STATEMENT OF

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ON

AN AFFORDABLE CARE ACT CHECK UP

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM
SUBCOMMITTEE ON HEALTH CARE, BENEFITS, AND ADMINISTRATIVE RULES

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Hearing on
An Affordable Care Act Check Up
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Chairman Jordan, Ranking Member Cartwright, and members of the Subcommittee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS') continuing work to implement the Affordable Care Act and provide consumers with affordable access to high quality health coverage.

Thanks to the Affordable Care Act, millions of Americans who were previously uninsured now have access to affordable, high-quality health care. An estimated 20 million more people now have coverage because law,[1] and at 9.1 percent, the uninsured rate for Americans is the lowest it has been on record.[2] Pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history.

The vast majority of Americans get their health insurance at work, and that has not changed. However, because of the Affordable Care Act, that coverage is stronger and more secure. Lifetime and annual dollar limits are now a thing of the past, and an estimated 105 million Americans had lifetime caps on their coverage lifted. Tens of millions of people have new access to preventive services with no cost-sharing. And consumers have new tools to appeal decisions made by their insurance companies.

The Affordable Care Act has resulted in cost savings for both consumers and taxpayers. The law requires health insurers to provide consumers with rebates if the amount they spend on health

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[1] https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf
[2] https://aspe.hhs.gov/sites/default/files/pdf/204986/ACARuralbrief.pdf

benefits and quality of care, as opposed to advertising and marketing, is too low. Last year, 5.5 million consumers received nearly $470 million in rebates. Since this requirement was put in place in 2011 through 2014, more than $2.4 billion in total refunds will have been paid to consumers. The law also eliminates out-of-pocket costs for certain preventive services, and women can no longer be charged more than men for the same coverage. In addition, the Affordable Care Act phases out the "donut hole" coverage gap for nearly 10.7 million Medicare prescription drug beneficiaries, who have saved an average of $1,945 per beneficiary.[3] Furthermore, the law has provided new transparency in how health insurance plans disclose reasons for premium increases and requires simple, standardized summaries so over 170 million Americans can better understand their coverage information and compare plans. These consumer protections did not exist six years ago.[4]

Since the Affordable Care Act became law, health care prices have risen at the slowest rate in 50 years. The Affordable Care Act's reforms to Medicare payment rates, along with likely "spillover" effects on prices in the private sector, have been major contributors to this recent slow price growth. The Congressional Budget Office (CBO) recently announced that compared with their and the Joint Committee on Taxation's 2010 projection, the current estimate of the net cost of the insurance coverage provisions over the 2016-2019 period is lower by $157 billion, or 25 percent.[5] In addition, CBO has estimated that the law will generate substantial deficit savings that grow over time, implying total savings of more than $3 trillion over the next two decades. Lower long-term deficits boost national saving, thereby increasing capital accumulation and reducing foreign borrowing, which raises wages and overall national income over time.

These cost savings have been coupled with a focus on improving the quality of care provided. The law created the Hospital Readmissions Reduction Program, which adjusts payments for hospitals with higher than expected 30-day readmission rates for targeted clinical conditions such as heart attacks, heart failure, and pneumonia. CMS has also undertaken several major quality improvement initiatives, such as the Partnership for Patients, all targeted at improving the quality

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[3] https://www.whitehouse.gov/the-press-office/2016/03/22/fact-sheet-health-care-accomplishments
[4] https://www.whitehouse.gov/the-press-office/2016/03/02/fact-sheet-affordable-care-act-healthy-communities-six-years-later
[5] https://www.cbo.gov/publication/51385#section3

of care for individuals as they move from one health care setting to another and reducing unnecessary hospitalizations.

We are already seeing national trends in health care improvements that are promising and likely a combined result of our efforts and tools provided by the Affordable Care Act. Since 2010, the rate of patient harm in U.S. hospitals has fallen by 17 percent. Cumulatively since 2010, this translates into 2.1 million avoided patient harms, like infections and medication errors, and an estimated 87,000 avoided deaths,[6] resulting in $20 billion in cost savings.[7] In addition, the hospital readmission rate for Medicare patients has fallen sharply in recent years. If the readmission rate had remained at its level before the Affordable Care Act's passage, a cumulative 565,000 additional readmissions would have occurred through May 2015. That's 565,000 times that a patient didn't have to experience an extra hospital stay.[8] The Affordable Care Act incentivizes hospitals to provide high-quality care and makes investments that help hospitals learn from each other how to keep patients safe. Ultimately, this shift towards quality and value will help patients receive, and doctors and other clinicians provide, the best care possible.

The Marketplace is Strong

The Marketplace was designed to foster issuer competition, facilitate consumers' comparison shopping, and ensure affordability through financial assistance, and research shows we are well on our way to accomplishing these goals. Three years in, the Health Insurance Marketplace is a competitive, growing and dynamic platform – a transparent market where issuers compete on price and quality, and people across the country are finding health plans that meet their needs, and their budgets. And, increasingly, the Marketplace is also serving as a laboratory for innovations and strategies that are helping us build a better health care system. For example, one issuer is creating plans based on the different needs of unique geographic communities, involving activities such as bringing together interdisciplinary teams focused on improving care for high-risk populations in particular communities.

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[6] https://www.whitehouse.gov/sites/default/files/page/files/20160322_aca_six_year_anniversary_slides.pdf
[7] http://www.ahrq.gov/professionals/quality-patient-safety/pfp/interimhacrate2014.html
[8] https://www.whitehouse.gov/sites/default/files/page/files/20160322_aca_six_year_anniversary_slides.pdf

Competition has worked to create more affordable choices for consumers. The average number of issuers remained stable between 2015 and 2016. On average, consumers were able to choose from 5 issuers for 2016 coverage, just as they could for 2015, and 88 percent of returning consumers were be able to choose from 3 or more issuers, translating into 50 plan options.[9]

Research also shows that consumers took advantage of these options, shopping for the coverage that best fit their and their families' needs. Approximately 67 percent of HealthCare.gov consumers selected a new plan in 2016, including all new consumers and 43 percent of returning consumers. Consumers who switched plans saved an average of $42 per month in premium costs, equivalent to over $500 in annual savings. The increase in the average premium, taking shopping into account, was 8 percent between 2015 and 2016; among the roughly 85 percent of HealthCare.gov consumers with premium tax credits, the average monthly net premium increased by 4 percent, or just $4. The average monthly tax credit amount in 2016 is around $290 and reduces a consumer's premium by 73 percent. After taking into account tax credits, nearly 7 in 10 HealthCare.gov consumers had the option of coverage for $75 or less in monthly premiums for 2016 coverage, and 74 percent had an option for $100 or less.[10] These tax credits, as of March 2016, have helped nearly 9.4 million Americans purchase health coverage through the Health Insurance Marketplaces.[11]

In addition to shopping for plans based on price, many consumers shopped for their plans based on health care providers and services. For the third Open Enrollment, for the first time, the Federally-Facilitated Marketplace (FFM) began to offer consumers the option of selecting plans by searching for plans that offered a specific hospital, physician, or prescription. In its pilot year, consumers chose this path 3.6 million times in just the 38 FFM states.[12]

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[9] https://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf

[10] https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf

[11] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html

[12] https://blog.cms.gov/2016/06/09/remarks-of-cms-acting-administrator-andy-slavitt-at-the-marketplace-innovation-conference/

As of March 31, 2016, about 11.1 million consumers had paid their premiums and had an active policy, or "effectuated" their coverage for the 2016 benefit year, [13] compared to 10.2 million individuals as of March 31, 2015, nearly a 9 percent increase.[14] Importantly, consumers are getting value for their money. Research shows that consumers say they can now afford primary care and prescription drugs they could not afford before the Affordable Care Act, and a majority are satisfied with their coverage.[15] J.D. Power found that consumers who bought coverage through the Marketplace were generally more satisfied than those with other types of insurance, including employer coverage.[16] Employer-sponsored coverage has not been disrupted, and employees now have options to move jobs without fear of their families being unable to afford and obtain coverage.

In February of this year, we issued the annual Notice of Benefit and Payment Parameters for the 2017 coverage year, along with related guidance documents. The rule finalizes provisions to: help consumers with surprise out-of-network costs at in-network facilities, provide consumers with notifications when a provider network changes, give insurance companies the option to offer plans with standardized cost-sharing structures, provide a rating on HealthCare.gov of each Qualified Health Plan's relative network breadth (for example, "basic," "standard," and "broad") to support more informed consumer decision-making, and improve the risk adjustment formula.

Enhancing Outreach to Young Adults

Since the ACA was enacted, the overall uninsured rate has fallen by more than 40 percent, and the uninsured rate among young adults has fallen by more than 50 percent. But younger and healthier adults are still more likely than average to remain uninsured.[17] In 2015, almost half of all uninsured individuals eligible for Marketplace coverage were between the ages of 18 and

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[13] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html
[14] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html
[15] http://www.commonwealthfund.org/acaTrackingSurvey/about.html
[16] http://www.jdpower.com/press-releases/2015-health-insurance-marketplace-exchange-shopper-and-re-enrollment-hix-study
[17] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-21.html

34.[18] Insuring these groups lets them invest in their health, protects them against catastrophic costs from serious illness, and helps young adults continue their education. It also contributes to a more balanced Marketplace risk pool and lower costs. CMS recently announced a series of actions to step up Marketplace outreach, especially to young adults, for the 2017 Open Enrollment.

Research during the 2016 Open Enrollment showed that young adults are almost twice as likely as older consumers to enroll because they receive an email about Marketplace coverage. During the upcoming Open Enrollment, we will draw on lessons learned this year about the messages, timing, and tactics that make email outreach more effective.

Also, new since the 2016 Open Enrollment, this year we will be able to email consumers with important proactive reminders in near-to-real time if they open an account to start an application, finish an application to select a plan, and when they select a plan pay to their first premium as the last step to gaining coverage. We've learned that sending an email, with the right information, at just the right time, can make a significant difference in whether someone gets covered, and those are lessons we'll act on this year.

In addition, we are making it easier for issuers to conduct outreach to young adults turning age 26 and moving off their parent's plans. Specifically, new guidance from the Department of Labor makes clear that the sponsors of employer plans can – and are encouraged to – provide additional information that will help young adults understand their options and enroll in Marketplace coverage as appropriate. Along with issuing new policy guidance, we are strongly encouraging insurers to contact these consumers with targeted information about Marketplace options. Additionally, on June 13, we provided states and outreach organizations with $32 million in additional funding to help with Medicaid and Children's Health Insurance Program (CHIP) outreach. In conjunction with that funding announcement, we reminded them of their obligation to help children aging out of Medicaid and CHIP transition to Marketplace or other coverage.

[18] https://aspe.hhs.gov/basic-report/health-insurance-marketplace-uninsured-populations-eligible-enroll-2016

Finally, HHS has created a network of diverse outreach partners. While we will keep building that network until the start of the 2017 Open Enrollment and beyond, we are excited to announce that this year's partnerships will include Lyft, the American Hospital Association, and coordinated young adult campaigns that include more than 75 partnering organizations. To help focus these efforts, the White House will host a National Millennial Health Summit on September 27, 2016.

Working with States to Benefit Consumers through Medicaid Expansion

Throughout its 50-year history, Medicaid has served as an adaptable program, adjusting to national and state-specific needs and meeting the health care needs of children, adults, pregnant women, seniors, and people with disabilities. For these low-income Americans, Medicaid has provided health insurance coverage that is affordable, accessible, and has served as the Nation's major source of long-term care coverage. CMS is committed to working with states to expand Medicaid in ways that work for them, while protecting the integrity of the program and those it serves.

As a result of the Affordable Care Act, states have the opportunity to expand Medicaid eligibility to individuals 19-64 years of age with incomes up to 133 percent of the Federal poverty level (FPL). For the first time, states can provide Medicaid coverage for low-income adults without dependent children without the need for a demonstration waiver. The Affordable Care Act provides full Federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent FPL through Calendar Year 2016, and then phases down in subsequent years to cover 90 percent of costs in Calendar Year 2020 and thereafter. This increased Federal support has enabled 31 states and the District of Columbia to expand Medicaid coverage to more low-income adults. The Administration has proposed in its FY17 Budget to make full federal funding available for the first three years a state takes up expansion. Primarily as a result of the expansion of coverage to low-income adults and the eligibility and enrollment simplifications CMS and states have made, since the beginning of the Affordable Care Act's first Open Enrollment Period, Medicaid/CHIP enrollment has grown by 15.0 million individuals, and

among Medicaid expansion states, the uninsured rate for non-elderly adults declined by 49.5 percent, compared to 33.8 percent in non-expansion states[19]

States that have expanded their Medicaid programs are documenting significant reductions in uncompensated care and the uninsured rate. Hospitals provided over $50 billion in uncompensated care in 2013; in 2014, there was a $7.4 billion reduction in uncompensated care costs, with 68 percent of the reduction coming from states expanding Medicaid.[20] And of the 12 states with the greatest reductions in uninsured rates from 2013 to 2015, 11 had expanded Medicaid eligibility.[21]

Importantly, beneficiaries are satisfied with their plans. According to a recent report from the Office of the Assistant Secretary for Planning and Evaluation (ASPE), 93 percent of new Medicaid enrollees report being satisfied with their health plans and 92 percent report being satisfied with their doctors. In addition, 78 percent of new Medicaid enrollees indicated that they would not have been able to access or afford their care prior to Medicaid expansion and enrollment. Unmet health care needs among low-income adults declined 10.5 percentage points after expansion, and the percentage of low-income adults reporting problems paying medical bills also declined by 10.5 percentage points.[22] Further, compared with non-expansion states, enrollees in expansion states saw a 41 percent increase in preventive service visits in community health centers; access to Medicaid prescription drug refills increased 25.4 percent in states that expanded coverage, compared to only 2.8 percent in states that did not expand coverage; and cost-related barriers to dental care fell from 30 percent in 2013 prior to Medicaid expansion to 25 percent in 2014 post Medicaid expansion.

Ongoing Efforts to Expand Upon Affordable Care Act Successes

Part of our job at CMS in overseeing ongoing development of the Affordable Care Act is to create a predictable and level playing field for consumers, providers, issuers, and other

[19] https://aspe.hhs.gov/sites/default/files/pdf/205141/medicaidexpansion.pdf
[20] http://aspe.hhs.gov/health/reports/2015/medicaidexpansion/ib_uncompensatedcare.pdf
[21] http://www.gallup.com/poll/189023/arkansas-kentucky-set-pace-reducing-uninsured-rate.aspx
[22] https://aspe.hhs.gov/sites/default/files/pdf/205141/medicaidexpansion.pdf

stakeholders, and to facilitate stability during these early years. Over the past several months, CMS has taken a set of actions which strengthen the risk pool, limit upward pressure on rates, and provide a strong foundation for the Marketplace for the long-term. This process is a continual ongoing commitment, and we have made meaningful progress.

Facilitating States' Improvement of the Rate Review Process

The Affordable Care Act brought unprecedented transparency into health insurance pricing. Before the Affordable Care Act, insurance companies in many states were able to raise rates without explaining their actions to regulators or the public. Today, the rate review process improves insurer accountability and transparency. It ensures that experts evaluate whether the proposed rate increases are based on reasonable cost assumptions and solid evidence and gives consumers the chance to comment on proposed increases. In 2015, rate review led to an estimated $1.5 billion in savings for consumers.[23] Most recently, CMS announced the availability of additional funding to state insurance regulators to use for issuer compliance with Affordable Care Act key consumer protections. This award opportunity enables states to seek funding for activities related to planning and implementing select federal market reforms and consumer protections including: essential health benefits, preventive services, parity in mental health and substance use disorder benefits, appeals processes, and bringing down the cost of health care coverage (also known as medical loss ratio provision).

Strengthening Special Enrollment Period Requirements

Over the last several months, the Marketplace has taken a number of steps to ensure that Special Enrollment Periods (SEPs) are there for consumers when they need them, while avoiding misuse or abuse. We've strengthened our rules and clarified our processes for SEPs, so that the people who need to can still easily get coverage, while making it hard for anyone thinking about taking advantage of them. We also eliminated 7 SEPs, including the SEP for individuals who owed the tax penalty for not having health insurance, contributing to an almost 30 percent year-over-year drop in the number of SEP enrollments during the three months after Open Enrollment.

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[23] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf

Continuing that work, in February we announced that we would begin verifying certain consumers' eligibility for enrollments made since April through five common Special Enrollment Periods. In addition, starting June 18 all individuals who qualify for these five Special Enrollment Periods are now asked to provide documents to prove their eligibility for that Special Enrollment Period at the time that they qualify. On our website, we have posted models of these eligibility notices that include lists of examples of acceptable documents people can submit to prove their eligibility for their Special Enrollment Period, as well as articles to help answer questions and assist consumers through this process. Consumers who qualify for and enroll in coverage through one of these five Special Enrollment Periods should provide the appropriate documents by the deadline listed in their notice to confirm eligibility for that Special Enrollment Period to avoid any disruptions to their coverage.

Refining Risk Adjustment Models

By reducing incentives for issuers to try to design products that attract a disproportionately healthy risk pool, risk adjustment lets them design products that meet the needs of all consumers, protecting consumers' access to a range of robust options. Earlier this year, CMS made a number of changes to improve the stability, predictability, and accuracy of the risk adjustment program for issuers. These changes include better modeling of costs for preventive services, changes to the data update schedule, and earlier reporting of preliminary risk adjustment data where available. We also published a Risk Adjustment White Paper and hosted a conference on March 31, 2016 to solicit feedback from issuers, consumers, and other stakeholders on additional areas for improvement.

Building off the Risk Adjustment White Paper and stakeholder feedback, we recently announced two additional important changes to risk adjustment that we intend to propose in future rulemaking. First, we intend to propose that, beginning for the 2017 benefit year, the risk adjustment model include an adjustment factor for partial-year enrollees. By accounting for the costs of short term enrollees in ACA-compliant risk pool, this change will support the Marketplace's important role as a source of coverage for people who are between jobs, experiencing life transitions, or otherwise need coverage for part of the year. Second, we intend

to propose that, beginning for the 2018 benefit year, prescription drug utilization data be incorporated in risk adjustment, as a source of information about individuals' health status and the severity of their conditions. We are also considering proposing additional changes to the model for 2018 and beyond.

Furthering Data Matching Accuracy

CMS takes very seriously its obligation to ensure that access to coverage and financial assistance are limited to those individuals who are indeed eligible. The Marketplace verifies eligibility for most consumers through electronic trusted data sources, but if consumers' data cannot be matched electronically we generate a data matching issue to request additional information from enrollees. Consumers who do not provide the necessary information will have their coverage or financial assistance ended or modified.

Unfortunately, eligible individuals sometimes lose coverage or financial assistance through the Marketplace during the year because they have trouble finding documents or navigating the data matching process. In addition to the direct impact on consumers, avoidable terminations due to data-matching issues also negatively impact the risk pool, since younger, healthier individuals appear to be less likely to persevere through the data matching process. In fact, in 2015, younger open enrollment consumers who experienced a data matching issue were about a quarter less likely to resolve their problem than older consumers.

This year, CMS made a range of improvements to the data matching process, such as updating our online application and improving systems functionality, to help consumers avoid generating data matching issues in the first place and to help them resolve these issues once generated. More recently, we have also intensified our outreach, and partnered with issuers so that they are reaching out to consumers about data-matching issues as well. These efforts are beginning to pay off, with a sharp reduction in total data-matching issues generated and an almost 40 percent year-over-year increase in the number of documents consumers have submitted to resolve these issues. Continued progress in this area should benefit both directly affected consumers and other consumers who will benefit from a stronger risk pool.

Moving Forward

Since the passage of the Affordable Care Act, millions of Americans now have access to high quality, affordable health care coverage, and we are controlling the growth of health care costs. From the outset, we knew that implementation of the Affordable Care Act would be a multi-year process, and we learn daily how to improve our operations and enhance the consumer experience by making the purchasing of health insurance easier and simpler for our customers. We look forward to continuing to benefit from suggestions from customers, assisters, brokers, issuers, and other key stakeholders on ways to improve our operations to ensure the American people gain the peace of mind of health insurance coverage. Using the tools created by the Affordable Care Act, we are working toward a health care delivery system that works better for everyone—where care is improved through better coordination and integration, where we spend our health dollars in smarter ways, and where our system is person-centered and healthier.

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Kevin Counihan serves as the Chief Executive Officer of the Marketplace and the Deputy Administrator at the Center for Medicare and Medicaid Services (CMS). In his role as Marketplace CEO, Kevin is responsible and accountable for leading the federal Marketplace, managing relationships with state Marketplaces, and directing the Center for Consumer Information and Insurance Oversight (CCIIO), which regulates health insurance at the federal level.

Kevin comes to the Department after most recently serving as the CEO of AccessCT, the state of Connecticut's health insurance exchange, since July 2012. As the AccessCT CEO, Kevin led the successful implementation of the state's marketplace where enrollment exceeded expectations.

Kevin has over 30 years' experience in the health care and insurance exchange industries. Prior to his Connecticut appointment, he held the position of President of CHOICE Administrators in California, a private health insurance exchange that serves 10,000 employer groups and their members. Prior to CHOICE Administrators, Mr. Counihan served as the Chief Marketing Officer (CMO) for the Commonwealth of MA Health Insurance Connector Authority (also known as the MA Health Connector). As CMO at the Health Connector, Kevin led a marketing campaign which set the bar for inventive outreach in local communities, including partnerships with strong local brands like the Red Sox. Prior to that position, Kevin was Senior Vice President of Sales and Marketing for Tufts Health Plan of Massachusetts from 1993 to 2005. He also served as regional Vice President for Cigna Corp., and has worked as an adjunct professor of health policy at Northeastern University since 2009.

Kevin holds an undergraduate degree from the University of Michigan and an MBA in finance and marketing from Northwestern University's Kellogg School of Management.