, again, there is fear because they have an established relationship and patients will follow their doctors. What is wrong about the last part of that video is, as I said, if you are in a different part of Georgia and your exchange does not have me, but then you go into that exchange three hours away, now your primary doctor is three hours away too. So you can't just pay more to see us anymore; you are excluded if we are not on that list. And United Healthcare's website says I am non-preferred, so you can still see me, but you have to pay more because your doctor is being penalized because he takes care of sick people.

Dr. McLAUGHLIN. The patients are numb. I think that is about all I can say.

Mr. DESJARLAIS. Okay.

Dr. McLAUGHLIN. And many of the patients who had a State subsidized plan in New York called Healthy New York received letters that that plan would end and they would have to go into the New York marketplace. I actually approached many of those patients that were in my practice; they never bothered to open the mail. They didn't even know that their plan terminated; I was the one that informed them. So these patients are numb, they are upset. And as you know as a primary care doctor, you don't work alone, you work with specialists. So Rahm Emmanuel had said that you can pay more for a plan that has your doctor. Well, it may have your doctor, one of them, but it may not have the four or five specialists that you see also. So there is a discontinuation of care no matter how you look at this.

Mr. DESJARLAIS. Dr. Novack, I am going to finish because you bring up a great point. Supporters of the healthcare law claim that 30 million people will gain insurance. Can you explain the difference between having a health insurance card, particularly one for a Government program, and having access for care? And I will just preface that with I came to Tennessee in 1993, a year before TennCare was instituted, which was a model for what we are experiencing now, and it didn't work. So I think you know very well that somebody can come in with that card and they need maybe an orthopaedic surgeon, and if you are in a rural area, they may have to go 100 miles or more to try to find that doctor and you might have to hire extra staff just to stay on the line at night, after clinic hours, trying to find a referral or someone who can accept it.

What are your experiences with that? Do you think it is a good idea to reform healthcare based on the expansion of Medicaid?

Dr. NOVACK. I don't think the data suggests that is a particularly good idea, and I think it is the unfortunate reality. And to touch on what you said, I know Congressman Gosar, the last time I was

here, made that point exactly in his opening remarks, that what we are seeing, unfortunately, is that a plan that was supposedly designed to help those who need the most, we are seeing in rural areas there are fewer and fewer doctors available, and we are seeing in inner cities the closure of clinics, the moving out of primary care doctors, the near complete absence of specialists in many cases. So, unfortunately, the groups that we really do want to do things to be able to help, unfortunately the law, while well intended, I just think we need to recognize is not doing what it said needed to be done. So this is beyond tinkering to make it better; this needs essentially a complete revamping and address the real problems.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Virginia, Mr. Connolly.

Mr. CONNOLLY. Thank you, Mr. Chairman, and thank you to our three panelists.

One might be forgiven, looking at this panel and the theater of it. Frankly, if Democrats had had the chance to put together a panel of three doctors, I guess we could ask you to wear your white coat. And I guess we could find three doctors, I know we could, who would praise the plan. But the idea, and this doesn't in any way disparage the value of your opinion or your experience, but the idea that your experience is to be generalized as universal is false, and it is a false premise and it does a disservice, in my opinion, to this discussion.

None of you are policy experts and none of you universally speak for your profession. You were asked at one point, by one of our colleagues, about how difficult it is to sign up. Well, if we are going through anecdotal experience, I can tell you that I and my entire staff must go on the exchange on Obamacare. All of us signed up, met the deadline. If you are under a certain age on my staff, the average premium cut ranges from 30 to 70 percent. They are happy as clams. The deductibles are comparable or better; the copays are comparable or better. I can tell you in my district of small businesses, who are crowing about the fact that when they went on the exchange they had better choices than they have currently. I talked to one the other day with four or five employees; he is going to save \$6,000 to \$7,000 a year.

It isn't an honest intellectual pursuit to deliberately cherry-pick facts and to deliberately put together a panel of critics of a piece of legislation that is admittedly complex.

You were asked about tort reform, as if tort reform was dispositive on the cost of healthcare. It is not. It is a factor, but, of course, what the questioner didn't say as a prelude to his question was, of course, on our side of the aisle we decided, a priori, to oppose it no matter what was in it. We didn't give it a chance. And the fact that an entire party decided to take a powder on a major piece of legislation precisely meant tort reform wouldn't be at the table in a meaningful way, at least as determined by them. Of course not.

We had a prominent Republican Senator in the other body who said if we defeat healthcare—this was before we even knew what was going to be in it; it didn't matter—it will be Obama's Waterloo. That tells you everything you need to know. It wasn't about healthcare. It wasn't about the quality of healthcare. It wasn't

about whether you are in a plan or you are properly reimbursed. It was about a political game to try to make him a one-term president, and it didn't work.

I hope some day we have a substantive hearing where we actually, as Republicans and Democrats, try to find out what is working, what isn't, and make it better. That is the history of transformative legislation in this field. Unfortunately, it is not the history here. We spent 46 votes in this Congress to simply repeal it, defund it, or gut it; not based on substantive analysis, not based on experience, but based on a political predilection to oppose this bill and this President, even though there are elements in the bill that actually came from Republican think tanks, the individual mandate being one of them. Not a Democratic idea; a Republican idea.

So I am glad you are here. Certainly have enjoyed listening to your testimony, but I have to put it in a different context. You will forgive me. And it is too bad that the panel couldn't have been more balanced and it is too bad Dr. Feder is kept waiting, when she was under the impression, as were we, that she could join this panel to provide a different perspective.

I yield back.

Chairman ISSA. I now ask unanimous consent that the gentleman from Virginia, Mr. Connolly's website, which I will put up there, from 2010 be placed in the record, in which he says, for the past years my constituents have told me we want health insurance reform, but only if it meets certain tests, Connolly said. Will it bring down premiums for families and small businesses, will it reduce the deficit and will it protect choice of plan and doctor?

Without objection, so ordered.

Chairman ISSA. We now go to the gentleman from—

Mr. CONNOLLY. Could I inquire of the chairman?

Chairman ISSA. YES.

Mr. CONNOLLY. Is it going to be the practice of this chairman to start to actually individually put members' websites into the record? Because we would be glad to return the favor on this side of the aisle.

Chairman ISSA. I have no problem at all. I asked for it because it was germane to your anecdotal statement of objection to their anecdotal statements, so it just seemed appropriate. And good staffing, as you know, Gerry, somebody looked and said, heck, Gerry used to be for what these people are testifying we are not getting, that is all.

Mr. CONNOLLY. I stand by the website. Those were the three criteria I used, and that is why I voted for the bill and continue to support it, Mr. Chairman. So happy to have it. Just wanted to make sure—

Chairman ISSA. No, we put it in because it was a historic piece. And, candidly, the requested individual from your side of the aisle is on the next panel, along with all the other non-medical doctors, and that is the reason it was divided. Medical doctors who were giving their anecdotal examples of what they see as practitioners, current practitioners, and then the think tank crowd will be next. And hopefully you will not disparage the think tank crowd for not being doctors.

Mr. CONNOLLY. No, Mr. Chairman, absolutely not.

Chairman ISSA. Thank you.

Mr. CONNOLLY. There was no disparagement of doctors, there was just a cry of the heart that some Democratic doctors not be at the panel.

Chairman ISSA. If you had suggested one, we might have had him.

Mr. Cummings.

Mr. CUMMINGS. Just for a second, Mr. Chairman. I would hope, Mr. Chairman, that we would not be engaged in putting members' campaign website stuff up or whatever.

Chairman ISSA. This is not a campaign. We would not—

Mr. CUMMINGS. Whatever.

Chairman ISSA. No, we would not put a campaign website.

Mr. CUMMINGS. What was that?

Chairman ISSA. This is in fact official property of the House of Representatives.

Mr. CUMMINGS. I just want to make sure. I am just so concerned that we stay focused on this and not be distracted by certain things. I thought it was a website campaign, and I think—but thank you very much.

Chairman ISSA. No, no, I appreciate it. But the reason we chose this was that it was said on the floor of the House, it is on a Government site, and it is pursuant to exactly why we chose this question, which is what is the impact to doctors. I know a couple weeks ago, when we were looking at failures of the website, something that we all are working on reforms to fix, we had a discussion about what about what about the fundamentals of the healthcare.

Mr. Cummings, I will say something to you here today. You and I do not control, we were not the committee of jurisdiction for the Affordable Care Act, but the exact problems that these doctors are talking about are what we have to take a leadership role in fixing. Mr. Horsford has left, but a lot of it began in the 1990s, when we thought we could simply pay less from the Federal docket in Medicare and Medicaid reimbursement. These are problems that are longstanding. The reason I am having them here today is I agree with what you said to me in a sidebar, which is when are we going to start fixing some of the individual parts of it. The Affordable Care Act is not going away in totality, but these doctors, and I take Dr. English particularly, are telling us about a chronic problem, which is are doctors being incentivized not to take the tough patients. And in some cases, and Mr. Cartwright alluded to this, in some cases it is our Government reimbursement. In some cases it is how insurance companies are reacting.

And I will pledge to you today I will treat how the Government acts and how insurance companies act the same in trying to get these doctors to be able to practice what they do. And we can have a discussion about how much reimbursement comes out of tax dollars, but hopefully today, both in the first and second panel, we are dealing with what is happening currently so that we can fashion some legislation that has to be bipartisan if we are going to fix it.

Mr. CUMMINGS. Well, thank you, Mr. Chairman. I just want to make sure we stay on track. I keep going back to what Dr. McLaughlin said. She said fix it, and it can be fixed. By the way,

Mr. Chairman, I appreciate what you said to Congressman Horsford, because he did raise some very legitimate concerns and I think that we can work in a bipartisan way. We can help these doctors be effective and efficient in what they do and help the American society. So thank you very much.

Chairman ISSA. Thank you.

The gentleman from Georgia.

Mr. WOODALL. Thank you, Mr. Chairman.

I thank you all for being here. My colleague from Virginia characterized you as Obamacare critics. I would not characterize you that way. I don't know how you would characterize yourself. I would characterize you each as patient advocates. And if that leads you to be critical of the Obamacare legislation, then fair enough. But to the gentleman's point, I thought he was exactly right: find out what is working and what is not, and make it better. I wish that had been the counsel this Congress had applied before the passage of the President's healthcare bill, because each of you has made testimony about patients that you had, patients that were receiving care, patients that were given the individual attention that they need, who will no longer because of this new legislation. Those folks weren't having problems; we created those problems. And you all are in the caretaking business much more than I am.

But the stories that you tell that touched me the most are the tales of the problems that we create, the uncertainty that you mentioned, Dr. Novack. There is no way to take those fears away. Those fears are real for those families today. If, six months from now, those fears turn out to be unrealized, we still won't be able to take away the pain and frustration those families have experienced today.

I tell everyone at town hall meetings that I thought the President identified exactly the right challenges; that healthcare costs were rising too fast and that many Americans did not have reliable access to care. I thought he crafted exactly the wrong solution to do that. I think we can work together to solve those problems. The concern is that, certainly from your testimony and from the experience of my constituents, we have created a whole new batch of problems.

I am going to ask you, Dr. English, you know my good friend Todd Williamson in Gwinnett County, Dr. Todd Williamson. He is a neurologist as well. He told me the other day—he is just a little bit older than you are—that here we are the largest county in the southeastern United States, one of the fastest growing. He has been in practice for more than 20 years. He has not seen a new neurologist come into Gwinnett County. I tried to look at the ages of folks in your practice. Are you the youngest in your practice or have you found some young neurologists coming in?

Dr. ENGLISH. I am not the youngest anymore. I wish I was.

Mr. WOODALL. Because that is one of those challenges. I look at the dollars that we have poured into the President's healthcare bill. Just today the headlines: Chicago Tribune, Only 7,000 Illinoisans Enroll in Obamacare Plans in the First Two Months; Weekly Standard, HHS Awards Another \$58 Million to Obamacare Navigators. The list goes on and on. Bergen County Record in New Jersey, Many New Jerseyans Stuck In Healthcare Limbo as December

23rd Deadline Nears; AP, 398 Alaskans Pick Marketplace Plans, Despite Untold Millions Spent There; Oregon Signs Up Just 44 People for Obamacare, Despite Spending \$300 Million.

What would have happened if we had spent those \$300 million on community health centers? I happen to be a huge community health center advocate. I believe folks are entitled to a level of care and I believe we can provide that interesting sliding scales, ability to pay. We already had such a mechanism in place.

My colleague from Virginia called this a pony show. When the question came to you, Dr. English, does Obamacare limit your patients' treatments and the answer came back yes, I don't know why that is not the end of the conversation. I don't know why there are not 435 members of Congress who say, you know what, we care about people and we care about people having access to care, and we want to improve the access to care for folks who don't have it; but if you have access to care today and we are doing things in this body that limit the medical professionals' ability to treat their patients, why can't we all decide that is wrong and that we should go back and take another crack at that?

The Affordable Care Act is important legislation, I heard from one of my colleagues, because it deals with preexisting conditions and access to care. I want to ask you, since you have been characterized as Obamacare critics, is there one of you, is there even one of you who does not believe that we should deal with preexisting conditions and that we should improve access to care? I will start with you, Dr. English.

Dr. ENGLISH. Of course we have to do all those things.

Mr. WOODALL. Have to do those things. Have to do those things.

Dr. McLaughlin?

Dr. McLAUGHLIN. Sir, physicians have always given charity care, love of their heart, to people who couldn't afford it. Always did.

Mr. WOODALL. Always did.

Dr. McLAUGHLIN. And always will continue to do so. But what this has created, sir, is a roadblock of unsurmountable proportions. The high deductibles that were imposed on these patients is nothing more than them not having insurance. Can we understand that?

Mr. WOODALL. Dr. Novack?

Chairman ISSA. The gentleman may answer, of course, doctor.

Dr. NOVACK. I agree with you.

Mr. WOODALL. Mr. Chairman, I know my time has expired, but we have found that collection of ideas on which we can agree, and I agree with my colleagues on the other side of the aisle; we should begin working towards those goals and we should do that immediately. I yield back.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Massachusetts for five minutes.

Mr. TIERNEY. Thank you.

Thank you for being here today. I wanted to ask. I think it was Dr. McLaughlin who made a comment that the insurance companies did not renew a patient's policies and, as a result, that was an issue. I wanted to ask you whether or not, when you were having this discussion with your patients who had their policies not re-

issued by their insurance companies, whether or not you looked and saw if those old policies had, as part of their coverage, the following services and benefits: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services, and chronic disease management, pediatric services, including oral and vision care. Did your patients in each case have all of those benefits and services?

Dr. MCLAUGHLIN. Sir, I can only speak of my small business plan because I—

Mr. TIERNEY. Well, let me ask you. You gave me information about your patients and what you thought were their situation, so I am asking you, before you reached a conclusion or an opinion on that, did you look at their policies to see whether or not they actually covered all of those benefits and services.

Dr. MCLAUGHLIN. The policies I referred to is Healthy New York, or State-run, and, yes, they had all those benefits.

Mr. TIERNEY. All of those services were in those.

Dr. MCLAUGHLIN. But the reason why the State canceled—

Mr. TIERNEY. So you are going to tell me now that that policy had each and every one of those services in it?

Dr. MCLAUGHLIN. Absolutely.

Mr. TIERNEY. Okay. Did you look to see whether or not any of your patients that you are talking about had been advised by their insurance company that they could go to an exchange in New York and compare and contrast what they now were offered with whatever else might be on that exchange as an alternative?

Dr. MCLAUGHLIN. They received notification of that, yes.

Mr. TIERNEY. Okay. And do you know whether or not they have gone and checked that out?

Dr. MCLAUGHLIN. I can't tell you what patients do.

Mr. TIERNEY. And do you know whether or not your patients were eligible for a subsidy, in other words, if they were earning less than over 400 percent of poverty?

Dr. MCLAUGHLIN. Again, obviously, as a physician, we don't know what a patient's earnings are, but I can tell you from the careers that I see—

Mr. TIERNEY. Well, that wouldn't be fair because—

Dr. MCLAUGHLIN. Well, it would be fair.

Mr. TIERNEY. So did you ask them whether or not any of them qualified for a subsidy and, if so, how much?

Dr. MCLAUGHLIN. Well, I can speak even of my own staff who were covered. Yes, they checked.

Mr. TIERNEY. I want to know about these patients that you were referring to.

Dr. MCLAUGHLIN. Yes.

Mr. TIERNEY. You weren't checking about your staff; you told us about patients.

Dr. MCLAUGHLIN. Some checked.

Mr. TIERNEY. And some?

Dr. MCLAUGHLIN. And some had a subsidy, some did not.

Mr. TIERNEY. Okay. And do you know which of them or which, how many of each, and whether or not it covered all or some of what they thought was an increase in the policy?

Dr. McLAUGHLIN. The closer that an individual, these patients, get to the upper limit of what qualifies for that subsidy, they were told that they would only save about \$5 a month on the premium. So a subsidy doesn't cover everything. It depends on how far away from the maximum that is covered.

Mr. TIERNEY. That is the idea of a sliding scale and a subsidy, right?

Dr. McLAUGHLIN. Correct.

Mr. TIERNEY. Okay. Did you also talk with your patients about the medical loss ratio part of the Affordable Care Act, that part that says that insurance companies have to now use up to 80 percent of their premiums for actual health services, as opposed to overhead and management, things of that nature?

Dr. McLAUGHLIN. With all due respect to the patient population, sir, they don't understand a medical loss ratio.

Mr. TIERNEY. Do you?

Dr. McLAUGHLIN. I do.

Mr. TIERNEY. Okay. So you are aware that in 2012 consumers saved \$3.4 billion through lowered premiums based on those new standards?

Dr. McLAUGHLIN. My plan did not have that; I got no refund.

Mr. TIERNEY. My question to you, though, was that if you are familiar with it, do you understand that in 2012 consumers saved \$3.4 billion through lower premiums based on those new medical laws.

Dr. McLAUGHLIN. I understand that, yes.

Mr. TIERNEY. And do you understand that, in addition, companies that did not meet those standards issued \$500 million in rebates?

Dr. McLAUGHLIN. Yes, I do.

Mr. TIERNEY. Okay. Do you know whether or not any of your patients were beneficiaries of those rebates?

Dr. McLAUGHLIN. Some of them were, yes.

Mr. TIERNEY. Okay. I just want to close out. I am not going to use all of my time on this, but with respect to a comment that was made earlier from somebody on the panel here about the history of this bill, and this was not a committee of jurisdiction, I was on one of the committees of jurisdiction. My memory is that during the coercive debate of this particular bill, tremendous effort was made to try and have it be a bipartisan measure, and we reached out and asked for participation of both sides of the aisle and one side decided not to participate. Incredibly, even when certain provisions that people thought were generally good, bills that were drawn by Republicans on that part were asked to be introduced, Republicans refused to introduce them. And even when some 12 to 15 of them were put in as amendments, those people who had drawn those original bills that were now the amendments voted against them. So I think it is some indication of the effort that has been made to try and have this be a joint effort all across the aisle, with everybody working on this, shows from the earliest parts of this whole exercise or whatever, a concerted effort, I think, with one part just

to not even be involved in it and not participate in trying to make it the best project it could possibly be, and I think that is part of what we are seeing a continuation of here.

Chairman ISSA. Would the gentleman yield?

Mr. TIERNEY. I am afraid I am out of time, according to your strict standards, Mr. Chairman.

Chairman ISSA. Okay. The gentleman's time has expired.

The gentlelady, Dr. McLaughlin, you were cut off several times because of limited time, but is there anything that you did not get a chance to answer?

Mr. TIERNEY. Mr. Chairman, is it your turn to question? Am I missing something here?

Chairman ISSA. It is the requirement—

Mr. TIERNEY. You just asked for me to yield to you and I have no time to yield, so now you are just—

Chairman ISSA. No, no. I am not asking any questions. The prerogative of the chair under the rules is to make sure that there is a full and complete, clear answer, and to correct the record, if necessary.

Mr. TIERNEY. That is not at all accurate.

Chairman ISSA. I am not correcting the record. This is a long-standing practice under both Republicans and Democrats. The gentleman had limited time. The gentleman, in his limited time, cut you off several times. If the doctor had anything that she felt was germane, I have always allowed witnesses to continue answering even after time has expired.

Was there anything, doctor, that you felt you needed to fully answer there was not time for?

Dr. McLAUGHLIN. The purpose of this committee is to talk about the limited networks and whether premiums were indeed lowered or not, was it not?

Chairman ISSA. That is correct.

Dr. McLAUGHLIN. And as I said to Mr. Cummings, we have 20 days to fix how we are going to provide care to patients with limited access, and there is no debating that. We talk about MS. I will talk about ophthalmology for a second.

Chairman ISSA. I apologize. I would love for you to do that. I just wanted to give you time on something that he had asked, which included subsidies. He cut you off during your statement on occupations of your patients and so on. Please, I am only trying to make sure the record is full. If there is anything you wanted to say about your patients and so on, that was the line.

Dr. McLAUGHLIN. The cutoff—

Mr. TIERNEY. Mr. Chairman, if it is an answer to my question—

Chairman ISSA. The gentleman is not in order.

Mr. TIERNEY. The reason that the witness was asked to move to another subject was she was not being responsive to my question. Now, if you want to ask a new question in a different direction, get some time.

Chairman ISSA. The gentleman is not in order, please.

Mr. TIERNEY. Well, neither is the chair, and I think we have an issue here as to whether you are going to be some sort of arbiter

of what my questions were, and now you are going to shut the microphone off.

Chairman ISSA. Yes.

Mr. TIERNEY. You are just a model of leadership, I tell you.

Chairman ISSA. Thank you.

Please limit yourself to anything that you felt was asked that you were unable to answer. I certainly want you to be germane, that is why I did ask you to stay to what the gentleman asked.

Dr. MCLAUGHLIN. Forty-five thousand dollars, I believe, is the income ceiling in New York to attain a subsidy. Forty-five thousand dollars in living in New York barely makes it. So most of the people who are going to be getting these insurance plans will not receive a subsidy, and they are going to have a difficult time paying these deductibles and paying their premiums. Thank you.

Chairman ISSA. Thank you.

The gentleman from Georgia, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

Look, I just have a couple simple questions. I have a daughter who fits the special needs category. Dr. English, I appreciate you being here from our home State, as well as the rest here. I am just going to ask a very broad sort of question and give a personal experience. One, I have heard it said many times, and I think one of the things that is being said here is there are a lot of things out there to fix. Well, this is one of the fixable laws, this is just one that is broken and it was inherently flawed. And that is just a disagreement that both sides of the aisle is going to have, and we are going to deal with that. I don't believe it can, but there are things that can be done. But we have to now deal with reality. Reality is that, as in the case of my daughter, who has spina bifida, early in life, before six years old, she had 30 major surgeries, three of which went eight hours plus, ranging just a vast array of different things. Now she is fine, she is 21 years old, and she actually rules the house if nothing else is said.

But doctors in her life, especially early on, were very important, and they still are. And we are making the transition, as I had a chance this morning to speak with Dr. English about the transition from pediatric to adult; and that is hard for a father, so I will just leave that at that. But she is a young woman.

The problem I have here, and I want you to address—I am going to stop here and just sort of open it up, and then if you don't have a lot to say, then, fine, we will be done and we will move forward. But the plans are hurting the very ones I believe they were intended to help, especially with the zones and especially with the areas of access, and especially on borders and especially those who need multidirectional or multi-physician care. Could you speak to that? Not the politics of this thing, but speak to what happens to a father who has a daughter named Jordan who may not be at 21, they may be at 6 or they may be at 5, and they are trying to get everything they can so that their daughter or son can move within the limitations of what you are now seeing. Can you speak to that for just a minute?

Dr. English, would you start? And then anybody else who would like to pick up.

Dr. ENGLISH. I will start. The problem is, as you said, this is the group of patients that we really need to provide for. I know your area, you are about an hour from us without traffic, depending upon the time of day.

Mr. COLLINS. Three and a half to four with traffic.

Dr. ENGLISH. So that is not a far place to go for somebody like that to see a pediatric surgeon. Boston if you are from Massachusetts, going to Boston is not a big deal for anybody in Massachusetts. But if you are out of the exchange district, then you don't have access and patients like your daughter will not have access; not to mention the Mayo Clinics of the world and Walter Reed and all of those places where a subset of patients have to go. So my concern is that, again, you have that card, but because of where you live, that is even going to restrict your access to the provider that you need.

Mr. COLLINS. And that actually increases cost because you don't have the collaborative effort that you could do in, say, a clinic setting or something else at times, and I think maybe you have that experience.

Dr. McLaughlin?

Dr. MCLAUGHLIN. You see, it is a team approach in many illnesses, and the whole team has to be with us, because this was allowed to be created now as all in-network coverage. Besides the high deductibles, all in-network coverage. That is not saying you can't go to see a specialist like Dr. English, but you would have to pay for it; and that won't go to satisfying your deductible or your out-of-pocket. So there are flaws in this. And I am not against the Affordable Care Act, but there are flaws in this that are increasing the costs to the patients, the very patients that you wanted to help, and this needs to be fixed.

Mr. COLLINS. Dr. Novack?

Dr. NOVACK. There will be some families who will see some improvement, but what we have changed with the law is really the set of who the winners and losers are. And again certainly to date, and there has been, frankly, not a shred of any actual, real-life evidence that the number of winners are going to even come close to approaching the number of losers.

Mr. COLLINS. And I think that is the concern that we are seeing in my office. That is the concern that is coming on that was just a natural outflow of this, and there are things that have to be addressed. It is a passionate issue, not just for the folks on Capitol Hill. In fact, for the 535 of us on Capitol Hill, we are just reflections of, really, the people in our districts who are dealing with this every day. The hearing is entitled Obamacare's Impact on Premiums and Provider Networks. Frankly, I appreciate the chairman bringing this and the ranking member being here, and the differences on both sides, but I would have to just say that Obamacare's impact on premium provider networks is a generic term for Obamacare's impact on the lives of people and families. And if we ever disconnect our discussions of insurance and healthcare and all this from the very people who need it, then we have made a mistake, and that is why this hearing is important, because it actually is dealing with those who actually need the help and the doctors that they need for day-to-day living.

I appreciate you being here.

Mr. Chairman, I yield back.

Chairman ISSA. I thank you, sir.

We now go to the gentleman from Illinois, Mr Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. I am pleased to report that I just came from a markup in Ways and Means, where, on a vote of 39 to 0, we voted to do a fix for three months of the SGR and kind of looking after the needs and concerns of doctors.

I also want to take a moment to just associate myself with the comments of my friend from Georgia, Mr. Woodall, who just spoke glowingly about community health centers and the accessibility, as well as impact, that they have had. I happen to have worked for two of them in civilian life and also had the good fortune to be president of our national trade association at one time, and I certainly think that they are a tribute to what can happen in the development of ambulatory care. So I just want to thank him for that comment.

As we begin, I want to make sure that we don't lose sight of the fact that many of these policies that we have talked about did not include basic services, such as hospital care and prescription drugs. They were what many people call junk policies that provided very bare bones coverage that would have resulted in catastrophic medical debt if policyholders became seriously ill. Back in September, a young woman named Aqualine Lori requested to testify at a hearing before this committee, and although she ultimately did not testify, Ranking Member Cummings read part of her statement into the record.

Like millions of other Americans, Ms. Lori had a preexisting condition, a rare blood disorder. In 2005 she needed emergency gallbladder surgery and suffered complications due to her condition. Although she had insurance at the time, her insurance company dropped her, refunded her premiums, and left her with a \$50,000 hospital bill. Although she spent years trying to appeal this decision, she was not successful. Eventually, the hospital she was treated at decided to forgive the bill.

My question to each of you, all of you are in the business of providing healthcare. You clearly have all interacted with insurance companies and know about insurance. Was this type of policy rescission common prior to the enactment of the reforms in the Affordable Care Act? And what were your experiences in each of your practices? And we could begin with you, Dr. Novack.

Dr. NOVACK. Sure. In my 13 years of practice and then 5 years of training before that up in the Seattle area, I have not seen it, and I have taken well over 1,000 days of on-call at multiple hospitals and seen over 50,000 patients. Most States actually have laws already that preexisted the ACA that prevented inappropriate rescissions, so that is a different issue that I think is being conflated a little bit incorrectly. So laws against canceling people's policy because you get sick have been against the law in most States for a long time. That is a different problem than this idea of people's insurance not being renewed.

Now, the idea that people who had preexisting conditions not being able to find affordable insurance, there is not likely a person

in this room, there is not a person I have ever come across in my 25 years of taking care of patients that doesn't feel like we need to do something or make policy changes to address that. The conclusion, however, is that the policies that were put forth through the Affordable Care Act are actually making these problems worse, and not better.

Mr. DAVIS. Dr. McLaughlin?

Dr. McLAUGHLIN. It was illegal to cancel the policy because of increased utilization of it for a serious medical illness. This wholesale nonrenewal of policies is shocking. It has been reported that the insurance companies felt that small businesses were a losing proposition to them economically, and this probably became a great opportunity to just rewrite those policies, which is why we are where we are today with so many small business policies being not renewed.

Hospitals, again, have always taken care of acute care conditions when somebody is uninsured, but we have to fix the problem that we are facing now, as much as it is laudable to see the people who have preexisting conditions can have insurance. Thank you.

Mr. DAVIS. Dr. English?

Dr. ENGLISH. Due to time, I don't really have much more to say than Dr. Novack. Obviously, we agree that there are changes that needed to occur, and now we are just pointing out that, unfortunately, this plan is having huge amounts of unintended consequences.

Mr. DAVIS. Mr. Chairman, with your indulgence, could I just simply ask the panel if they would agree that many of these policies were in fact junk policies that we have been talking about?

Dr. NOVACK. I don't think that there is any evidence to date that the 5.5 million people who have had their policies cancelled, I haven't seen exact numbers, what percentage those are "junk policies." A lot of them were ones because they didn't actually contain some of the new mandates in the law.

Dr. McLAUGHLIN. No one in my practice had a junk policy.

Dr. ENGLISH. I have nothing else to add.

Mr. DAVIS. Thank you very much.

Mr. GOSAR. [Presiding.] I thank the gentleman from Illinois.

I would now like to recognize the gentleman from Michigan, Mr. Bentivolio.

Mr. BENTIVOLIO. Thank you, Mr. Chairman. Mr. Chairman, we now know that you can't keep your insurance, even if you liked it. You can't keep your doctor, even if you have been seeing him for the last 30 or 40 years. You can't keep your hospital. Premiums are increasing and we have higher deductibles. Obamacare raided \$700 billion from Medicare, including \$300 billion from Medicare Advantage alone, to pay for the ACA. 2,250 physicians were terminated from Medicare in Connecticut alone. Most of the orthopaedic surgeons in Dayton, Ohio dropped. In Florida, 250 physicians from one medical center dropped.

In January, Mr. Chairman, I am sure we will discover thousands, if not tens of thousands, of people, to their dismay, that they thought they signed up for the ACA, but because of a glitch in Healthcare.gov did not. Mr. Chairman, the website itself is in question. A website that asks the most personal, intimate questions

does not have the proper security protocols to ensure the personal medical data of our citizens that are safe and secure.

Obamacare created a panel of 15 unelected bureaucrats, called the Independent Payment Advisory Board, who have the power to control the types of treatment seniors receive through Medicare. And according to Dr. Jason Fullmer and Dr. David Gratso, this unelected body will have the unprecedented ability to singlehandedly change the allocation of healthcare resources should Medicare spending exceed medical inflation, which, for the record, it consistently does.

Dr. Novack, what are your views on this IPAB, I believe it is called, the Independent Payment Advisory Board?

Dr. NOVACK. Sure. As I mentioned earlier, I just think it is a serious area of concern. I don't think that for those of us, and actually for most families, that creating another new layer of bureaucracy that are making determinations about accessibility is a step in the right direction. I would add that I think that there is fairly significant bipartisan opposition to the Independent Payment Advisory Board because of the way it is structured and how their decisions effectively have the ability to bypass Congress.

Mr. BENTIVOLIO. Do you have evidence that competition and choice is a better way to increase value and reduce cost than Government bureaucracy and experts?

Dr. NOVACK. I think there is a fair amount of evidence that if we increased transparency, provide more information to patients, that a lot of patients will make better decisions. That is also true on the physician side. And a lot of those solutions are a lot simpler and cost a lot less than the \$2.5 trillion to \$3 trillion we are spending on the Affordable Care Act over the next 10 years.

Mr. BENTIVOLIO. Thank you. Do you think that many people signing up for coverage don't know that their doctor or their children's doctor will still be in their network and they will still be able to visit their family doctor?

Dr. NOVACK. I think the evidence of this panel is not only do the patients not know, but we don't know either.

Mr. BENTIVOLIO. Mr. Chairman, we are consistently unearthing the lies, half truths, and distortions of this poorly conceived law.

Dr. Novack, what do you anticipate will occur next year when people go to their doctor and find out they are no longer covered?

Dr. NOVACK. Well, congressman, it gets back to this uncertainty issue, that already, on the provider side, we spend enormous amounts of time, as was mentioned, enormous number of phone calls trying to sort through some of these very complicated issues regarding health insurance. And, by the way, this is not just for people in the private market; it is not just for people on Medicaid; it is equally true for people with Medicare and the 130,000 pages of regulations that go along with Medicare.

This is only going to grow. So at least for our practice, since we have no idea what the exchange will bring, and this 90-day grace period issue is such an enormous issue for us that we don't feel that we can actually see patients under these exchange contracts that we were pushed into without choice until this body or other bodies actually figures out what the rules are going to be so we can continue to provide services and be able to pay our staff.

Mr. BENTIVOLIO. Thank you very much.

Chairman ISSA. [Presiding.] Would the gentleman yield?

Mr. BENTIVOLIO. Yes.

Chairman ISSA. Dr. Novack, I just want to make it clear. Under this 90-day plan, if you have, let's say, a \$2 million practice, including the pay you pay all your people and so on, you could end up with, 90 days, one-quarter of that, \$500,000 of patients that aren't covered and don't pay. That is the kind of exposure you could have, is paying all your people, paying out \$500,000, and getting back none of it. That is the uncertainty that was in the law, is that correct?

Dr. NOVACK. Right. And the concern is almost all insurance, is my understanding, there is always a 30-day grace period, right? Because sometimes we forget to send a check in. Things happen. But under the law the exchange plans have a 90-day grace period. For the first 30 days the insurers are required to actually pay the bill. But when we go do an insurance authorization on day 31, it is going to look like the patient has insurance, but the insurance company is going to hold payment, and if that premium is not paid by day 90, the insurance company says, well, it is not our problem, go collect it from the patient. And generally speaking, in those settings, talking to hospital people as well, your collection rate is about one or two cents on the dollar for that money.

Interestingly, we had a conversation with one of the newer insurers that is going to be on the exchange in Arizona and we said we would like some kind of protection against this exact problem. We didn't have an issue in terms of what the payment rate was going to be for services, we just said we need some kind of protection; and they were unwilling to provide us that protection, so we walked away from that contract.

Chairman ISSA. I want to thank all our witnesses today. I certainly think that we closed on a good note. The fact that there is something that I think all the people on this side of the dais can agree on is that we certainly need to make sure, just as if you were taking a Visa or Mastercard and you checked it and it was good, your expectation is that when you let the gas or the other product leave your store, that it would be honored, and not that 60 or 90 days later you would find out, retroactively, you weren't going to get paid. So as we look at the many problems presented here on this first panel, I think that is certainly a good example of one that we look forward to working together to try to fix and fix quickly.

Again, doctors, I thank you for remaining in this industry, remaining in your practices, and offering us some ideas of where we need to keep from driving you and doctors like you out.

And I recognize the gentleman from Maryland for a closing.

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

I want to thank all of you, too, for what you do every day. You have very, very important jobs. You bring a quality of life to life and in many instances save lives, saving sight. It is so important. I want you to be paid. I want you to be paid for what you do. At the same time, I also want people to have an attitude of staying well and, if they get sick, knowing that that insurance card that they have means something. And I heard what you said, Dr. McLaughlin, about the various situations that you found yourself

in with your mom. So some kind of way we have to balance all of this.

You know, Congressman Tierney was so accurate. A lot of these things probably could have been resolved when the bill was being put together, but there was a lot of give and take and a lot of things happened that I think we could have avoided a lot of what we have here now. There are problems, but you are right, we have to fix this, and it has to be a can-do attitude, and not one of just throwing up our hands. Because you know what? The people who suffer are the very people that you try to help everyday.

So I thank you for what you do. I also thank you for bringing the passion that you bring to your professions. We understand. You are just trying to help people, to get them well and keep them well, and we really appreciate you. Thank you.

Dr. MCLAUGHLIN. I thank you so much for this opportunity.

Chairman ISSA. Thank you all. And, again, you will have seven days, if you want to put additional statements or other material in the record.

We will now take a short recess for the second panel.

[Recess.]

Chairman ISSA. I want to thank all of you for your patience. We will now welcome our second panel of witnesses. Professor Judith Feder is a Professor of Public Policy at the McCourt School of Public Policy at Georgetown University and a Fellow with the Urban Institute. Mr. Edmund Haislmaier, welcome back, is a Senior Research Fellow for Health Policy Studies at the Heritage Foundation. And Dr. Avik Roy, M.D., is a Senior Fellow at the Manhattan Institute for Policy Research.

As you saw on the first panel, pursuant to the rules of the Committee, would you please rise and raise your right hands to take the oath.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth and nothing but the truth?

[Witnesses respond in the affirmative.]

Chairman ISSA. Please be seated. Let the record reflect all witnesses answered in the affirmative. Dr. Roy?

STATEMENT OF AVIK S.A. ROY, M.D.

Dr. ROY. Chairman Issa, Ranking Member Cummings and members of the Oversight Committee, thank you for inviting me to speak with you today about the Affordable Care Act.

My name is Avik Roy, I am a Senior Fellow at the Manhattan Institute for Policy Research, in which capacity I conduct research on health care and entitlement reform.

I am an advocate of market-based universal coverage. I believe that the wealthiest country in the world can and should strive to protect every American from financial ruin due to injury or illness. Furthermore, I believe that well-designed, subsidized insurance marketplaces are among the most attractive vehicles for achieving these goals. It is for these reasons that I am deeply concerned about the way the ACA's insurance exchanges have been designed and implemented. Most of all, I am concerned that the law will

drive up the cost of health insurance, especially for people who shop for coverage on their own.

As you know, the ACA makes substantial changes to the individual health insurance market. The law broadly bars from charging different rates to the sick and the healthy and requires insurers to raise rates on younger individuals in order to partially subsidize care for the old. It mandates that insurers cover a broad range of services that individuals might not otherwise choose to purchase. The law taxes premiums, pharmaceuticals and medical devices in a manner that has the net effect of increasing the cost of insurance.

Earlier this fall, I and two colleagues from Manhattan Institute completed the most comprehensive study to date of individual market premiums in 2014 relative to 2013. We examined the five least expensive plans available in the individual market for every county in the United States, averaged their premiums and adjusted the result to take into account those who, due to pre-existing conditions, could not purchase insurance at those rates. We examined premiums for 27, 40 and 64 year old men and women.

We then compared those rates to the five cheapest plans on the ACA exchanges, apples to apples comparison. Our analysis found that the average State would see a 41 percent increase in underlying premiums prior to the impact of subsidies. Among the States seeing large increases are Nevada, 179 percent, New Mexico, 142 percent, North Carolina, 136 percent, Vermont, 117 percent, and Georgia, 92 percent. Our analysis did find that eight States will see average premiums decrease under the law, including Massachusetts of negative 20 percent, Ohio, negative 21 percent and New York, negative 40 percent.

Of the six categories we studied, 27 year old men face the steepest increases with an average hike of 77 percent; 40 year old women received the mildest increase with an average of 18 percent.

We also studied the impact of the law's premium assistance payments on exchange premiums. Our analysis found that for individuals of average income, taxpayer funded, insurance subsidies primarily flow to those nearing retirement. This is because the elderly will stay pay more for insurance on average than younger individuals and because the subsidies are designed to fix a percentage of one's income devoted to paying health insurance premiums.

Taking subsidies into account, 64 year old men will pay on average 19 percent less for insurance under the ACA system, whereas 27 year old men will pay 41 percent more.

The Manhattan Institute analysis indicates that we are indeed likely to see a fair amount of adverse selection on the exchanges. People who consume an above average amount of health care services, such as sicker or older individuals, have a compelling economic incentive to enroll in the ACA marketplaces. Healthier and younger individuals, however, have less of an incentive, even when one takes into account the individual mandate.

Our analysis did not directly examine the degree to which exchange-based plans have higher deductibles and narrower provider networks relative to plans available in 2013. There have been, however, many anecdotal reports of people paying higher premiums for plans with higher deductibles and narrower physician networks

than the plans they previously enjoyed. In particular, prestigious academic medical centers that specialize in the most complex cases in the various diseases tend to provide costlier care than the typical American hospital. These facilities have been mostly excluded from the exchange-based provider networks.

It is not inherently a bad thing for individuals to choose plans with higher deductibles and narrower networks, especially if those choices allow Americans to reduce their monthly premiums. In theory, by encouraging price competition among health care providers, exchanges could exert a downward pressure on overall health costs.

The problems is that in the case of the ACA, many individuals are reporting higher premiums for less attractive health coverage in a way that will all in all increase national health spending. It would be one thing if the ACA was forcing Americans off their old plans, and offering them more attractive plans at a lower price. But millions of Americans are likely to see less attractive coverage at a higher price. If they do, then the Affordable Care Act will not live up to its name, and its goal of universal coverage will remain unfulfilled.

Thank you.

[Prepared statement of Dr. Roy follows:]

**Testimony Before The House Oversight and Government Reform
Committee**

December 12, 2013

Obamacare's Impact on Premiums and Provider Networks

Avik Roy

Senior Fellow, Manhattan Institute for Policy Research

Written Statement

Chairman Issa, Ranking Member Cummings, and members of the Oversight Committee: thanks for inviting me to speak with you today about the Affordable Care Act.

My name is Avik Roy, and I'm a Senior Fellow at the Manhattan Institute for Policy Research, in which capacity I conduct research on health care and entitlement reform.

I am an advocate of market-based universal coverage. I believe that the wealthiest country in the world can, and should, strive to protect every American from financial ruin due to injury or illness. Furthermore, I believe that well-designed, subsidized insurance marketplaces are among the most attractive vehicles for achieving these goals.

It is for these reasons that I am deeply concerned about the way in which the ACA's insurance exchanges have been designed and implemented. Most of all, I'm concerned that the law will drive up the cost of health insurance, especially for people who shop for coverage on their own.

**The Manhattan Institute study: Underlying premiums increase by an
average of 41%**

As you know, the ACA makes substantial changes to the individual health insurance market. The law broadly bars insurers from charging different rates to the sick and the healthy, and requires insurers to raise rates on younger individuals in order to partially

subsidize care for the old. It mandates that insurers cover a broad range of services that individuals might not otherwise choose to purchase. The law taxes premiums, pharmaceuticals, and medical devices in a manner that has the net effect of increasing the cost of insurance.

Earlier this month, I and two colleagues at the Manhattan Institute completed the most comprehensive study to date of individual-market premiums in 2014 relative to 2013. The analysis can be found here:

<http://www.forbes.com/sites/theapothecary/2013/11/04/49-state-analysis-obamacare-to-increase-individual-market-premiums-by-avg-of-41-subsidies-flow-to-elderly/>

We examined the five least-expensive plans available in the individual market for every county in the United States, averaged their premiums, and adjusted the result to take into account those who, due to pre-existing conditions, could not purchase insurance at those rates. We examined premiums for 27-, 40-, and 64-year old men and women.

We then compared those rates to the comparable ones on the ACA exchanges. Our analysis found that the average state will see a 41 percent increase in underlying premiums, prior to the impact of subsidies. Among the states seeing large increases are Nevada (179%), New Mexico (142%), North Carolina (136%), Vermont (117%), and Georgia (92%). Our analysis did find that eight states will see average premiums decrease under the law, including Massachusetts (-20%), Ohio (-21%), and New York (-40%).

Of the six categories we studied, 27-year-old men face the steepest increases, with an average hike of 77 percent. 40-year-old women see the mildest increases, with an average of 18 percent.

Subsidies will mainly benefit the elderly

We also studied the impact of the law's premium assistance payments on exchange premiums. Our analysis found that, for individuals of average income, taxpayer-funded insurance subsidies primarily flow to those nearing retirement. This is because the elderly will still pay more for insurance, on average, than younger individuals, and because the subsidies are designed to fix the percentage of one's income devoted to paying health insurance premiums.

Taking subsidies into account, 64-year-old men will pay on average 19 percent less for insurance under the ACA system, whereas 27-year-old men will pay 41 percent more.

Adverse selection is likely to occur

The Manhattan Institute analysis indicates that we are indeed likely to see a fair amount of adverse selection on the exchanges. People who consume an above-average amount of health care services, such as sicker and older individuals, have a compelling economic incentive to enroll on the ACA marketplaces. Healthier and younger individuals have less of an incentive, even when one takes the individual mandate into account.

While many in the press are focused on the exchange enrollment figures that HHS released yesterday, what's more important than the *number* of people who enroll in the exchanges is the *composition* of the people who enroll in the exchanges. This will give us a sense of whether or not marketplace premiums are likely to further increase in 2015 and 2016, exacerbating the problem of adverse selection.

H.R. 3362, the Exchange Information Disclosure Act, would require HHS to provide weekly updates on exchange enrollment statistics. A greater degree of transparency and regular disclosure from HHS would be a desirable outcome. I would encourage the Oversight Committee to consider the importance of requiring HHS to disclose the kind of information that would help us monitor adverse selection; that is to say, indicators of health status, such as age.

Higher deductibles and narrower networks

Our analysis did not directly examine the degree to which exchange-based plans have higher deductibles and narrower provider networks relative to plans available in 2013. There have been, however, many anecdotal reports of people paying higher premiums for plans with higher deductibles and narrower physician networks than the plans they previously enjoyed.

In particular, prestigious academic medical centers that specialize in the most complex cases, and the rarest diseases, tend to provide costlier care than the typical American hospital. These facilities have been mostly excluded from exchange-based provider networks.

It is not inherently a bad thing for individuals to choose plans with higher deductibles and narrower networks, especially if those choices allow Americans to reduce their monthly premiums. In theory, by encouraging price competition among health care providers, exchanges could exert a downward pressure on overall health costs.

The problem is that, in the case of the ACA, many individuals are reporting higher premiums for less attractive health coverage, in a way that will, all in all, increase national health spending.

It would be one thing if the ACA was forcing Americans off of their old health insurance policies and offering them more attractive plans at a lower price. But millions of Americans are likely to see less attractive coverage at a higher price. If they do, then the Affordable Care Act will not live up to its name, and its goal of near-universal coverage will remain unfulfilled.

I look forward to your questions, and to being of further assistance to this committee.

* * *

For a further discussion of narrow networks in the ACA exchanges, please read the following:

<http://www.forbes.com/sites/theapothecary/2013/09/24/yes-obamacares-exchanges-will-narrow-your-choice-of-doctors-and-thats-a-good-thing/>

Chairman ISSA. Thank you.
Ms. Feder?

STATEMENT OF JUDITH FEDER, Ph.D

Ms. FEDER. Chairman Issa, Ranking Member Cummings and members of the Committee, I welcome the opportunity to speak with you today about the Affordable Care Act. My views are my own, not those of Georgetown University or the Urban Institute, where I have spent much of my career. And over my career there and elsewhere, I, like you, have watched the millions of Americans without health insurance rise to 50 million people and go without care, even as Americans who have health insurance spend more and more to hold onto it. At long last, the Affordable Care Act enables us to assure Americans access to affordable health care. We have a simple choice: effectively implement the law or resign ourselves to the unacceptable status quo, a status quo that I believe is quite different, the evidence tells us, from the rosy picture that we were left with in the last panel, where everybody gets their care and their doctor and all is well.

My own research has contributed to a substantial body of literature demonstrating that insurance matters. Americans without health insurance get less care, get it later in the course of the illness and are more likely to die than Americans without it. And to the extent they get care, that care is paid for by those of us who have health insurance and our insurance premiums and through our local, State and Federal taxes.

Who are the uninsured? They are mostly workers, or in families of workers, who are not offered coverage through their jobs the way most of us are. Pre-ACA, they have few options to protect themselves. Coverage in the non-group or individual market with denials of coverage for pre-existing conditions and limited benefits and non-renewals simply does not work for people with they get sick. Far from living up to the promise that people who have this insurance can keep their doctor or their doctors paid for, Mr. Chairman, as I heard you argue, the limits on their annual payments as well as other limitations frequently leave them high and dry, and that is what the evidence tells us.

And while Medicaid provides an invaluable safety net for people who are eligible, it is far from an empty cart or an empty promise, and research shows us it actually does get people access to care. Except in a few States with waivers from Federal law, Medicaid excludes coverage of adults who are not parents of dependent children, no matter how poor they are. So the very same low and modest earners who can't get coverage through their jobs can't get public protection.

It is these giant holes in our health financing structure that the ACA aims to fill. As Avik said, the ACA requires insurance to end discrimination based on pre-existing conditions, gender and other factors to cover the range of services health professionals typically provide and to eliminate dollar caps on annual and lifetime benefits. And so that people don't wait until they get sick to enroll, the ACA accompanies these requirements on insurers with requirements on individuals, to purchase coverage or pay a penalty. And to make that requirement feasible and coverage affordable, the

ACA provides tax credits and other protection to limit people's premiums and cost-sharing as a share of income.

These policies together make it possible to transform what is an empty card in individual America today into what insurance is supposed to be: available, adequate and affordable. And the ACA addresses the holes in Medicaid by expanding its eligibility to people with incomes below 138 percent of the poverty level, regardless of their family status. Until 2017, that expansion is fully financed by the Federal Government with Federal financing gradually dropping to 90 percent for 2020 and subsequent years. States will ultimately pay 10 percent.

Analysis shows that the expansion will make States financially better off by reducing the burden of uncompensated care, while contributing to the overall health of State economies. Indeed, research shows that because taxpayers in all States contribute to financing for the ACA, citizens in States that choose not to participate in Medicaid will actually pay for benefits in other States, without reaping any of the benefits for themselves, in addition to Federal funds.

And while the ACA expanded coverage by improving the market outside employment, it is important to emphasize that the law leaves the employer-sponsored insurance that most of us depend on fundamentally as it is today. Despite claims to the contrary, the analyses by CBO, Rand and my colleagues at the Urban Institute show that employer-sponsored health insurance will remain the core of the American health insurance system. Essentially, we have left roughly 150 million people who rely on employer-sponsored insurance, their coverage is the same as it has been, not with some improvements, and not more effective. They were not the group that we were talking about this morning, and that is the coverage outside of employment.

At the same time, I see my time going, we are seeing the slowest cost growth that we have seen in history, in part a function of the ACA's elimination of overpayments to Medicare and promotion of initiatives to support efficient, higher quality care. And that is affecting everyone.

By filling the gaps in our current financing structure and slowing the growth in our health care costs, the ACA has enormous potential to address the flaws in our health care system that all of us decry. The biggest barrier I see to realizing the law's potential is the political resistance to its implementation, with too many States unwilling to establish their own marketplaces or to expand Medicaid, despite the enormous advantage to their own citizens.

Come January 1st, millions of Americans will for the first time have access to affordable insurance they can count on when they are sick, along with the benefits people are already reaping from the ACA.

Chairman ISSA. The gentlelady's entire statement will be placed into the record.

[Prepared statement of Ms. Feder follows:]

Chairman Issa, Ranking Member Cummings and members of the committee, I welcome the opportunity to speak with you today about the Affordable Care Act. I have spent my career at Georgetown University and elsewhere examining the challenges facing our nation's health care system and exploring ways to improve it. Over that time, I have watched the number of Americans without health insurance rise to 50 million people, even as Americans who have health insurance spend more and more to hold onto it. At long last the Affordable Care Act enables us to assure Americans access to affordable health care. We have a simple choice: effectively implement the law or resign ourselves to the unacceptable status quo.

My own research has contributed to a substantial body of literature demonstrating that Americans without health insurance get less care, get it later in the course of illness, and are more likely to die than Americans without it.¹ And to the extent they get care, it is paid for by those of us who have health insurance—in our insurance premiums and through our local, state and federal taxes.

Who are the uninsured? They are mostly workers, or in families of workers, who are not offered coverage through their jobs, the way most of us are. Pre-ACA they have few options to protect themselves. Coverage in the nongroup or individual market simply does not work to protect people when they get sick.² Individual insurance denies

¹ Institute of Medicine, "America's Uninsured Crisis," Washington, D.C., National Academy Press, 2009
http://books.nap.edu/openbook.php?record_id=12511

² Statement of Sabrina Corlette, Georgetown University Health Policy Institute to the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, November 14, 2013
<http://docs.house.gov/meetings/IF/IF14/20131114/101481/HHRG-113-IF14-Wstate-CorletteS-20131114.pdf>

coverage or requires exorbitant premiums for people with pre-existing conditions; limits covered services (often excluding prescription drugs, for example); and limits total dollars in benefits, leaving people who think they are insured at huge financial risk. People who want to keep that insurance typically find that insurers make it impossible—raising premiums or imposing other barriers to limit the risk that the insurer will have to pay claims.

Although Medicaid provides an invaluable safety net for people who are eligible, many poor and modest wage workers also lack access to its protections.³ Medicaid's health insurance focuses overwhelmingly on low income children, pregnant women, and people with disabilities. Except in a few states with waivers from federal law, Medicaid excludes coverage of adults who are not parents of dependent children—no matter how poor they are. The very same low and modest earners who cannot get coverage through their jobs, then, cannot get public protection.

It is these giant holes in our health financing structure that the ACA aims to fill. To guarantee available coverage in the individual market, the ACA requires insurers to accept everyone; it prohibits rate variation based on health status and gender, and it limits rate variation based on age. To guarantee adequate coverage, the ACA requires coverage of “minimum essential health benefits” defined to cover the range of services health professionals typically provide; and prohibits dollar caps on annual and lifetime benefits. To prevent adverse selection (that is, enabling people to wait until they get sick to enroll),

³ Kaiser Family Foundation, “Medicaid—A Primer,” March 1, 2013. <http://kff.org/medicaid/issue-brief/medicaid-a-primer/>

the ACA accompanies these requirements on insurers are with requirements on individuals—to purchase coverage or pay a penalty. And to make that requirement feasible and coverage affordable, the ACA provides tax credits and other protection to limit people's premiums and cost-sharing as a share of income. These policies together make it possible to transform what is now offered as individual insurance into what insurance is supposed to be—available, adequate and affordable.

The ACA addresses the holes in Medicaid by expanding its eligibility to people with incomes below 138 percent of the federal poverty level (about \$15,900 for an individual and \$32,500 for a family of four), regardless of their family status. Financing for that coverage expansion is fully federal until 2017 and gradually declines to 90 percent in 2020 and subsequent years. The Supreme Court ruled that states have the choice of whether or not to participate in that expansion. But analysis shows that the expansion will make states financially better off by reducing the burden of uncompensated care, while contributing to overall health of state economies.⁴ Indeed, because taxpayers in all states contribute to financing for the ACA, citizens in states that choose not to participate in Medicaid actually pay for benefits in other states—without reaping any of the benefits in additional federal funds.⁵

⁴ John Holahan et al., "The Cost and Coverage Implications of Medicaid Expansion," Kaiser Family Foundation, November 2012 http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384_es.pdf

⁵ Sherry Glied and Stephanie Ma, "How States Stand to Lose or Gain Federal Funds By Opting In or Out of the Federal Expansion," The Commonwealth Fund, December 2013 http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf

Despite claims to the contrary, the law leaves the employer-sponsored insurance that most of us depend fundamentally as it is today. Indeed, with a limited affordability exception, workers offered coverage are not eligible for subsidies in the ACA's new marketplaces, which are explicitly limited to people not offered coverage through their jobs. Except for requirements that children's coverage extend to age 26, preventive benefits be available without cost-sharing, and some consumer protections, the benefits and operation of large-employer plans are largely untouched by the law. Analyses by CBO, Rand, and my colleagues at the Urban Institute show that employer-sponsored health insurance will remain the core of the American health insurance system.⁶

Alongside its support for coverage expansion, the ACA has contributed to a remarkable slowdown in health care cost growth. Health care spending per person from 2010-2013 is growing at the lowest annual rate on record for any three year period,⁷ in part a reflection of the ACA's elimination of Medicare overpayments and promotion of initiatives supporting more efficient, higher quality and more patient-centered delivery of health care services.

By filling the gaps in our current financing structure and slowing the growth in our health care costs, the ACA has enormous potential to address the flaws in our health care system that all of us decry. The biggest barrier I see to realizing the law's potential is the

⁶ Linda Blumberg et al., "Why Employers Will Continue to Provide Health Insurance," The Urban Institute, October 2011 <http://www.urban.org/UploadedPDF/412428-The-Impact-of-the-Affordable-Care-Act.pdf>

⁷ Executive Office of the President, "Trends in Health Care Cost Growth and the Impact of the Affordable Care Act," November 2013 http://www.whitehouse.gov/sites/default/files/docs/healthcostreport_final_noembargo_v2.pdf

political resistance to the law's implementation. Roughly half the states are rejecting the Medicaid expansion that is so clearly in the health and fiscal interest of their citizens; more than half are rejecting the opportunity to design their own insurance marketplaces; and the Congress is not providing the federal government adequate resources to perform its responsibilities, as well as to substitute, where it can, for states' unwillingness to act. States' resistance to the Medicaid expansion will leave more than five million Americans uninsured whom the law could insure—not only burdening the affected families but the providers and the insured population who will continue to face the challenge of uncompensated care. States' resistance to creating their own marketplaces along with inadequate support for federal administration may similarly undermine enrollment in private insurance.

But through Medicaid and those marketplaces enrollment is now moving forward. Come January 1, millions of Americans will, for the first time, have access to affordable insurance they can count on when they are sick. Along with the benefits people are already reaping from the ACA—like expansion of coverage to 26 year olds on their parents' policies, preventive care services provided without charge, enhancement of prescription drug coverage for Medicare beneficiaries—new coverage through Medicaid and the marketplaces will be delivering on the promise of the Affordable Care Act.

The faster we move to deliver on that promise, the better. The ACA creates an enormous opportunity to address flaws we all recognize in our health financing system. It does not fix all the system's flaws, and its own "fixes" will need improvement as we go along. All

of us should be working together to make the law work. To impede its implementation and return to a world without the ACA—with 50 million people uninsured, insurance markets that deny coverage based on pre-existing conditions, and rapidly escalating costs—is simply unacceptable.

Chairman ISSA. We now go to the gentleman—

Ms. FEDER. May I finish the sentence? I thought you said earlier that everybody got to finish their sentences.

Chairman ISSA. You may finish the sentence, but not the entire script. You are one minute past, and you did say you were wrapping up. The gentelady will finish the sentence.

Ms. FEDER. I will be glad to. Along with the benefits that we see people already reaping, we need to move forward to implement the real promise of the ACA. Standing in its way and standing for the unacceptable status quo is simply wrong.

Chairman ISSA. I thank the gentelady. We now go to the next witness, Mr. Haislmaier.

STATEMENT OF EDMUND F. HAISLMAIER

Mr. HAISLMAIER. Thank you, Mr. Chairman, Ranking Member Cummings, for inviting me to testify today.

I am focusing my testimony on the issue the committee asked me to talk about of limited provider networks in the exchange plans under the Patient Protection and Affordable Care Act. You have a copy of my written testimony. I will simply summarize a few of the points.

Obviously, as you have heard in the panel before, provider contracting is nothing new. It is a two-way street. It is up to both the insurers and the providers to come to terms. If one of them doesn't like the terms, you don't have a contract. That shouldn't surprise anyone.

Is there something significant or different about the contracting and the networks in plans in the health insurance exchanges under the Patient Protection and Affordable Care Act? There appears to be, based on the widespread news reports, and by that I mean from all sectors of the Country and involving all different types of providers. With that said, nobody has at this point any definitive, conclusive handle on the extent to which those provider networks are different from the ones that we see out there today. We just simply don't know, in part because some of those networks are still being built, or those contract negotiations are still ongoing.

What we do know, though, is that in a number of cases, the insurers are offering network coverage that is significantly less than what they offer in plans outside of the exchanges. The thing I would direct the committee's attention to as a policy matter is that what I see driving at least some of this, because the assumption has been that well, the consumers would be price sensitive, and the insurers are trying to keep prices down so they exclude providers.

But I think the design of a portion of the law actually drives this. I am specifically referring to the cost-sharing subsidies. Most of the attention has focused on premium subsidies. But the law has a second set of cost-sharing subsidies that pays the insurer to reduce the cost-sharing for lower income enrollees.

The problem with that is that because the cost-sharing for a significant portion of their expected enrollees is nominal, the insurers have reason to expect that there will be higher utilization, and indeed, HHS confirms that, HHS is adjusting the cost-sharing subsidies to reflect their estimate of higher utilization.

Essentially what is happening is the insurers will get paid, but they are no longer able to use a tool of cost-sharing to steer patients to be more prudent consumers. Thus they must rely on other tools, and that is, I think, one of the reasons we are seeing narrower networks in these plans.

The other interesting thing that I found in research that I did which was published at the beginning of the month, and I think I am the only one who has done this so far, is I analyzed all of the insurers who are participating in the exchanges and looked at them and their businesses in the State today and sort of the insurers that are not as well, to see what kind of patterns emerge.

One of the interesting patterns that has emerged from that is 20 percent of the carriers who have gone into the exchange, their principal business in the State where they went into the exchange is Medicaid managed care. And indeed, we do find evidence that these plans recognize a structure, meaning the patient faces very low premiums and only nominal cost-sharing for a generous benefit package that looks a lot like what they are dealing with in Medicaid managed care. Indeed, I quote one of the CEOs of those plans saying, yes, it looks essentially the same, that is why we went in.

Given that, my expectation of how this plays out is that individuals at the lower end of the 100 to 400 percent of poverty that would be subsidized, 100 to 200 percent will probably gravitate towards the silver plan, particularly if you have been uninsured. The tradeoff of low premiums and low cost-sharing for limited provider access is not necessarily something that you are going to be terribly upset about, especially if you are coming from not having insurance.

However, somebody who is used to having insurance, who makes more money, who is maybe 300 to 400 percent of poverty, paying higher deductibles and co-pays for a limited provider network is not going to be attractive. So I expect those individuals would probably move to bronze plans or, certainly above 300 percent of poverty the subsidies are quite small, they might just look for coverage elsewhere.

So I think that is going to be the dynamic that plays out. At this point it remains to be seen how many of these more limited networks we see in the coming days. But I expect that that will probably be fairly prevalent.

My time is about to expire, Mr. Chairman, so I thank you again and would be happy to answer questions.

[Prepared statement of Mr. Haislmaier follows.]

Mr. Chairman, Ranking Member Cummings: thank you for inviting me to testify today. My name is Edmund F. Haislmaier and I am a Senior Research Fellow in Health Policy at the Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

My testimony today focuses on the issue of limited provider networks in the new exchange plans.

In the last several months there have been numerous reports of insurers limiting the provider networks for plans they offer through the exchanges. Reviewing the media stories on the subject from various parts of the country indicate that the phenomenon is both widespread and significant. Even so, we do not yet have a complete picture. In part, that is because some insurers appear to still be in the process of negotiating and contracting with providers.

Of course, health insurers and medical providers negotiate contracts all the time, and provider access under any health plan depends on the results of those negotiations.

However, the exchanges are a new market, so there is considerable public interest in the coverage that will be offered through them. Even though we do not yet have a complete picture, the accumulating evidence indicates that provider access through many exchange plans will be more restrictive than in other markets. That is particularly evident in those instances where an insurer is offering exchange coverage with significantly fewer participating providers than in the plans it sells off the exchanges.

Many reports attribute the more limited provider networks in exchange plans to a desire by insurers to limit premiums and the expectation that exchange enrollees are likely to be more price-sensitive consumers. However, limited provider networks are also the product of the way that the subsidies for exchange coverage are designed.

The Patient Protection and Affordable Care Act (PPACA) provides both premium subsidies and cost-sharing subsidies for exchange coverage, and both sets of subsidies vary based on enrollee income.

Most of the attention has so far focused on the premium subsidies for exchange enrollees with family incomes between 100 percent and 400 percent of the Federal Poverty Level (FPL). Those premium subsidies are calculated at enrollment based on the individual's family income and with reference to the second-lowest-cost Silver plan that is offered in the enrollee's location. For example, if it is determined—by applying the statutory formula to the enrollee's income—that an enrollee will be responsible for paying \$100 a month for coverage, and if the reference plan (second-lowest-cost Silver plan) costs \$250 a month, that enrollee's subsidy will then be set at \$150 a month.

Once the enrollee's premium subsidy is calculated, he can apply that amount to the purchase of any available exchange plan in the Bronze, Silver, Gold, or Platinum coverage levels, with responsibility for paying the difference (if any) between the subsidy

amount and the total premium. So, to continue the foregoing example, if the enrollee picks a more expensive plan, say, one costing \$300 a month, he would have to pay \$150 a month for coverage (\$300 premium minus \$150 subsidy). If instead the enrollee picks a less costly plan, say, one with a \$200 a month premium, he would only have to pay \$50 a month for coverage (\$200 premium minus \$150 subsidy).

However, the cost-sharing subsidies work very differently. To start with, they only apply to Silver plans—so an enrollee must buy a Silver plan to benefit from the cost-sharing subsidies. Second, the cost-sharing subsidies are paid directly to the insurer, without the enrollee knowing the amount. All that the enrollee knows is that the deductibles and co-payments that come with his coverage are less than the plan's standard amounts. For example, if the plan's deductible is \$2,000 but an enrollee's income qualifies for cost-sharing subsidies that pay the insurer to lower his deductible to \$500, the enrollee will be told that, for him, the deductible is \$500. The plan's premium, and the premium subsidy that the enrollee receives, remain the same. Thus, for the same premium, the enrollee will be getting the plan with lower cost-sharing requirements.

Of course, that makes the actual cost of the plan to the insurer (for that enrollee) more expensive than the stated premium, but the federal government pays the insurer the additional cost-sharing subsidy to cover the difference.

Thus, different individuals can purchase the same plan for the same, nominal premium, while, based on their different incomes, ending up with different deductible and co-pay levels for their coverage. The accompanying Table illustrates how this will work. The third row in the Table shows the effect of the premium subsidies. An enrollee with an income of 400 percent of the FPL will be responsible for paying \$364 a month for the reference plan (the second-lowest-cost Silver plan), while an enrollee with an income of 100 percent of the FPL has to only pay \$19 a month for the same coverage. The federal government pays the difference (if any) between those amounts and the plan's premium to the insurer as a premium subsidy.

The next 14 rows in the Table show how the plan's various cost-sharing provisions will also be adjusted based on enrollee income. Thus, an enrollee with an income of 400 percent of the FPL will have a \$2,000 deductible and be charged a \$45 co-pay for each doctor visit, while an enrollee at 100 percent of the FPL will have no deductible and be charged only \$3 for each doctor visit—even though both enrollees bought the same plan.

Those adjustments, of course, increase the real cost of the coverage for the second enrollee, but the nominal premium remains the same. Instead, the federal government pays the insurer a second set of subsidies (the cost-sharing subsidies) to cover the difference between the real and nominal premium that results from the requirement that the insurer reduce the plan's deductibles and co-pays for lower-income enrollees. The result is that lower-income enrollees will pay very little in either premiums or out-of-pocket expenses for their coverage, while the PPACA's complicated subsidy scheme will reimburse insurers for the extra cost of those features.

TABLE 1

Sliding Scale Benefits (Single Person)

Percent of FPL	100%-150%	150%-200%	200%-250%	250%-400%
Annual Income	\$11,490-\$17,235	\$17,235-\$22,980	\$22,980-\$28,725	\$28,725-\$45,960
Consumer Portion of Premium for Silver Plans (balance paid by Federal subsidy)	\$228-\$684/year (\$19-\$57/month)	\$684-\$1,452/year (\$57-\$121/month)	\$1,452-\$2,316/year (\$121-\$193/month)	\$2,316-\$4,368/year (\$193-\$364/month)
Deductible	None	\$500	\$1,500 medical deductible	\$2,000 medical deductible
Preventative Care Copay	No cost	No cost	No cost	No cost for 1 annual visit
Primary Care Visit Copay	\$3	\$15	\$40	\$45
Specialty Care Visit Copay	\$5	\$20	\$50	\$65
Urgent Care Visit Copay	\$6	\$30	\$80	\$90
Lab Testing Copay	\$3	\$15	\$40	\$45
X-Ray Copay	\$5	\$20	\$50	\$65
Generic Medication Copay	\$3	\$5	\$20	\$25
Emergency Room Copay (waived if admitted)	\$25	\$75	\$250	\$250
Emergency Medical Transportation Copay	\$25	\$75	\$250	\$250
Hospital Care and Outpatient Surgery	10%	15%	20% of the plan's negotiated rate	20% of the plan's negotiated rate
Drug Deductible	None	\$50, then pay the copay amount	\$250, then pay the copay amount	\$250, then pay the copay amount
Preferred Brand Copay After Drug Deductible	\$5	\$15	\$30	\$50
Maximum Out-of-Pocket	\$2,250	\$2,250	\$5,200	\$6,350
Actuarial Value	94%	87%	73%	70%

Source: Covered California, "2014 Sliding Scale Benefits: Single Person," http://www.coveredca.com/PDFs/English/CoveredCA_HealthPlanBenefitsSummary.pdf (accessed September 23, 2013).

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However, this design creates a problem for insurers. A substantial share of their exchange enrollees are likely to be on the lower end of the income scale. That is because lower-income individuals are not only more likely to be uninsured and seeking coverage, but will also find exchange coverage more attractive, as they will be able to buy plans with very low co-pays and heavily subsidized premiums.

The problem is that insurers know that the very low co-pays charged to lower-income enrollees will have virtually no effect on their demand for health care services. The Department of Health and Human Services also recognizes that enrollees in plans with very low cost-sharing are likely to consume more services. That is why the formula HHS created for calculating cost-sharing subsidy payments to insurers includes an "induced utilization factor." Essentially, HHS estimates that the very low cost-sharing amounts for enrollees with incomes between 100 percent and 200 percent of the FPL will induce those enrollees to consume an average of 12 percent more medical care, relative to higher income enrollees charged normal levels of cost-sharing.¹

¹ Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014," *Federal Register*, Vol. 78, No. 47, pp. 15410- 15540, March 11, 2013.

However, even with such adjustments to the cost-sharing subsidies, insurers recognize that the only way they will be able to control plan costs is by limiting coverage to a smaller number of providers willing to accept low reimbursement in return for a high volume of patients.

Given that dynamic, it is not surprising that in analyzing insurer exchange participation patterns I found that, among the 254 insurers participating in the exchanges, 50 of them (or 20 percent) had Medicaid Managed care as their current principle business in the state in which they are offering exchange plans.²

However, 14 states do not have Medicaid managed care and, hence, have no carriers currently offering such coverage. Among the 36 states and the District of Columbia that operate part of their Medicaid programs through managed-care plans, nearly half (49.5 percent) of the carriers participating in their exchanges operate Medicaid managed-care plans in the state. Indeed, in 28 instances Medicaid managed-care accounts for *over 90 percent* of the carrier's current business in the state. Thirty-one states will have at least one insurer with Medicaid managed-care business in the state offering coverage on the exchange, and in 18 states half or more of the insurers in the state's exchange currently have Medicaid managed-care business. Indeed, in six states Medicaid managed care is the principal current business of half or more of *all* exchange carriers—six of the 11 in Texas, three of the five in New Mexico, two of the four in Indiana, and one of the two each in Delaware, Mississippi and Rhode Island.

It appears that those insurers saw in the PPACA's exchange subsidy design an end result that looks a lot like Medicaid managed care—and thus, decided to offer coverage on the exchanges. It is a business model that they already know how to successfully implement. Indeed, the CEO of Molina, one of the larger Medicaid managed care insurers, was recently quoted in the Miami Herald explaining that “Medicaid is essentially an individual market for low-income patients...and Medicaid has premiums that are paid for by the state. The reason we went after the exchange is we feel there are a lot of similarities.”³

The PPACA's reduced cost-sharing design also likely explains why exchange participating insurers that do not currently operate Medicaid managed-care plans are also offering narrow network plans on the exchanges. For instance, California Blue Shield has no Medicaid managed-care business, but the plans it offers on the California exchange restrict enrollees to about half the number of providers in its regular network for non-exchange plans. In New Hampshire the only carrier offering coverage on the state's exchange is Anthem (a subsidiary of WellPoint). Because New Hampshire is a state that does not contract with managed-care plans for Medicaid, Anthem has no Medicaid

² Edmund F. Haislmaier, “Health Insurers’ Decisions on Exchange Participation: Obamacare’s Leading Indicators,” Heritage Foundation *Backgrounder* No. 2852, November 12, 2013, http://thf_media.s3.amazonaws.com/2013/pdf/BG2852.pdf.

³ Daniel Chang, “Obamacare Plans for South Florida Vary Widely in Prices, Value,” *Miami Herald*, October 5, 2013, <http://www.miamiherald.com/2013/10/05/3672251/obamacare-plans-for-south-florida.html>.

managed-care business in the state. Yet for its New Hampshire exchange plans, Anthem includes only 16 of the state's 26 hospitals in its network.

Given the parameters set by the PPACA, narrow network plans are less the product of a desire to keep premiums low, or improve quality, but rather of the need to control costs in a market where the insurer cannot rely on standard levels of cost sharing to encourage patients to be judicious consumers of medical services. Put simply, when the government pays insurers to lower cost sharing to the point that some patients are charged less than the price of a sandwich for a visit to the doctor, and calling an ambulance could be cheaper than calling a taxi, insurers know that their only recourse is to limit their plans to covering a smaller group of low-cost providers.

Even though insurers can adjust for the inability to use cost sharing to influence patient behavior by offering narrow network plans, that response creates another problem—one for which they do not have a solution. The new problem is that while relying on a limited network of providers accommodates lower-income enrollees who face only nominal cost sharing, it also makes the plan much less attractive to higher-income enrollees.

For instance, in San Diego, the premium for the second-lowest-cost Silver plan for a 40-year-old is \$308 a month. Consider two 40-year-old enrollees living in San Diego; one with an income at 150 percent of the poverty level (\$17,235 a year), and the other with twice that income at 300 percent of the poverty level (\$34,470 a year). The first enrollee pays \$57 a month for that plan, with the federal government paying the remaining \$251 in a premium subsidy. The Table shows that the government also pays the insurer a cost-sharing subsidy to lower the insured's deductible to zero, and his physician co-pays to \$3 and \$5.

The second enrollee pays \$273 a month for the same plan, with the federal government paying only a \$35 a month premium subsidy. Furthermore, the second enrollee does not qualify for reduced co-pay amounts. The Table shows that his deductible is \$2,000 and that his physician co-pays are \$45 and \$65. If the plan only pays for visits to a limited network of providers, that might be an acceptable trade-off for the first enrollee, but is likely to be an unattractive proposition for the second one—who is paying much more in premiums, has a substantial deductible, and is charged higher co-pays for each visit. Thus, the second enrollee is much less likely to buy the coverage.

Because the PPACA's cost-sharing subsidy design essentially forces insurers to adopt more limited provider networks for at least the Silver-plan level of exchange coverage, those plans will be less attractive to enrollees with incomes between 250 percent and 400 percent of the FPL—as they do not benefit from reduced cost sharing and also get much less in premium subsidies. That could result in enrollees in the bottom half of the exchange income scale (100 percent to 200 percent of the FPL) clustering in Silver plans while those in the upper half of the exchange income scale (200 percent to 400 percent of the FPL) gravitate toward Bronze-level plans that cover more providers and offer lower premiums, but impose higher deductibles and more cost sharing. Indeed,

for those with incomes between 300 percent and 400 percent of the FPL, the premium subsidies offered for exchange coverage are so small that many might decide to instead seek coverage elsewhere.

To the extent that limited provider networks in exchange plans are a function of the structure of the PPACA's cost-sharing design, it is difficult to see how any additional regulatory actions might produce expanded provider access.

For example, some state lawmakers, of both parties, are now considering enacting so-called "any willing provider laws." Such laws require insurers to contract with any medical provider willing to accept the insurer's rates and terms. Yet, enacting such laws would likely make little difference. That is because, under any health plan, access to specific providers is as much a product of provider decisions as of insurer decisions. So, while any willing provider laws require the insurer to offer contracts to all providers, those providers could still decline to participate if they were not satisfied with the rates and terms offered by the insurer. Thus, even with an any willing provider law, an insurer that believes that the financial viability of its plan offering depends on providers accepting lower payment rates could still end up with a narrow network plan if a significant number of providers refuse to accept the insurer's rates.

Another option would be to exclude from the exchanges insurers that offer plans with only limited provider networks. However, such a move would further limit the, already limited, coverage options available to exchange enrollees.

For example, back in August Washington State's Insurance Commissioner declined to certify four Medicaid managed care insurers seeking to offer coverage on that state's exchange due to the Commissioner's concern that the provider networks for the plans those carriers intended to offer would be too limited. However, that prompted a strong push back from the members of the state's exchange board who were, naturally, focused on having more carriers participate in the state's exchange. In the end, the four carriers and the Commissioner were able to resolve their differences sufficiently so that the carriers were allowed onto the exchange.⁴ However, Washington State has three other carriers participating in its exchange (for a total of seven). It would be much more difficult for officials to exclude carriers with limited networks from the exchanges in the 23 states that have three or fewer participating carriers.

In sum, there is no way for government to either force providers to accept lower rates, or conversely, to force insurers to offer money losing plans. As long as the federal government insists on exchange plan designs that restrict the ability of insurers to use meaningful copays to induce enrollees to be prudent consumers of medical services, insurers will, of necessity, rely on restricting enrollee access to the subset of providers willing to accept lower reimbursement.

⁴ Amy Snow Landa, "Kreidler approves Coordinated Care plans for insurance exchange," *The Seattle Times*, September 5, 2013, <http://blogs.seattletimes.com/healthcarecheckup/2013/09/05/kreidler-approves-coordinated-care-plans-for-insurance-exchange/>

Mr. Chairman, this concludes my prepared testimony. I thank you and the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

Chairman ISSA. Thank you.

I now ask unanimous consent that an article in Bloomberg in September of this year be placed into the record. It is entitled Recession, Not Health Law, May Be Responsible for Cost Curbs. Without objection, so ordered.

Dr. Roy, you mentioned free market as a better way to get a working system. Earlier on the first panel, I asked all three doctors about the practice that the Federal Government, in its reimbursement, pays different rates for the identical treatment depending upon where you have it. Isn't that an example of an inherently flawed system in that if a hip replacement done in a clinic that specializes in it does therapeutically and equally good or better job with equal or better results, and does it for a more efficient way, whatever that term means, less overhead, generally, that by paying them less and by paying a hospital more, you are essentially driving up the cost of health care by subsidizing hospitals, even if they have higher overhead? Isn't that correct?

Dr. ROY. It is. And it is a distortion that Medicare introduced into the market and has been around, and has gotten worse over time as Congress tries to tweak that problem and make it better. Sometimes there are unintended consequences that make it worse as well.

Chairman ISSA. In my own State of California, we are seeing hospitals buying up clinics and physician practices at a high rate, paying them essentially as much as they, more than their practice is really worth, not because they are generous to the doctors, but because the anticipated revenue growth means that the same doctor doing the same job in the same facility, once they become part of a hospital, pays more. Therefore, the hospital is doing this in order to increase its revenue.

Is that something that, in a small way, we should be attacking as part of our reform?

Dr. ROY. We should. In fact, I believe MedPAC has recommended, modifying the reimbursement structures that Part B and Part A pay the same rate in that instance, so that this arbitrage can't continue. I would also mention that hospital consolidation broadly, provider consolidation broadly, something that the ACA actually accelerates, is a serious problem which is driving up market power for these providers and driving up prices in the commercial market.

Chairman ISSA. One last question, and I think for a couple of witnesses, in 1960, we spent 5 percent of GDP, a then smaller GDP, on health care. And we lived about 7 and a half years less long than we do today. Today we are spending roughly 18 percent of GDP, that is not just almost five times, four times the amount, but actually with GDP growth in constant dollars, we spend about five times as much on health care as we spent then.

I will start with you, Doctor. As a physician, is there a real justification, in spite of all the improvements, is there a real justification for spending five times as much in real dollars on health care, or have we essentially built inefficiencies into the system? And if so, does the Affordable Care Act attack any of those inefficiencies?

Dr. ROY. The Affordable Care Act increases the amount that we are going to spend on health care, unfortunately. And I do agree

that it would be nice to spend less. We don't need to spend as much. There is an enormous amount of inefficiencies in the way we deliver and pay for health care. These are longstanding problems which some things about the Affordable Care Act may address, we hope. But broadly speaking, it goes in the other direction.

Chairman ISSA. Mr. Haislmaier, just a couple of questions. First of all, you were at the table at Heritage during the Affordable Care Act markup, were you not?

Mr. HAISLMAIER. I was at the Heritage Foundation, yes. I wasn't participating in the markup.

Chairman ISSA. I wasn't at the table either, despite what Mr. Tierney said. But when you watched that process, were there any ideas that came out of Heritage or other, if you will, conservative Republican groups that you saw being accepted as amendments from any source? Particularly I want to talk about medical malpractice reforms such as MICRA.

Mr. HAISLMAIER. No, on medical malpractice, actually, we had somewhat of a different opinion than some of our friends in Congress who wanted a Federal solution. We thought it should remain at the States.

Chairman ISSA. But I am just saying, the Affordable Care Act barred it.

Mr. HAISLMAIER. Yes, my observation is that frankly, the bipartisanship ended right about, and I could look up the exact date, it was July of 2009, it was the day they finished the Health Committee markup in the Senate. In that markup, the Republicans had made a number of substantive changes, all of which were voted down on a party line vote, and then proposed a lot of technical changes to which, in my opinion, was the worst-drafted of all the bills that were considered. And they accepted like a hundred of those and then announced they had a bipartisan bill. I think at that point is when the Republicans walked away.

Because I had been working with members and there were things they were drafting to submit that at that point they just didn't submit them. It was clear that there was not going to be any meaningful input.

So the interest in doing something bipartisan pretty much stopped about mid-July from what I can tell, because the demands for me to help people draft things just evaporated.

Chairman ISSA. Thank you. Mr. Cummings?

Mr. CUMMINGS. Dr. Feder, according to doctors, for America some States "have much stronger requirements for general providers and also for essential community providers." Some of these stronger State requirements include the following. The reason I am going to this is because the people on the panel before basically blame the Affordable Care Act for the reason why they may not be on a provider network. But these are some State guidelines and requirements. A provider covered person ratios by specialty or primary care, geographic accessibility, waiting times for appointments with participating providers, hours of operation, volume of technological and specialty services available to serve the needs of covered people who require advanced or specialty care.

Dr. Feder, so if there concerns within a State about the adequacy of provider networks, who can consumers go to and what actions can States take to address those concerns?

Ms. FEDER. Mr. Cummings, you are rightly raising that the Affordable Care Act actually establishes requirements or calls for requirements for network adequacy. As in many areas of the law, it leaves it to the State to enforce those requirements. I think we need attention to them, it is a legitimate requirement.

It does fall to the insurance commissioner in the State, and States have different degrees of willingness and ability to address it, and we are not seeing an active enough effort in that regard, and we need to attend to it.

Mr. CUMMINGS. You have decades of experience in assessing, Dr. Feder, the health care system. We hoped to have you on our first panel, but here you are. Dr. Feder, one of the most critical features of the Affordable Care Act is the expansion of Medicaid eligibility to millions of low income adults. Prior to the ACA, Medicaid eligibility was restricted primarily to low income children, their parents, people with disabilities and seniors. In most States, adults without dependent children were not eligible.

According to a study issued on October 23rd by Kaiser Family Foundation, only about 30 percent of poor, non-elderly adults had Medicaid coverage in 2012. Under the ACA, Medicaid eligibility can be expanded to cover all non-elderly adults with incomes below 138 percent of the Federal poverty level. The Federal Government would pay the States 100 percent of the costs for the first three years, and then phase down its match to about 90 percent by 2020. Is that right?

Ms. FEDER. It is correct, Mr. Cummings.

Mr. CUMMINGS. Now, despite this huge level of Federal assistance, as many as 25 States have decided not to be a part of the expansion, leaving millions, literally millions of their own citizens without health care, is that right?

Ms. FEDER. That is absolutely true.

Mr. CUMMINGS. Now, Dr. Feder, what is your opinion of States that refuse to expand their Medicaid programs?

Ms. FEDER. My opinion of the States, I am sad and disappointed for their citizens, both the citizens who need care and the citizens who are contributing to paying for care through their taxes and other States that do expand. Expansion, research shows from the Commonwealth Fund and the Urban Institute ran how much in the interest of States this expansion is. I believe it is only political opposition to this law that is depriving these citizens of access to care and the States of needed revenue.

Mr. CUMMINGS. So by not participating, are they leaving significant resources on the table that could be used for their citizens?

Ms. FEDER. They sure are.

Mr. CUMMINGS. And sadly, a lot of these people are getting sick and sicker, and sadly, some of them will die early?

Ms. FEDER. We know of that. Essentially the Institute of Medicine found that lack of insurance kills. So your statement is correct.

Mr. CUMMINGS. Why is the expansion of Medicaid an important component of the Affordable Care Act? Why is that so important?

Ms. FEDER. Well, we have a big hole, as you point out, in our safety net coverage, our floor of protection. That is that if you are not the parent of a dependent child or disabled or old, you really are not eligible for coverage in most States. That hole is a vestige of an old-fashioned welfare system that kind of assumed that these people would get coverage through their jobs. They don't get coverage through their jobs. They are left out of employer-sponsored coverage, and they are left out of the public safety net, and that is why they needed to expand it.

Mr. CUMMINGS. Now, the Commonwealth Fund issued a study this month showing that States that expand Medicaid will gain important benefits beyond covering poor people, such as reducing uncompensated claims. Tell me something. I remember reading something about Missouri, and a lot of the hospital administrators came and said to the government, you have to accept this because our hospitals are going to be in trouble if we don't provide for Medicaid expansion. Can you explain that to us?

Ms. FEDER. Sure. Hospitals, although they don't provide unlimited care, and people without insurance don't get all they need, hospitals get stuck dealing with people who don't have insurance coverage. And they have to provide emergency care, it doesn't mean everything, but they are stuck and they don't get paid.

What this law created was the opportunity they get paid for patients who walk in the door and they are counting on it.

Mr. CUMMINGS. Just one last question, Mr. Chairman. The same study says by choosing not to expand Medicaid, some States will lose billions of dollars, and I talked to Senator Cruz about this the other day. Texas, for example, will forego an estimated \$9.58 billion in Federal funding in 2022, taking into account Federal taxes paid by Texas residents. The net cost to taxpayers and States in 2022 will be more than \$9.2 billion.

Similarly, Florida's decision not to participate will cost its taxpayers more than \$5 billion in 2022, and Georgia, I could go on. Dr. Feder, what will this mean with regard to sick people in those States? By the way, in Texas, one out of every four persons has no insurance.

Ms. FEDER. That is where most of our insurance is and it is going to stay there. Those people are left without access to care, and as you said, they are more likely to suffer and more likely to die as a result.

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

Mr. GOSAR. [Presiding] I thank the gentleman.

Dr. Feder, are you a physician?

Ms. FEDER. No, sir.

Mr. GOSAR. Is Medicaid financially sustainable? Yes or no. It is an easy one.

Ms. FEDER. It is not, actually.

Mr. GOSAR. It is really easy.

Ms. FEDER. No, it is not, because it is about long-term care, largely, which is what—

Mr. GOSAR. No.

Ms. FEDER. Medicaid costs are growing very slowly. We have too many low-income people—

Mr. GOSAR. Based on reimbursement rates it is unsustainable. Would you agree with that?

Ms. FEDER. Not the—I thought you were talking about financially.

Mr. GOSAR. It is financially unsustainable. Dr. Roy, would you agree with that?

Dr. ROY. It is unsustainable, I should just say, I am not a physician, although I did go to medical school.

Mr. GOSAR. Mr. Haislmaier, it Medicaid sustainable financially?

Mr. HAISLMAIER. No, not in the present form.

Mr. GOSAR. Not in its present form. Even expanding, it is not either, is it?

Ms. HAISLMAIER. No, it is not sustainable in its present form, and the expansion will simply add to that in a number of ways. It could be, if you reformed it along different lines, but that is a different subject for a different day.

Mr. GOSAR. Dr. Roy, you heard the comments and you saw Ms. Feder just talk about. What is your opinion in regard to, are we not just chasing our tail with the expansion of Medicaid?

Dr. ROY. I recently published a book entitled How Medicaid Fails the Poor. It details in 48 pages how the reimbursement structure of the program, how it underpays physicians for care, has led to very poor access for those individuals. That is leading to poor health outcomes. So the most definitive study on the score was conducted in the State of Oregon, was published in the New England Journal of Medicine by a panel of esteemed health economists, which showed that Medicaid, compared to being uninsured, showed no improvement in health outcome.

Mr. GOSAR. So because you actually get a card, does it mean something when you have a card if you don't have providers to see you?

Dr. ROY. You heard the earlier panel this morning, just having a card that says you have health insurance is not the same thing as access to care. And that is a distinction that I fear that the Affordable Care Act has not understood well.

Mr. GOSAR. So when we are reimbursing physicians below market rates, they don't even make a profit, we just heard the gentleman basically make a comment that it is up to the States to enforce proper panels. So we are going to force physicians to take fees that they can't even pay their own bills?

Dr. ROY. In Massachusetts, under the most recent health reform bill they passed in 2012, they considered a provision that would have required all licensed physicians in the State to accept all forms of payment. The physicians rebelled and that was not included in the law. But that is something that we may see more of over time, an effort to do that. And that would be problematic.

Mr. GOSAR. So let me ask the next question. You are very familiar with debt coming out of school. Are physicians coming out of school with less debt or more debt?

Dr. ROY. More debt, unfortunately. The cost of medical school has skyrocketed, it has increased perhaps more than health inflation.

Mr. GOSAR. So reducing their fees is going to help them better pay that?

Dr. ROY. It has discouraged a lot of new physicians from accepting Medicaid patients. And again today, all the studies and surveys show the percentage of physicians who are willing to accept new Medicaid patients is substantially lower than it is for private insurance in particular and Medicare, where that is also increasingly a problem. Over time, as States expand their Medicaid programs, they will face further fiscal pressures. The only real mechanism that States have to keep their budgets under control under Medicaid is to turn down the amount they pay physicians and hospitals to care for those patients.

So this problem is only going to get worse over time, and Medicaid expansion will accelerate that.

Mr. GOSAR. We heard earlier in the panel, the earlier panel talking about patient dumping. So this is like Federal patient dumping onto States for that jurisdiction.

Dr. ROY. In my experience, physicians who are already caring for patients are really reluctant to let that patient go, just out of a humanitarian interest. But they are very reluctant to take on new patients, to commit to new patients under that reimbursement structure.

Mr. GOSAR. Because it puts them in a harmful situation, does it not? Because they can't abandon the patient, because that is a litigation issue.

Dr. ROY. There are very ethical problems here

Mr. GOSAR. So understanding rural and urban dictations, we are really skewing the benefits for rural. I am from rural Arizona. We are seeing huge catastrophic access issues. I mean, in the previous Administration, we tried to look at federally qualified health centers, which the gentlelady didn't bring up, because they are not allowed to turn away anybody. It is a sliding fee scale, if I am not mistaken, right?

Dr. ROY. Yes.

Mr. GOSAR. They can't turn anybody away. So that was part of the safety net. Unfortunately, I practiced kitty-corner from, when I saw the patients they didn't want to see. Because they skewed the results. What they did is they Medicaid and Medicare patients and skewed them to a one percentage of the day and they took fee for service patients and insurance patients and they took them in at a regularly scheduled appointment. Very skewed results.

Dr. ROY. One thing we should point out is that what the market price would bear would really be in a free market system for paying doctors and hospitals. We don't know, because we don't have a free market for health care, because Medicare in particular and also Medicaid have so distorted what the prices are for a lot of services. The evidence suggests that in general, the prices for these services in the United States are higher than they are in other countries.

Mr. GOSAR. And I am going to take the liberty, since I gave the gentleman a little extra time, that is one of the reasons why we don't have a lot of family care physicians, isn't that true, is that government has skewed that process and the reimbursement rate, so that everybody goes into the specialty, because that is how you can make a living.

Dr. ROY. Which is what you will hear every physician say, they get paid for procedures, for writing prescriptions, they are not paid for their time. And that is what a lot of physicians like about so-called concierge or retainer practices, they are finally paid for their time and they can spend more time with their patients. Unfortunately, the evolution thereof may lead to a two-tiered system where you have the doctors treating Medicaid patients who don't spend a lot of time with those patients.

Mr. GOSAR. One last question. We hear of this downticking in expenditures for health care due to the ACA. I don't agree with that, I think they have a lot to do with the economy. Would you agree?

Dr. ROY. Yes, in fact, I have written about this. In general, across the OECD countries and developed world there has been a massive slowdown in the growth of health expenditures, driven by the global economy. Also, there has been substantial evolution in the United States of an increase in the use of high deductible plans with health savings accounts in the employer market. That is also leading to a slowdown in spending.

Mr. GOSAR. I thank the gentleman.

Mr. CUMMINGS. Would the gentleman yield for just a second?

Mr. GOSAR. I would happily yield.

Mr. CUMMINGS. Why don't we want to give the President any credit? Any credit? I mean, I hear this over and over again, that the cost of insurance is going down, and you are trying to say that President Obama and his efforts with the Affordable Care Act have no effect?

Dr. ROY. As you know, sir, the bulk of the Affordable Care Act has not been implemented yet. So it is very improbable that the Affordable Care Act is having a system-wide effect on health spending.

Mr. CUMMINGS. Ms. Feder?

Ms. FEDER. I think there are two challenges. I think we agree a lot on the power of the recession in bringing costs down. But what is missing from that picture is that Medicare, that in the Affordable Care Act, by making Medicare a more efficient, effective payer in terms of the reductions in overpayments, and there may be room to go, but that made a big difference to spending.

And that the whole thrust of the Affordable Care Act on the cost containment side is to move to a more efficient delivery system in many of the ways that people on both sides of the aisle would like to see it move. That part has not had much effect yet I would agree. Although the Administration does point to the reductions in readmission rates to hospitals has already shown an influence of those policies.

Mr. GOSAR. Mr. Haislmaier, I would like to give you the opportunity.

Mr. HAISLMAIER. This really gets to the core of the debate over health care. The chairman was talking about the percent of GDP. We all know that we as a country spend more per capita, percent of GDP than any other country in the world on health care. We also are all pretty much across the political spectrum not satisfied with the results.

Mr. GOSAR. Right.

Mr. HAISLMAIER. It is uneven, too many uninsured, et cetera. So I do this in my general audience talks, I make the observation that what we have here is a value problem. The value is the relationship between what we are spending and what we are getting, I don't care whether you are buying a hamburger or you are buying health care. We are either paying too much for what we are getting or we are not getting enough for what we are paying.

So the central challenge in health care is how do you improve value in the system. Ideally, what you would like to do is get more and pay less. I think we would all agree on that. I don't think there is any disagreement on that.

The problem comes in on how are you going to do it. As my colleague just pointed out, there is a view point that she holds and is embodied in this legislation that we can do this by having better micromanagement of doctors and hospitals and insurers and all the rest.

The other view, that I hold and my other colleague holds is that the way you do this is to have Government limit itself to what it is competent at doing, which is pretty much in this case taking money from A and giving it to B and stay out of trying to run the rest of it. If you want to give B a little more money than C, that is fine too. But just move it to a patient-centered system where people can pick and choose and seek value and be rewarded for providing value.

I look at the system as do folks on the other side, and we all look and we say well, gee, look at Merrill or Geisinger or InterMountain Health or Cleveland Clinic, they all provide better results at a lower price. And I look at the system and I say, okay, if that is true, why aren't they eating everybody else's lunch? Why aren't other hospitals having to come to their standards or go out of business? Thanks to my office, I have a BlackBerry, but they aren't so good, they are getting their lunch eaten by Apple. Why isn't that happening in hospitals? Because we are propping them up with all these payments, et cetera.

The other side looks at it and says, look, we can go into Merrill and study how they do it and then we are going to write a bunch of rules that tells everybody else how to do it, then we come out with the Affordable Care Act and the accountable care organizations. It is just a difference of how you go about doing it.

Mr. GOSAR. I hear you. Thank you.

I now recognize the gentlelady from New Mexico, Ms. Lujan Grisham.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman, and I have to say I really appreciate the panels and this committee. I am not a doctor, although I have a J.D., and so Dr. Feder, thank you for your graduate work. I will tell you that I think I can be qualified as a health care expert for three reasons. I am a patient. Every single day, all the time, more than I want to be, try not to be, try to do everything right, doesn't matter.

Two, I am a primary caregiver for a chronically sick mother who is incredibly complicated. I don't care what system you put her in, she is all by herself, she is navigating it, she is doing concierge, she is on Medicare, she is on Medicaid, she is on indigent care, she is on U and M care, she is on her own, she is married to a dentist,

doesn't matter. It is exhausting, complicated, so complex I could spend the rest of my life explaining it to her. And she is a smart woman. Gave birth to me.

But I can't do it. And I have done health care and policy making for 30 years.

So here is, for me, what is telling. You say that there has been an economic downturn, not that that is what you said, but the economy itself has played a huge role in the reduction of health care costs. CBO says exactly the opposite. We can work every single day, and we can get experts from every single place to give us a different opinion. We have the most complicated, convoluted system in the world.

And the Affordable Care Act at least tries to level that in many ways, but I am one of those policy makers that think we need to go do a lot more. And I spent 20 years before the Affordable Care Act and before States were figuring out how to do Medicaid waivers, and before we made changes to Medicare. I watched HMOs and provider networks shift and change every time there was a profit motive to do that. Every single time.

I dealt with patients who were left out, left under, left cold no matter how much they were privately paying for their health care. It depends on who you are, where you live, what is going on. And what I mean by who you are, you are more likely to be chronically sick or not and are you living in an urban center or not.

So we are going to have to do not one size fits all, we have to do many sizes all the time. And this is a great experience about many people get better care as a result of the Affordable Care Act and get access. In New Mexico, we are paying some of the lowest rates in the Country because of the Affordable Care Act. Our problem is going to be insurance regulatory oversight and we don't have enough insurance companies. I never thought I would say that in my entire life. But it happens to be true in this case, regardless of what my personal opinions are. It is true in this case.

So what I am really interested in is using experts such as yourself and others to start thinking about ways, because we just cost shift in this Country. What we are even proposing to some degree is more cost shifting. Costs shift back to the States. Costs shift back to the individuals. Costs shift back to business. Costs shift back to veterans. What do we have, nine, ten, eleven independent systems of care that no other country has, and a not very robust public or community health system? Those are the real reasons that health care doesn't quite work in the way that we want it to.

And we hope that all three of you stay dedicated to help us navigate those critical next steps. Because I don't think the Affordable Care Act is responsible for shifts and limited access. I think it may exacerbate that in some cases. I don't think coverage means access. And I that will improve it in some way. I hope that we are wise and brave enough here to really use experts such as yourselves. I never mean to do these diatribes, but there are no simple questions, and there are certainly no simple answers. There are not.

Except that if we don't start leveling the playing field, and we don't start really focusing on consumers and we are not brave enough here to deal with the folks who still have significant problems before the Affordable Care Act, with the Affordable Care Act,

through the Affordable Care Act, I pay more because of the Affordable Care Act. But that is because I am required to go to the D.C. exchange. Not because I am a consumer left to navigate through the Affordable Care Act rules in my own State.

So it depends on the real details of those issues. So on the one hand, I can tell you that I am one of those folks who is complaining, and on the other hand, I can tell you that I am really glad that more people are helping me help you pay for my mother's chronic care procedures every single day. And I will tell you that she is more than happy to help pay for everybody's maternity care, so it all gets leveraged out. Because I was also county commissioner.

Because it is not just Medicaid. Medicaid's gaps are paid for by local government, which is paid for by taxpayers. It is all paid for by all of us, every single day, all of the time.

So I guess my question is, and Mr. Chairman, thank you so very much. Is there a way that this committee can continue to work hard to get as much valid information about really what we can do, starting today? Because my provider networks changed. Because every time you do a reform we open a window for somebody to legally do adverse selection and cherry-picking. And that is not dealt with at the Federal level at all. And if I was a for-profit insurance company, and it is legal, why would I create a network that has the sickest patients? Why would you do that? You cannot. So you don't.

And that is not all the reasons that occurs, but make no mistake, in my opinion, there is no one here on any panel that can demonstrate that that is not part of the reason that this always happens. So thanks for being here, Dr. Feder and all the other doctors on the panel. I thank you for my diatribe. I feel great today, I can get my pens out of my finger and I am going to try not to be one of the expensive high-end users of health care no matter what I pay.

Thank you, Mr. Chairman.

Mr. GOSAR. I thank the lady from New Mexico and I had hoped that she would sign onto my bill on repealing McCain-Ferguson after listening to you. One of the things that you have to look at is getting to the least common denominator. And I will talk to you about that in a second. Mr. Cummings?

Mr. CUMMINGS. Just briefly, Mr. Chairman, I will close. I want to go back very briefly to Dr. Roy, something you said. I am not asking questions, I am just giving a statement. On September 9th, 2013, CBO Director Doug Elmendorf issued a paper entitled The Slowdown in Health Care Spending. Drawing from multiple sources, the paper concluded that health care spending growth had slowed dramatically across the Country. The slowdown in health care cost growth has been sufficiently broad and persistent to persuade us to make significant downward revisions to our projections of Federal health care spending, he said.

He goes on to say specifically, CBO found that relative to a 2010 baseline projection through 2020, Medicare spending is 15 percent lower than projected, Medicaid spending is 16 percent lower than projected. Now, this is the CBO. And private health insurance premiums, per enrollee, are 9 percent lower than projected. He goes

on to say, the paper also made clear, by the way, that these reductions, and listen to this, are apparently not because of the financial turmoil and recession but because of other factors affecting, and this goes to what you said, Dr. Feder, the behavior of beneficiaries and providers.

And with that, I say this. Witnesses on the prior panel said, we have to get it right, we have to fix it. Chairman Issa a few minutes ago talking to one of our colleagues, Mr. Horsford from Nevada, said that there are things we have to do try to fix certain parts of this. And we have to. We have to get this done and get it done in a way where there is a win-win-win-win-win. I do believe that that is possible. And again, I say, coming from having traveled some 20 hours on a plane to go to Nelson Mandela's memorial, I have to tell you, I left there saying to myself, we are so fortunate in this Country, we are so fortunate to be where we are. We can accomplish anything. We just have to put our minds to it.

And somebody once said, it is not that people don't know what to do. It is whether they have the will do it and do it. So again, I want to thank you all. Your testimony has been extremely helpful. And we are going to go forward.

Mr. GOSAR. I thank the gentleman. I would like to ask the gentleman a question. Do you believe the actuaries from the Centers for Medicare and Medicaid?

Mr. CUMMINGS. Give me the specific question.

Mr. GOSAR. Would you think that their oversight of spending would be more deliberative and more accurate than CBO?

Mr. CUMMINGS. I am not sure, but one thing I do know.

Mr. GOSAR. They deal with it every day, this is their due diligence, the actuarials deal with numbers.

Mr. CUMMINGS. Well, the fact is, again, I quote what I just quoted, I do again, the costs are coming down according to CBO. And the reason why I got a little upset a few minutes ago, Mr. Chairman, and I appreciate your question, but it seems like this President gets no credit for anything. Nothing. Zilch. And over and over again, when everything goes well, some say it must have been a mistake, it must have been a fraud. If it goes bad, it was his fault.

The fact is that there is a lot that can come out of this. We just have to have the will to get it done. And we will get it done.

Mr. GOSAR. I just want to go back to my question. The actuaries at the Centers for Medicare and Medicaid Services, who do not answer to the White House, said yesterday in the Journal of Health Affairs that the costs eased because of the economy, not because of Obamacare. Would you agree with that, Dr. Roy?

Dr. ROY. Yes, that is the overwhelming evidence. I would just add that I am an admirer of the President. If the Affordable Care Act is successful in achieving its stated goals, I will be absolutely thrilled. My concern is that it will not, and I think it is my obligation to alert the committee to the concerns that I have shown.

Mr. CUMMINGS. You asked me a question, I just want to answer it in fairness to you. Earlier this year, the Centers for, they also said this. The Centers for Medicaid and Medicare and Services issued a report finding that national health spending had slowed to only 3.9 percent in the years between 2009 to 2011. This rep-

resents the lowest growth rate in health care spending since government began keeping these statistics in 1960.

Mr. GOSAR. Being a dentist, just so that I am fair about this, I can tell you about that spending. And dentistry didn't sell its soul to the Federal Government, for the most part. And there are problems don't get me wrong. But the problem is expendable money. We have seen it go down. There is nobody who is flush with money in their pockets to buy increased care or to do investing in health care. There is none.

I believe personally empowering patients. That is what Nelson Mandela would have wanted. Because empowering patients, not to make them cripples, but to make them entrepreneurs and to hold onto their health care and demand that system to benefit them. Patient centered, patient friendly. Has to start. And that is not what was included before Obamacare or in Obamacare. It is a government-dictated centric relationship.

I want to see the patient benefit and be empowered, not to be a cripple. So I want to thank the witnesses for coming forward. We appreciate it. With that, we will adjourn this meeting.

[Whereupon, at 1:12 p.m, the committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

**AMENDMENT TO THE
TESTIMONY OF PATRICIA A. McLAUGHLIN, M.D.
AT A HEARING OF
THE US HOUSE OF REPRESENTATIVES
OVERSIGHT AND GOVERNMENT REFORM COMMITTEE
DECEMBER 12, 2013
(Submitted on December 18, 2013)**

During the testimony Congressman Elijah E. Cummings queried what could be suggested to 'fix' the problems being outlined by myself, Jeffrey B. English, M.D. and Eric N. Novack, M.D. This is the basis of my amended written testimony. I welcome the fact that Congressman Darrell E. Issa, Chairman of this Committee together with Congressman Cummings, the Ranking Minority Member, recognize that the doctor-patient relationship is in need of immediate assistance. Only through this spirit of non-partisan actions will the needs of the patient be served first. Time is of the essence. January 1, 2014, is only a couple of weeks away. You must take steps to assure that the goal of health care reform – to see to it that patients are able to receive affordable quality medical care in a timely manner – is met.

By now, most will agree that there were unintended consequences in application of the Affordable Care Act off-setting the good intentions and hard work of many policy makers and government representatives. It has come to light, and will continue to gather momentum, that millions of American individuals and small group business employers with health coverage will have their current health plans cancelled, as the latter reach their policy anniversary date throughout 2014. The insurance companies have stated that these non-renewals are due to ACA regulations preventing 'grandfather' protection. Many of these former plans met the needs of those insured and our citizens were happy with their plan and wanted to keep their doctors. Many have questioned why these plans were deemed substandard.

Another group was unexpectedly affected: two-person small businesses owned and operated by married couples. They are having their small business health plans cancelled; reportedly by notice that the minimum required for a small business group rate under the ACA regulations consists of two non-related employees of the business. They are questioning what seems to them to be completely unfair. After all, they both run the business operations and pay the required business taxes. As was reported in the *New York Times* Tuesday, December 17, 2013, "thousands of writers, opera singers, music teachers, photographers, doctors, lawyers and others are learning that their health insurance plans are being canceled and they may have to pay more to get comparable coverage, if they can find it." To address this problem, you must pass legislation to eliminate the prohibition contained within the ACA on self-employed persons joining a chamber of commerce or association health plan.

The newly structured, ACA compliant health insurance plans, in New York State and across the country, often have far more restrictive networks of participating hospitals and physicians than

do the present plans about to be canceled. This will be creating an artificial shortage of doctors and facilities and lead to an access to care crisis, likely to result in patient morbidity. Our policymakers, federal and state, must take steps to assure that patients are able to have coverage that enables them to access care from a comprehensive choice of physicians and hospitals, rather than having a little plastic card that gives the illusion, but not the reality, of having insurance coverage. One must be able to actually access the care.

Many of these Exchange plans and newly minted small business health insurance plans, especially those with the least costly monthly premiums, have set deductibles in the range of several thousand dollars. The patients bare this cost first, before the commencement of insurance plan cost-sharing often with additionally high co-insurance amounts, some as high as 50%, at the Bronze level, on the Exchanges. It is good that preventative care is covered outside the deductible, but meeting illness expenses and medications costs will be difficult. Most previously uninsured and those fortunate to have been previously insured with small co-payment requirements only, will not understand the concept of the first dollar expense responsibility due to high deductibles and high co-insurance amounts. Perception from the public will be that this was not 'affordable' as promoted. The other metal plans offered on the Exchanges, with lower deductibles and lower co-insurance cost-sharing percentages (10% - 40%) have monthly premiums that are out of the reach of many individuals not eligible for the government subsidy. In many cases, these premiums are higher than prior plans due to expanded benefits under the ACA, many of which are simply not universally necessary for every individual.

Past history with present-day consumer driven health plans with high deductibles have seen many examples of patients self-imposing a delay in seeking care, because they do not have access to funds to pay the high deductible. They do not even ask the physician for payment plans. The physician is even prevented from offering charity because the patient simply does not present to the office or emergency department. Delaying much needed care often results in making the patients more gravely ill. In turn, the eventual cost of health care increases with this delay. Our policymakers, federal and state, must find ways to assure policies are sold on Exchanges that will be more likely to provide 'first dollar' coverage so that patients truly avail themselves of needed health care.

Physicians and facilities are also businesses. Overhead expenses must be paid to remain in operation. High deductible plans significantly prolong the time to receive payment from the patient for services rendered, often over many months. Unfortunately, a significant amount of dollars will never be paid by the patients, many of whom will be financially unable to do so. The viability of the medical offices to remain open will be threatened.

Foremost, we must restore freedom to both patients and to physicians. We must eliminate artificial barriers to accessing care. 'Networks' have become too restrictive and too dangerous. We must restore the ability of a physician to prescribe the best medication for a patient's condition, especially necessary for patients stable on certain medications or combinations of medications for chronic conditions. Insurance formulary options have become too restrictive. Care is compromised. Doctors and their small numbers of support staff do not have the time to appeal medication denials on a case by case and daily basis.

While there are certainly good intentions to having full comprehensive coverage mandates, the significant trade-off is that it has resulted in increased premiums, deductibles and co-insurance amounts. Health insurers have limited networks and greatly limited out-of-network coverage to control those costs, thereby greatly reducing a patient's choice of physician and hospital which is desired, particularly when dealing with difficult medical conditions.

At a recent medical conference, I had the pleasure to meet a colleague from Australia. The country has a simple system and all parties are pleased. The basic protection for patients comes in the form of the government setting a reference point price for all medical costs and funds that amount for all of its citizens. The de facto precedent for government set pricing already exists in America, as most insurance companies calculate their benefit amount as a percentage of Medicare's fee schedule. The difference from the American system comes as the physicians in Australia are given the freedom to accept that amount, but they are also allowed to seek a higher fee to meet their operating expenses. The 'gap' amount becomes the patient's responsibility. The patient has the freedom to go to the doctor of his or her choice. The 'gap' amount can be off-set through private insurance, should the patient feel that such insurance is necessary. The government encourages the citizens to come off the government coverage and pays a subsidy to partially cover the cost of the private policy. The patient is empowered to make decisions about their health care spending dollars. Doctors are not restricted and their doors remain open to all. Insurance companies also have reference price payments, paying X dollars for a Y procedure, and it makes no matter to them where the patient seeks to have their care rendered. Costs have been contained through free-market competition between physicians based upon the freedom of choice given to the patients. This is a simple win-win solution.

In the short term, certain small steps are needed to allow medical offices to survive in the initial months of 2014. Insurance company member ID cards must be uniformly transparent and state the 'provider' network being assigned to that member's plan. This simple move will protect both the patient from unanticipated invoices for possible out-of-network visits that are not covered, and will protect the doctors from possible loss of income for that visit. Also, real-time adjudication for the cost of care is needed in the environment of high deductible and high co-insurance coverage. The physicians must be able to collect for their services, at the time of service. The insurance companies have this technology already in place with all pharmacies. This must be extended to physicians and facilities. The Medical Society of the State of New York has made this request of the New York Exchange, and this is a step Congress needs to also take at this time.

Since these new ACA compliant individual and small business plans as well as Exchange plans are nearly all in-network, and due to the previously described artificial shortage of available physicians due to network limitations, it would be helpful to the patients if they could also apply the cost of care, outside the network, to their in-network deductible and to their out-of-pocket maximum. Most patients will be shocked to learn that such is not the case. They do not have the ability or past experience to fully understand such a radically new benefit concept. To make this fully understandable, transparency about pricing is key. This applies across the board.

I would ask you, the members of Congress, to consider passing legislation that would permit all plans with high deductibles to have access to Health Savings Accounts and to consider raising the ceiling on these HSA contributions. The tax advantages to the patients will allow these accounts to be filled and serve as the buffer against the high deductibles. Remember, we don't want the patients to delay seeking needed care.

I would also ask that Congress consider allowing individuals, with incomes above that required for a subsidy, but unable to afford these new metal plans, to join purchasing groups that could be hosted by State Medical Societies. Collectively this would lower premium costs. Further allow individual purchasers of health insurance the same pre-tax allowance or deductions as provided to employers.

Physicians have always performed acts of charity and will continue to do so. Community Health Centers have been valuable in the past and will continue to function unless prevented by network limitations.

Finally, another critical component to address in a long-term fix, involves passing legislation to contain the exorbitant cost of medical liability insurance, which many studies show adds substantial sums to health care costs generally because of the fear of being sued. This step, taken by the great State of Texas is one example that shows how this has decreased health care costs.

In the interim, I would welcome public service announcements advising patients that choosing a plan based upon price alone is insufficient. As long as the current networks are allowed to remain, the patient must be aware that they need to verify if a certain hospital of their choosing is considered as in-network. Then they need to see if the doctor(s) are also available in that same insurance plan. I would ask that the insurance companies assign the necessary personnel to update the information weekly, at a minimum, so that there is no misleading information.

Much is needed to improve your hard work. Both sides must work together to fix these problems as our patients are going to bear the brunt of them beginning on January 1, 2014. Our citizens, our patients are counting on Congress to keep this non-partisan and work with physicians to restore the United States of America's health care system to its greatness. As I have noted, many steps can be taken to address some of the most immediate problems patients will face, especially the extremely high deductibles and limited physician and hospital networks, but I would urge that you go further. Boundaries have no place in a country that is free. Long-term solutions require freedom of choice, freedom to set prices for services, and freedom to privately contract. Embrace this model and you will solve the high cost and limited access issues we have brought forth to your attention.

Thank you, again, for the honor to appear before this Committee and to offer my humble suggestions. For the sake of the patients and for the doctor-patient relationship, we must all stay focused and expedite a workable solution.

Patricia A. McLaughlin, M.D.



Statement

of:

The National Association of Chain Drug Stores

for:

**United States House of Representatives
Oversight and Government Reform Committee**

Hearing on:

Premiums, Provider Networks and the Health Care Law

December 12, 2013

9:30 a.m.

2154 Rayburn House Office Building

National Association of Chain Drug Stores (NACDS)
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NACDS Comments to House Oversight and Government Reform Committee
Premiums, Provider Networks and the Health Care Law
December 12, 2013
Page 2 of 3

The National Association of Chain Drug Stores (NACDS) thanks the Members of the House Oversight and Government Reform Committee for consideration of our comments for the hearing entitled "Premiums, Provider Networks and the Health Care Law." NACDS and the chain pharmacy industry are committed to partnering with Congress, the Department of Health and Human Services, patients, and other healthcare providers to improve the quality and affordability of our nation's healthcare system.

NACDS represents traditional drug stores along with supermarkets and mass merchants with pharmacies. Its 125 chain-member companies include regional chains with a minimum of four stores to national companies numbering their stores in the thousands. NACDS members also include more than 800 suppliers of pharmacy and front-end products, and nearly 40 international members representing 13 countries. Chains operate more than 40,000 pharmacies, and employ a total of more than 3.8 million employees, including 175,000 pharmacists. They fill over 2.7 billion prescriptions yearly, and have annual sales of over \$1 trillion. For more information about NACDS, please visit www.NACDS.org.

NACDS is concerned about the lack of federal and state regulation addressing restricted pharmacy networks within the Affordable Care Act (ACA) exchange plans. Preferred networks in the pharmacy sector may interfere with patient access to quality care. The use of preferred networks limits patient access to pharmacy providers whose services improve lives and help address poor medication adherence, an issue that costs the nation approximately \$290 billion annually.¹ That amounts to 13% of total healthcare expenditures, and is associated with costs of about \$47 billion annually for drug-related hospitalizations and an estimated 40% of nursing home admissions.²

NACDS believes that patients should be free to choose their pharmacy provider. Nearly all Americans (92%) live within five miles of a community retail pharmacy.³ Open networks provide greater access and more choices, particularly in more rural areas with fewer

¹ New England Healthcare Institute, 2009, Thinking outside the Pillbox: A System-Wide Approach to Improving Patient Medication Adherence for Chronic Disease

² Id.

³ Source: NCPDP Pharmacy Provider File, ArcGIS Census Tract Files, and NACDS Economics Department.

pharmacies. Additionally, community pharmacies meet patients' needs for convenient access through a highly competitive environment that gives consumers choices in how their medications and healthcare services are provided.

By limiting the number of pharmacies that participate in a network, exchange plans are limiting patients' access to knowledgeable professionals that play a critical role in providing care and cost savings. People who take prescription medications regularly, manage chronic diseases, use emerging pharmacy services, and who are older have even stronger positive opinions about access to a pharmacy of their choice.

Similar to the concerns regarding restricted networks, NACDS is also concerned that restricted drug formularies in exchange plans may interfere with patient access to important medications. It appears that exchange plans are using the same restricted formularies for insurance products sold across all metal tiers, and that the average drug co-insurance for a top formulary tier drug in a silver or bronze plan is 40%.⁴ It further appears that there are formulary gaps for certain high cost drugs.

NACDS is concerned that patients who face restricted drug formularies and cost sharing may choose to skip their necessary medications, because they simply cannot afford the out-of-pocket costs. Overall care for these patients may prove more costly in the long run, defeating the goals of providing high quality, more affordable care.

Thank you for the opportunity to share our concerns about restricted networks and restricted formularies in health exchange plans. Although these may appear to reduce short term costs, we believe that they result in lower healthcare quality and greater overall healthcare costs. We look forward to continuing to work with the committee to advance policies that improve patient quality of care in a cost-efficient manner.

⁴ Caroline F. Pearson, Avalere Health, PlanScope: Exchange Implementation Update & Initial Formulary Findings, October, 2013.



FOR THE RECORD

**Statement
on
The Affordable Care Act's Impact on Premiums and Provider Networks**

**America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004**

**Submitted to the
U.S. House Committee on Oversight and Government Reform**

December 12, 2013

I. Introduction

AHIP is the national association representing health insurance plans. Our members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to comment on issues surrounding provider networks and the strategies our members are employing in this area to hold down costs and premiums for enrollees. We thank the committee for examining these issues and how they are impacted by implementation of the Affordable Care Act (ACA).

Health plans and employers have explored and implemented a range of strategies designed to improve efficiency, clinical effectiveness, and value – and have a meaningful impact on bending the current, unsustainable health care cost curve. One such strategy involves the use of high-value provider networks. Over the past several years, health plans and employers have begun to redesign benefits to encourage the utilization of higher-value providers. Relying on data relative to provider performance, health plans and employers can identify providers with a demonstrated ability to deliver quality, efficient health care and offer consumers incentives, such as reduced cost-sharing, to obtain care from those high-value providers. Health plans' use of high-value networks is also an important way that plans can preserve benefits and keep premiums affordable as the ACA is implemented.

Our statement focuses on the following topics:

- Background information on provider networks and why they are used by health plans;
- The coverage options that are available for 2014 in the federally-facilitated Marketplace (FFM);
- The emergence in recent years of high-value provider networks;
- Evidence showing the benefits of high-value provider networks;

- The role of high-value provider networks in preserving benefits and affordable coverage at a time when the health insurance marketplace and health care system are undergoing sweeping changes; and
- Future opportunities for high-value provider networks.

II. Background Information on Provider Networks

Provider networks have been a mainstay of private health insurance coverage for the past 25 years – providing consumers with access to a broad range of high-quality hospitals, physicians, and other health care providers along with financial incentives for enrollees to obtain care within the plan’s provider network. Virtually all private health insurance coverage – including benefits administered by private plans in public programs such as Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP) – utilizes provider networks to deliver health care benefits and services. An estimated 90 percent of all hospitals and physicians participate in health plan networks.¹

The most prevalent option for individuals and families covered under employer-sponsored coverage are Preferred Provider Organization (PPO) plans – covering 57 percent of covered workers and dependents.² PPOs provide subscribers with access to both in-network and out-of-network care – with lower cost-sharing requirements and out-of-pocket costs when using care delivered by in-network, preferred providers. Other network-based plans – including Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), and Point of Service (POS) plans – cover the balance of individuals.³ Today, less than 1 percent of

¹ The Value of Provider Networks and the Role of Out-of-Network Charges in Rising Health Care Costs—A Survey of Charges Billed by Out-of-Network Physicians. America’s Health Insurance Plans; August 2009.

² Employer Health Benefits 2013 Annual Survey. Kaiser Family Foundation. <http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20132.pdf>

³ HHS offers the following description of different plan types (available at: <https://www.healthcare.gov/what-are-the-different-types-of-health-insurance/>):

“Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs): HMOs and EPOs may limit coverage to providers inside their networks. A network is a list of doctors, hospitals, and other health care providers that provide medical care to members of a specific health plan. If you use a doctor or facility that isn’t in the HMO’s network, you may have to pay the full cost of the services provided. HMO members usually have a primary care doctor and must get referrals to see specialists. This is generally not true for EPOs.”

“Preferred Provider Organizations (PPOs) and Point-of-Service plans (POS): These insurance plans give you a choice of getting care within or outside of a provider network. With PPO or POS plans, you may use out-of-network providers and facilities, but you’ll have to pay more than if you use in-network ones. If you have a PPO plan, you can visit any doctor without a referral. If you have a POS plan, you can visit any in-network provider without a referral, but you’ll need one to visit a provider out-of-network.”

employees and families are covered under traditional indemnity products which do not use provider networks.

Provider networks are part of a broad array of tools and strategies used by health plans – including financial incentives for consumers, disease and care management for individuals with chronic conditions, prevention and wellness, and collaborating with providers on payment and delivery reforms – to deliver high-quality and cost-effective care to patients and consumers. By contracting with hospitals and physicians that have met standards set by established accrediting organizations, health plans work to ensure that patients have access to high-quality and effective care. These industry-wide standards, established by independent accrediting organizations such as The Joint Commission (on Accreditation of Healthcare Organizations), are used to evaluate health care organizations such as hospitals, home health, rehabilitation and other facilities to ensure that these facilities meet state-of-the-art standards including patient safety goals and credentialing standards for practitioners to ensure high quality care for patients.⁴ Consumers benefit when receiving care in-network – because they have peace of mind that the provider meets such standards for the quality of care they deliver – and lower cost-sharing and out-of-pocket costs. Moreover, using network providers protects patients and consumers from excessive costs due to “balanced billing.” That is, consumers benefit from health plans’ negotiated payment rates to contracted providers (when satisfying deductible or co-insurance amounts) and, likewise, participating providers are barred from charging any additional costs to subscribers.

III. Federal Marketplace Plans for 2014

Data from the states where the federal government is operating the Exchange (Federally-Facilitated Marketplace, or FFM) show that consumers will have a large number of health plans to select from when making coverage choices for 2014. On average, individuals shopping in the FFM will be able to choose from 53 qualified health plans.⁵ Consumers in many states also will have the option to choose among different plan designs – PPO, HMO, EPO, or POS – selecting the one that best fits their needs. The vast majority of states will offer at least two different plan design types, with 17 of these states offering three or four plan design choices (Appendix 1). Across all FFMs, the PPO is the most prevalent plan design (40.6% of all plans), followed by HMO (39.8%), EPO (13%), and POS (6.6%).

⁴ http://www.jointcommission.org/assets/1/18/Physicians_and_The_Joint_Commission.pdf

⁵ “Health Insurance Marketplace Premiums for 2014.” Department of Health and Human Services (HHS), Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief. September 2013. Available at: http://aspe.hhs.gov/health/reports/2013/marketplacepremiums/ib_marketplace_premiums.cfm.

Although these plans may differ in the way they structure their network of providers, all health plans must meet robust standards for network adequacy and access to care. Professional accrediting organizations, such as the National Committee for Quality Assurance (NCQA) and URAC, require plans to develop standards for access and availability of services and measure themselves against these standards annually – including standards for the number and geographic distribution of providers. Plans are evaluated based on how they meet network adequacy and access to care benchmarks – such as the ability of members to get regular appointments, urgent care appointments, after hours care, and member services by phone.⁶ NCQA and other organizations are also seeking to improve measures for evaluating plans on their networks and access to care – including focusing on quality of care and related delivery system innovations.

IV. The Emergence of High-Value Networks

The use of high-value provider networks is one component of a larger effort to redesign benefits by creating financial incentives to encourage the utilization of higher-value treatments and services, such as evidence-based preventive care, and lower utilization of unnecessary treatments and services.

Value-based provider networks are currently being designed in two ways:

- (1) The use of tiers of health care providers and facilities based on specified performance metrics, including cost efficiency and measures of quality. Copayments are then reduced for consumers who seek care from those providers and facilities that fall into a higher-performing tier and are increased for those providers and facilities that fall into a lower performing tier.
- (2) The creation of smaller provider networks comprised of selected, high-value providers who have a track record of providing high-quality, cost-efficient care to patients. Some health plans and employers have introduced products featuring these smaller networks of providers who have demonstrated their performance on quality and cost criteria.

State and federal network adequacy laws ensure that consumers have access to a sufficient number and type of physicians and hospitals in health plans' provider networks. These network designs have become part of a larger effort on the part of health plans and employers to help

⁶ NCQA – Network Adequacy and Exchanges White Paper, 2013.

preserve benefits, mitigate the impact of rising costs, and promote quality care, while still providing access to a range of health care professionals and facilities.

A 2011 Mercer survey of employers found that 14 percent of large employers were using small networks of high performers. A 2011 Kaiser/ HRET survey of employers similarly found that approximately 20 percent of all firms nationally offer a tiered or high-value network option.

Moreover, a recent study of small employers and their perspectives on health insurance coverage found that small employers were interested in health plans with smaller provider networks if they resulted in lower costs. Specifically, a majority of small employer respondents (57 percent) indicated that they would choose a smaller provider network if it resulted in 5 percent lower premiums and an even greater percentage (82 percent) would choose a smaller network if it resulted in 20 percent lower premiums.⁷

A poll of consumers showed a similar preference, with a majority of respondents (58 percent) preferring “less expensive plans with a limited network of doctors and hospitals” to “more expensive plans with a broader network of doctors and hospitals.”⁸

Strong Quality Criteria

While the use of tiered or smaller networks has raised questions of similarities to the 1990s managed care products, the science of quality measurement has improved significantly since the 1990s, and there is now a heavy emphasis on quality as well as efficiency in selecting providers for high-value networks.

Using widely recognized, evidence-based measures of provider performance, such as those endorsed by the National Quality Forum (NQF), health plans and employers can create tiered, or smaller, networks of providers comprised of clinicians and facilities that score well on measures of efficiency and quality. A recent survey of health plans examined performance measures used by private payers and found that the performance measures used in high-value network and tiering programs most often focus on cardiovascular conditions,

⁷ J. Gabel, “Small Employer Perspectives on the Affordable Care Act’s Premiums, SHOP Exchanges, and Self-Insurance,” *Health Affairs* 32, no. 11 (2013): 2032-2039, available online at <http://content.healthaffairs.org/content/32/11/2032.full.html>.

⁸ The Morning Consult, National Healthcare Tracking Poll: August 2013, available online at <http://themorningconsult.com/tracking-poll-topline-results-august-2013/>.

diabetes, preventive services, and patient safety. Not surprisingly, these areas of focus were consistent across other payment and delivery reform strategies as well, including accountable care organizations, patient-centered medical homes, and pay-for-performance.⁹

V. Evidence Showing the Benefits of High-Value Provider Networks

A growing body of data indicates that high-value networks can help drive consumers to better-performing providers and facilities while helping to reduce spending. For example:

- One plan's program assesses providers across 21 specialties based on quality of care and cost efficiency, with the best-performing providers receiving a "Premium Two-Star" designation. This program yields an estimated average savings of 14 percent, with savings ranging from 7 to 19 percent depending on physician specialty.¹⁰
- Another plan's tiered provider network uses clinical performance and cost efficiency criteria to assess providers in 12 specialties and enables employers to set the level of incentives to drive employee behavior. The plan reports that its high-value providers are 1 to 8 percent more cost efficient relative to other providers within the network.¹¹
- Recognizing in-network hospitals and selected specialties (general surgery, ob-gyn, cardiology, orthopedics, and gastroenterology) on quality, cost efficiency, and accessibility performance generated savings for one plan of up to 10 percent.¹²
- A study of a high-value network in California found that the use of provider tiers resulted in 20 percent lower health care costs and 20 percent higher quality.¹³

⁹ A. Higgins, "Provider Performance Measures in Private and Public Programs: Achieving Meaningful Alignment with Flexibility to Innovate," *Health Affairs* 32, no. 8 (2013): 1453-1461, available online at <http://content.healthaffairs.org/content/32/8/1453.full.html>.

¹⁰ UnitedHealthcare Insurance Company, UnitedHealth Premium Designation Program: FAQ for Employers (2011).

¹¹ Institute of Medicine, *U.S. Roundtable on Evidence-Based Medicine* (Washington: National Academies Press, 2010).

¹² BlueCross BlueShield of North Carolina, *New BCBSNC Products Offer Cost Savings for Individuals and Employers* (Chapel Hill, NC: BlueCross BlueShield of North Carolina, December 12, 2012).

¹³ R. Steinbrook, "The Cost of Admission – Tiered Copayments for Hospital Use," *New England Journal of Medicine* 350, no.25 (2004): 2,539-2,542, available online at <http://www.ncbi.nlm.nih.gov/pubmed/15201407>.

- In California, some of the largest employers – including the state employee program (CALPERS) – have offered a high-value plans option with premium savings of up to 25 percent over traditional broader network plans.¹⁴
- Health plans are also incorporating high-value and tiered networks as part of new innovations in care delivery and payment – including adoption of patient-centered medical homes and value-based insurance design. By combining multiple payment and benefit design strategies, these innovations are assuring greater value and efficiency in care delivery while promoting affordable coverage.¹⁵

Additional Advantages of High-Value Networks

Many of the new payment and delivery reform models rely on close collaborations between employers, health plans, and provider groups to achieve better health outcomes, such as through accountable care organizations. Selective and/or smaller provider networks can make these collaborations easier to implement and affect positive change in the patient population.

Additionally, while it may be too early to see quantitative evidence, the increased use of tiered or smaller networks based on performance metrics potentially could have an effect among providers more broadly, motivating providers outside of these networks to improve their performance so that they may be included in such networks in the future.¹⁶

High-value networks can also be an effective way at addressing high provider prices that, according to health policy experts, lie at the heart of the health spending problem in the United States.¹⁷ By providing financial incentives for consumers to select high-quality and cost-efficient providers, high-value networks and related initiatives can help constrain provider prices through market forces while rewarding efficiency and value.

¹⁴ Duke Helfand. "A shift toward smaller health networks." *Los Angeles Times*; April 3, 2011.

¹⁵ Joseph Burns. "Narrow Networks Found to Yield Substantial Savings." *Managed Care*; February 2012.

¹⁶ H. Meyer, "Return of the Narrow Network," *Managed Healthcare Executive*, July 1, 2012, available online at <http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/return-narrow-network>.

¹⁷ Chapin White et al. "High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power." *Center for Studying Health System Change*; September 2013.

VI. The Role of High-Value Provider Networks in Preserving Benefits and Affordable Coverage Amidst Sweeping Changes to the Health Insurance Marketplace and Health Care System

The ACA includes a broad array of insurance market reforms, such as guaranteed issue, community rating, and prohibiting pre-existing condition exclusions. These reforms are intended to work in tandem with the new insurance marketplaces, subsidies, and the individual coverage requirement to expand health insurance coverage. By expanding access to care and broadening coverage, the law adds new benefits and new costs to the health care system.

- The reform law expands access to insurance and broadens insurance benefits. Anyone can sign up, including those with pre-existing conditions. These new benefits bring new costs.
- New rules strictly limiting how much premiums can differ among people in the same community will increase premiums for younger and healthier individuals.
- A new sales tax on health insurance that begins in 2014 will result in higher costs for working families, small businesses, and seniors. We are deeply concerned that the ACA health insurance tax will undermine efforts to control costs and provide affordable coverage options to the American people. This tax will be particularly painful for vulnerable populations, including consumers who buy coverage on their own and small business owners who struggle to provide coverage to their employees, and will also adversely impact seniors and individuals with disabilities who rely on the Medicare Advantage program as a health care safety net, and state Medicaid health plan programs that serve low-income individuals. We strongly support bipartisan legislation to delay and ultimately repeal this burdensome tax.

High-value networks are an important tool for health plans in assuring that premiums are affordable while preserving access to comprehensive and important benefits. As a result of the high-value networks that health plans have implemented, premiums in the new marketplaces are lower than they would be without these network changes. According to the U.S. Department of Health and Human Services (HHS), individuals purchasing coverage in the new Exchanges will have “significant choice and lower than expected premiums.”¹⁸

¹⁸ ASPE Issue Brief. Health Insurance Marketplace Premiums for 2014, September 25, 2013.

The health reform law also imposes deep funding reductions in the Medicare Advantage program – the part of Medicare through which private plans provide comprehensive medical coverage to seniors and other Medicare beneficiaries. Over 14 million Americans, or roughly 28 percent of all Medicare beneficiaries, have chosen to enroll in a Medicare Advantage plan because of the better services, higher-quality care, and additional benefits these plans provide. Analysis of federal data shows that Medicare Advantage is an important option for low-income and minority Medicare beneficiaries. Beneficiaries who choose to enroll in Medicare Advantage express high satisfaction with their coverage and benefits.

The ACA imposes \$200 billion in funding cuts on the Medicare Advantage program over a ten-year period. To date, only 10 percent of the cuts originally estimated by the Congressional Budget Office have gone into effect. In addition, not taken fully into account at the time of ACA passage was the impact of the health insurance tax that begins in January. Over the next two years, that tax alone will mean a reduction of approximately \$500 - \$1,000 per beneficiary per year on top of the Medicare Advantage cuts made in the legislation. Finally, further destabilizing this program is the impact of sequestration cuts and the threat that such cuts will continue into the future. Due to the cumulative impact of these cuts, overall Medicare Advantage funding is failing to keep pace with the growth in health care costs.

These cuts are a direct threat to the choices and benefits of Medicare Advantage enrollees. While many beneficiaries are already seeing fewer choices and higher premiums as a result of these cuts, the impact is likely to be greatly exacerbated as even larger cuts are phased in over the next few years and the Quality Bonus Demonstration Project comes to an end. Establishing high-value provider networks is one way health plans can help preserve benefits and mitigate the cost impact on beneficiaries as these changes take effect.

VII. Future Opportunities for High-Value Provider Networks

Currently, Medicare Advantage plans are not permitted to vary copayments within their provider networks, making them unable to differentiate higher-value providers from lower-value providers. Yet, efforts are underway to use provider performance data to calculate hospital and physician payment modifiers within the traditional Medicare fee-for-service program. Similar provider performance data could be used to promote value-based choices by beneficiaries in Medicare Advantage plans if such plans were allowed to tier providers based on value and offer beneficiaries cost-sharing incentives to act on this information.

As the use of high-value networks continues to grow in the private sector, similar strategies to promote value should be explored for use within public programs so that consumers enrolled in all types of health insurance products have the information necessary and the opportunity to make decisions based on value.

VIII. Conclusion

Thank you for considering our perspectives on these critically important issues. Our members remain strongly committed to working with Congress, the Administration, and other stakeholders to expand access to high quality, affordable coverage options.

Appendix 1

FFM Health Plan Options – By State ¹				
Alaska	PPO			
	30			
Alabama	PPO			
	13			
Arkansas	PPO	POS		
	29	24		
Arizona	PPO	HMO		
	101	71		
Delaware	PPO	HMO	EPO	
	4	5	12	
Florida	PPO	HMO	EPO	POS
	27	125	53	36
Georgia	PPO	HMO	POS	
	1	57	5	
Iowa	PPO	HMO	EPO	POS
	28	10	8	42
Illinois	PPO	HMO	POS	
	69	12	6	
Indiana	HMO	POS		
	53	1		
Kansas	PPO	POS		
	53	12		
Louisiana	PPO	HMO	POS	
	26	10	26	

Maine	PPO	HMO	POS	
	7	12	12	
Michigan	PPO	HMO		
	25	44		
Missouri	PPO			
	48			
Mississippi	PPO	HMO		
	11	18		
Montana	PPO	POS		
	25	4		
North Carolina	PPO	HMO	POS	
	26	8	22	
North Dakota	PPO	HMO		
	29	4		
Nebraska	PPO	HMO	POS	
	26	15	16	
New Hampshire	HMO			
	11			
New Jersey	HMO	EPO	POS	
	2	31	3	
Ohio	PPO	HMO		
	89	55		
Oklahoma	PPO	HMO	POS	
	36	21	3	

Pennsylvania	PPO	HMO	POS	
	70	49	16	
South Carolina	HMO	EPO	POS	
	8	27	17	
South Dakota	PPO	HMO		
	12	23		
Tennessee	PPO	EPO		
	66	8		
Texas	PPO	HMO	EPO	
	30	65	6	
Utah	PPO	HMO	POS	
	4	87	5	
Virginia	PPO	HMO	POS	
	28	52	26	
Wisconsin	PPO	HMO	EPO	POS
	29	112	12	32
West Virginia	PPO			
	13			
Wyoming	PPO	HMO		
	5	13		
TOTAL FFM	PPO	HMO	EPO	POS
	960	942	157	308

¹ Counts are based on the number of unique "Plan Marketing Name" entries, by state and product type, on HHS's QHP Individual Medical Landscape File. Available at: <https://data.healthcare.gov/dataset/QHP-Individual-Medical-Landscape/ba45-xusy>. While these numbers represent the total number of plan offerings in a state, they may not represent the actual number of plans available to a specific individual since not all plans are offered in all geographic rating areas within a state. Similarly, catastrophic plans are included in these totals, although enrollment in these plans is restricted to those under 30 or those who meet certain income requirements.

THE WALL STREET JOURNAL.

Review & Outlook

Juking the ObamaCare Stats**HHS won't disclose the enrollment data that really matter.**

Updated Dec. 11, 2013 7:35 p.m. ET

Most of Washington seems to have bought the White House claim that the 36 federal exchanges are finally working, and glory, glory, hallelujah. But if that's really true, then what explains the ongoing secrecy and evasion?

On Wednesday the Health and Human Services Department continued its Victorian-era strip tease and allowed a glimpse into the Affordable Care Act's "enrollment" for November. Out of respect for a free press, reporters ought to boycott these releases because they're so selective that they reveal little about real enrollment. But we'll try to parse the data as best we can without the White House high gloss.

A charitable reading suggests that ObamaCare's net enrollment stands at about negative four million. That's the estimated four million to five and a half million people who had their individual health plans liquidated as ObamaCare-noncompliant—offset by the 364,682 who have signed up for a plan on a state or federal exchange and the 803,077 who have been found eligible to receive Medicaid.

HHS is boasting of enrollment for November that was four times as high as October, yet 62% of the total was in the state exchanges, some of which are marginally less prone to crashing than the federal version. Then again, 41 states posted sign-ups only in the three or four figures, including eight states that run their own exchanges. Oregon managed to scrape up 44 people. Among the 137,204 federal sign-ups, no state is reaching the critical mass necessary for stable insurance prices.

The larger problem is that none of these represent true enrollments. HHS is reporting how many people "selected" a plan on the exchange, not how many people have actually enrolled in a plan with an insurance company by paying the first month's premium, which is how the private insurance industry defines enrollment. HHS has made up its own standard.

Insurers know that the hardest part of doing business in the individual market is getting customers to write a check. People are accustomed these days to automatic payroll deductions and the unseen lost wages of employer-sponsored insurance. Many Americans may enroll on the exchange but then fail to pay once they see monthly costs that could range from the equivalent of a cellphone bill if they qualify for subsidies (President Obama's favorite comparison) to premiums that can exceed \$1,000 or huge deductibles for the unlucky who must overpay to finance the insurance of others.

HHS also hasn't built the tools that would allow people to pay through the exchange. Customers must contact their putative insurer, who may not be aware of their existence because the federal exchanges continue to produce corrupted data on the "back end" that are crucial for insurers.



Associated Press

After stonewalling for weeks about the error rate, HHS now says it is down to 10%, which we suppose is good enough for government work. But some insurers are still processing applications by hand, not least because one of five customers are submitting them on paper, not electronically.

HHS is trying to conjure the appearance of progress and specificity even as it conceals everything that is relevant to ObamaCare's performance. The bureaucracy will tell you it fielded 3,495,276 inquiries at the federal call centers and that 28,412,684 people visited Healthcare.gov. But it will not tell you the demographics and health status of new beneficiaries, or what type of plans they're selecting, or HHS's enrollment goals over time.

In other nondisclosure news, the House Oversight Committee turned up letters Wednesday showing that HHS ordered the private contractors partly responsible for the Healthcare.gov fiasco not to cooperate with congressional investigations or hand over documents. For no pertinent reason, HHS reminds them that they signed contracts obligating them not to share information with "third parties."

HHS goes on to note that "If you receive a request for this information from Congress, CMS will respond directly to the requestor and will work with the requestor to address its interests in this information." Explaining how the government managed to waste hundreds of millions of dollars building a website in 2013 might be in the public interest, so what are they afraid the contractors will produce?

The reason for all this obstruction and statistical juking is so the White House can get the press corps and Democrats to believe that the worst is over and that ObamaCare is now rolling toward success. On that score they've succeeded. But it's impossible for an outsider to know what the truth really is because HHS and the White House continue to manipulate and bury the real statistics.

Bloomberg

Recession Not Health Law May Be Responsible for Cost Curb

By Alex Wayne - Sep 19, 2013

The four-year slowdown in U.S. health-care spending will end next year, and there is no sign the [Affordable Care Act](#) will significantly curb the acceleration in costs, government actuaries said in a report.

President [Barack Obama](#) has said the 2010 health-system overhaul helped curb national medical spending, which that year rose 3.9 percent, or about half pre-recession levels. Actuaries at the Centers for Medicare and Medicaid Services, who don't answer to the White House, said yesterday in the journal *Health Affairs* that costs eased because of the economy, not Obamacare.

This report won't be good news for those who have argued that the Affordable Care Act would reduce costs. It provides strong evidence that the slowdown in spending isn't related to the health law, said James Capretta, a policy analyst at the American Enterprise Institute in Washington who worked in the administration of former President George W. Bush.

"It certainly adds one more piece to the puzzle for those who say 'hey wait a second, this isn't the final word on how to reform American health care,'" he said in a phone interview.

The report also contradicts independent economists who had attributed spending reductions more to the Affordable Care Act and changes in the health system, such as shifts in employer benefits. The CMS actuaries, who track medical spending by the government, individuals and insurers, examined 50 years of data and found no evidence of costs deviating much from the economy.

"Once the economy improves substantially we would expect health spending to respond in kind," Gigi Cuckler, an economist who tracks actuarial information at CMS, told reporters. "We're not convinced that that relationship has been broken in the past couple of years."

Unpopular Law

The Affordable Care Act has never been popular. The bill passed through a Democratic-controlled Congress with no support from the Republican Party and only 37 percent of Americans surveyed said they currently support it, according to an August poll by the nonprofit Kaiser Family Foundation.

Since enactment, most Republican governors have refused to cooperate with the law's expansion of Medicaid and an effort by some in Congress to defund the law is taking center stage in the showdown over the federal government's budget and debt ceiling.

The \$1.3 trillion Affordable Care Act seeks to extend coverage to most of the nation's 50 million uninsured by expanding state Medicaid programs and creating government-run insurance exchanges to buy subsidized medical plans. The law also includes measures that cut drug costs for seniors, cover children with pre-existing illnesses and let young adults stay on their parents' plans.

Economic Burner

Obama has claimed credit for helping to contain medical spending, saying in his February [state of the union](#) speech that "already, the Affordable Care Act is helping to slow the growth of health-care costs."

"The Affordable Care Act holds insurers accountable for cost increases and encourages smarter care, two factors which are contributing to the slowdown of growth in costs," said Joanne Peters, a spokeswoman for the Department of Health and Human Services, in an e-mail. "Already consumers have saved billions of dollars in premiums thanks to the rate review, medical-loss ratio provisions, and policies to promote quality and value in Medicare."

Spending on hospital visits, medications and other care rose 3.9 percent to \$2.8 trillion in 2012, roughly matching growth in the previous two years, the report shows. Growth is projected to be 3.8 percent this year and 6.1 percent in 2014.

U.S. Expenditures

Total U.S. health-care expenditures will average 5.8 percent annually through 2022, the actuaries said, about 1 percentage point faster than projected gross domestic product. Health spending will surpass \$5 trillion then, accounting for almost one-fifth of the economy, up from 18 percent this year.

The growth figures are well below the spending increase of close to 8 percent before the U.S. entered an 18-month recession in December 2007. Independent economists have tried to explain the slowdown by linking it to the effects of the health law.

David Cutler, a Harvard economist and former Obama campaign adviser, published a study in *Health Affairs* in May that calculated the recession accounted for only 37 percent of the slowdown in health costs from 2003 to 2011, with the majority of the change being "unexplained." And Ceci Connolly, the managing director of PriceWaterhouseCoopers Health Research Institute, said last year that the lower growth rates are a "new normal" that can't be attributed to the recession alone.

"We believe the slowdown is a combination of the recession hangover, actions taken by employers and individual consumers and some structural changes in the industry," Connolly said yesterday in an e-mail response to questions.

Company Cutbacks

There is evidence to support her argument. [Walgreen Co. \(WAG\)](#), [Sears Holdings Corp.](#) and [Darden Restaurants Inc. \(DRI\)](#) are choosing to give employees a stipend to buy insurance from a private exchange instead of the company providing coverage directly. [Trader Joe's Co.](#), the closely held grocery store chain,

has said it will move part-time workers at its 400 stores onto the Obamacare exchanges, and [United Parcel Service Inc. \(UPS\)](#) decided to drop health benefits for 15,000 of its workers' spouses who can get insurance through another company.

Other large employers, including International Business Machines Corp. and Time Warner Inc. have this year moved their retirees into private exchanges from company-picked plans.

Newly Insured

The overall impact of the Affordable Care Act won't be insignificant either. About 11 million uninsured Americans will gain insurance coverage next year alone, when the core parts of the health law kick in, the actuaries said.

"In our projections we have incorporated some modest savings regarding delivery system reforms," Cuckler, the CMS economist, said. "At this time, it's a little too early to tell how substantial those savings will be in the longer term.'

Over the long term, health-care spending has grown about 2 percentage points faster than GDP, according to Stephen Heffler, director of the National Health Statistics Group in the actuary's office. "There is a very tight relationship between economic growth and health spending growth," he said at the briefing.

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