

**EXAMINING THE AFFORDABLE CARE ACT'S
PREMIUM INCREASES**

HEARING

BEFORE THE

**COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM
HOUSE OF REPRESENTATIVES
ONE HUNDRED FOURTEENTH CONGRESS**

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EXAMINING THE AFFORDABLE CARE ACT'S PREMIUM INCREASES

Wednesday, September 14, 2016

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

The committee met, pursuant to call, at 9:03 a.m., in Room 2154, Rayburn House Office Building, Hon. Jason Chaffetz [chairman of the committee] presiding.

Present: Representatives Chaffetz, Mica, Duncan, Jordan, Walberg, Amash, Gosar, Farenthold, Massie, Meadows, DeSantis, Mulvaney, Buck, Walker, Blum, Hice, Carter, Grothman, Hurd, Palmer, Cummings, Maloney, Norton, Lynch, Cooper, Connolly, Duckworth, Kelly, Lawrence, Lieu, Plaskett, DeSaulnier, Welch, and Lujan Grisham.

Chairman CHAFFETZ. The Committee on Oversight and Government Reform will come to order. And without objection, the chair is authorized to declare a recess at any time.

We have an important hearing today examining the Affordable Care Act premium increases. There is a deep concern, I think, in most Americans about the cost of health care.

Under the Affordable Care Act, health insurance premiums are soaring, soaring to say the least. President Obama promised multiple times that the Affordable Care Act would lower a family's health insurance premium by \$2,500. We would love to hear from any Americans who think that their health care premiums went down \$2,500.

American families are still waiting for the cut in cost. Instead, the health care insurance premiums have skyrocketed under the Affordable Care Act. The New York Times this summer acknowledged the Affordable Care Act is causing increased premiums warning to its readers "Get ready for big increases."

In Utah, health insurers in the individual market requested premium increases of nearly 30 percent on average. Most Americans are seeing even higher proposed premium increases. Conceding to the massive premium increase, the administration then relies on tax subsidies. However, regardless of the subsidies, Americans are feeling the full brunt of just how costly the Affordable Care Act is.

Second, under the Affordable Care Act, with soaring premiums, many Americans then must pay massive deductibles. Health care costs are one of the top concerns for families, and even people with insurance oftentimes can't afford to use it, especially individuals enrolled in high-deductible health plans under the ACA. Again, this is no longer deniable. Another New York Times article re-

ported “Many say high deductibles make their health law insurance all but useless,” all but useless.

Third, remember the promise for the increase competition. According to the New York Times again, in many parts of the country, “Customers will be down to one insurer when they go to sign up,” hardly a choice. Insurers are seeing unprecedented losses on the exchange. Losses on the exchanges are reaching into the billions of dollars with the health insurance industry. As a result, several large insurers are pulling out of the exchanges with the concerns of even more insurers pulling out this year unless premiums are going to be allowed to be increased significantly.

According to an analysis done for the New York Times, 17 percent of Americans may only have one insurer to choose from, 17 percent. UnitedHealthcare, Aetna are limiting their participation in the marketplace. And I know that Chairman Meadows is particularly concerned about that in North Carolina where they may face the prospect of having no insurer participating at all.

This committee has been warning for almost a year about the collapse of the co-op program. HHS has refused on numerous occasions to provide us with the information about the program. Then, this week, another co-op failed. There are only six left, down from 23.

And finally, of course, we cannot forget the ACA was sold on one of the biggest political lies of all times: “If you like your plan, you can keep it. If you like your doctor, you can keep your doctor.” That wasn’t true ever. It was a political lie. Even the President had to apologize for that one.

Today, I want to hear from industry about why premiums continue to increase under the ACA and hear about their proposed solutions and how we can lower premiums for Americans. I want to hear from the State regulators to learn more about the challenges they are facing as premiums skyrocket and more insurers pull out of the health insurance exchanges. And finally, I want to hear from HHS on the implementation of the ACA. I want to know what can be done to control premium increases and to get younger, healthier individuals enrolled in the health insurance.

To our HHS Health and Human Services witness, I would like to point out the sad truth about the health care law. Every step of the way this administration—everything the administration has told us that would be just fine and it is not. It is not just fine. You can keep putting lipstick on it but it doesn’t look good and it ain’t good.

So premiums will go down, HealthCare.gov will work, these are all things that they told us would be just great. Co-ops, they would be there. They are failing, failing, and failing. It is only when faced with the undeniable evidence or public outcry do we finally hear that maybe the ACA isn’t quite so perfect.

So I look forward to good discussion today. We all care about health care insurance. We have got an important hearing next week that Elijah Cummings and I have been working hard on to deal with some of the costs that Americans are going through. EpiPen in particular is something that we will be addressing next week. But we are here to talk about the ACA and the problems

that are associated. We need some candid talk and some solutions. So it is going to be a good hearing.

Chairman CHAFFETZ. I now recognize the ranking member, Mr. Cummings of Maryland.

Mr. CUMMINGS. Thank you very much, Mr. Chairman, and I want to thank you for holding this hearing. This is a very important hearing. And I thank you, all of our witnesses today, for testifying on this very important subject.

I would like to start off by reading a few headlines. Let me start with this one: "Anthem BlueCross dramatically raising rates for Californians with individual health policies." Here is another one: "Health insurance rates soar as Oregon regulators nod." And here is another one: This one says, "Millions in U.S. can't afford health insurance."

The thing is, these headlines are not from today or this week or even this year. They are from several years ago before Congress passed the Affordable Care Act. Of course, that will not come as a surprise to anyone who remembers how horrible the individual insurance market was before Congress passed the Affordable Care Act.

Insurance companies used to be able to discriminate against women. They could charge more for people with preexisting conditions from asthma to cancer. They could impose exclusions and caps on coverage. They could terminate policies when people got sick, and they could deny coverage altogether. People who were lucky enough to get health insurance were often stuck with whatever premiums the insurance companies decided to charge.

These premiums were increasing by double digits every year, double digits every year. Before we passed the Affordable Care Act, the individual insurance market was indeed a complete mess.

The purpose of today's hearing is to examine recent increases in health insurance premiums.

The Republicans love to attack the Affordable Care Act even though it has improved the health care of millions of our fellow Americans and millions of our constituents. But there is one critical fact that they do not want you to know. Premium increases have actually been lower than the Congressional Budget Office predicted when Congress passed the Affordable Care Act. They are lower than we anticipated. Based on CBO's projections at that time, they estimated that premiums would be 12 percent to 20 percent higher than they are today.

Here is another key fact you will never hear Republicans admit: National health care spending has slowed even more significantly than projected when we passed the Affordable Care Act. That includes spending across Medicare, Medicaid, any private insurance market. National health care spending for 2014 through 2019 will be \$2.6 trillion less, \$2.6 trillion with a T, trillion than CMS projected in 2010 when we passed the Affordable Care Act. Of course, all this is happening as the Affordable Care Act expands health coverage for 20 million Americans, offers them more comprehensive coverage, and ends the discrimination of the past. As a result, we now have the lowest uninsured rate in our nation's history.

Unfortunately, my Republican colleagues do not want to talk about these facts. This is the rest of the story. They want to attack

the ACA for political reasons without offering solutions of their own. From day one, Republicans have been focused on undoing and undermining this law. They have taken every single opportunity to sabotage it by any means necessary. They challenged the law in court, tried to defund it, and voted more than 60 times—hello, 60 times—to repeal or weaken it. They are truly obsessed.

If we want to talk about premium increases, we need to also talk about drug companies that are jacking up the prices of their drugs. And I want all of our witnesses to talk about that, drug companies that are jacking up prices and how does that affect premiums. One of the biggest drivers in premium increases is skyrocketing prescription drug prices. And that is across the board, not just for people with plans under the Affordable Care Act.

For that reason, I am very pleased that the chairman agreed to the request from Democrats to hold a hearing next week to examine the massive price increases with EpiPens, and including Representative Grace Meng, Stephen Lynch, Tammy Duckworth, and Peter Welch, all requesting a hearing. And, Mr. Chairman, I do appreciate you doing that and working with us to get the documents that we will be getting from Mylan.

Let me be clear. I have told my staff, prescription drug prices and the unconscionable raising of those prices is one of my top three priorities in this Congress. And the reason why it is one of the top three priorities is because I think it is unfair. It is like putting a gun to a sick person's head and say either you pay or you go into bankruptcy, either you pay or you get sicker, either you pay or you die. So we cannot even have this discussion about premium increases unless we address that, and I hope that our witnesses will do that.

So a majority of Americans—Democrats, Republicans, and independents by the way—believe that this is our number one health care priority as a nation, number one. It used to be the Affordable Care Act. Now, it is prescription drugs. That is Republicans, Democrats, independents. They are saying this is a major problem, and you know why? Because it is affecting them every single day, and they are tired of it.

One of the reasons why I think the American public is so frustrated, they want us to do something about these problems. They don't want us to just skirt down the road and say lolly, lolly, have a good day. They are trying to get well. As one of my constituents said to me, Congressman, I can get the treatment but can't get the cure. I can't afford the cure.

So I am so glad that we are having this hearing. But let's be clear. There is something else that goes to the bottom line of this. It is the health care of Americans. It is health care of Americans. We are all in this country right now. We are all on this planet right now. And it would be nice for us to do everything in our power to keep our nation healthy. And how do you keep the nation healthy? You keep the individuals healthy because when you keep the individuals healthy, you have a stronger company.

And so with that, Mr. Chairman, again, I appreciate it. I am excited about the EpiPen hearing coming up. I am excited about possibly bringing Shkreli back. He said he wants to come back. That would be very nice. I hope he provides some testimony this time.

And I thank you again and again, witnesses, thank you. And I yield back.

Chairman CHAFFETZ. I thank the gentleman.

I am not sure Pharma boy is coming back, but I appreciate your passion on it.

We will hold the record open for 5 legislative days for any members who would like to submit a written statement.

Let's now recognize our panel of witnesses. We are pleased to welcome Dr. Mandy Cohen, the chief operating officer and chief of staff to the Office of the Administrator at the United States Department of Health and Human Services; Mr. Al Redmer, Jr., commissioner of the Maryland Insurance Administration, speaking on behalf of the National Association of Insurance Commissioners; Mr. Chris Carlson, principal at Oliver Wyman, speaking on behalf of America's Health Insurance Plans; Mr. Kurt Giesa, partner and head of the Actuarial Healthcare Practice at Oliver Wyman, speaking on behalf of Blue Cross Blue Shield Association; and Mr. Topher Spiro —

Mr. SPIRO. Spiro.

Chairman CHAFFETZ. Spiro, sorry. Spiro, vice president of Health Policy at the Center for American Progress.

We thank you for being here. Pursuant to committee rules, all witnesses are to be sworn before they testify, so if you will please rise and raise your right hand.

[Witnesses sworn.]

Chairman CHAFFETZ. Thank you. You may be seated. Let the record reflect that the witnesses all answered in the affirmative.

In order to allow time for discussion, we would appreciate it if you would limit your oral testimony to no more than 5 minutes. Your entire written statement will be made part of the record.

Dr. Cohen, you are now recognized for 5 minutes.

WITNESS STATEMENTS

STATEMENT OF MANDY COHEN

Dr. COHEN. Thank you so much. Thank you, Chairman. Thank you, Ranking Member Cummings and members of the committee. Thank you for the invitation to discuss CMS's continuing work to implement the Affordable Care Act and provide consumers with affordable access to high-quality health coverage.

The changes to the Affordable Care Act has made our health system—are providing countless Americans the security that comes from knowing that they'll have access to health coverage when they need it. At the same time, this fundamental shift to a health insurance market that serves all consumers regardless of their health history requires all of us—consumers, issuers, State regulators—to work together to build and test new businesses, coordinated care systems, and reform payment models in order to provide the care people need.

We're making historic gains in coverage. As of earlier this year, an estimated 20 million more Americans have coverage because of the law, and 8.6 percent of—and an 8.6 uninsured rate for Americans is the lowest on record. We believe these remarkable results are at a lower cost than the Congressional Budget Office originally

projected with coverage provisions costing 25 percent less than the original estimates.

But we do expect 2017 to be a transition year for the marketplace with several one-time factors putting upward pressure on premiums. Because the individual market previously operated by excluding sick people, no one knew how much it was going to cost to start covering everyone. As a result, some marketplace issuers initially priced below the cost of new enrollees and now they need to catch up.

As evidence of this fact, independent experts have estimated that marketplace premiums are currently 12 to 20 percent lower than what CBO predicted when ACA was passed. This year also marks the end of some of ACA's premium stabilization programs, which were designed to support the new market in its early years.

However, with high consumer satisfaction, more people getting care, and an improving risk pool, data shows that the future of the marketplace is strong and we're confident issuers will continue to participate given the growth opportunities.

Nonetheless, we know that premium increases have real-life consequences for families. That's why it's so important that the marketplace has built-in protections for consumers. The marketplace provides tax credits that mirror premium increases so consumers are always protected. Even with significant rate increases, the majority of consumers can access coverage for less than \$75 per month.

And we continue to work in partnership with State Departments of Insurance, who remain the primary regulators of health insurance in the States to help support their efforts to effectively enforce ACA's rate review provisions. Rate review ensures that in every State proposed rate increases are evaluated by experts to make sure they are actuarially sound and justified.

It's also important to remember that for the roughly 150 million Americans who get coverage through their employer, premium growth has slowed. Four out of the five last years have seen the slowest growth rate on record, saving families millions of dollars.

Since the ACA was passed, health care prices have risen at the slowest rate in 50 years, but we know more needs to be done. Just as in the private sector, rising health care costs impact all of CMS programs, and we work every day to control health care costs for the benefit of taxpayers, beneficiaries, and consumers.

We're working to improve affordability and quality for all consumers whether they get their coverage—no matter where they get their coverage by rewarding health care providers for the quality of the care that they deliver, not the quantity.

Many health plans are meeting the challenge of providing quality coverage to all with marketplace serving as a laboratory for those innovations and strategies that are helping build a better health care system overall. Innovative insurers are succeeding in serving these new consumers, and it's paying off for the marketplace as a whole. Per-member, per-month costs in the ACA individual market actually fell slightly by .1 percent from 2014 to 2015, which is a positive sign to the long-term health of the individual market risk pool.

States that saw above-average growth in enrollment also saw an above-average drop in costs, showing that growth of enrollment is leading to a broader, healthier risk pool that brings down costs.

We're also using the tools at our disposal to make the marketplace even more attractive for consumers and issuers alike. Over the past several months, CMS has moved aggressively on things like special enrollment periods. We've made improvements to the risk adjustment program, which could bring more certainty to the marketplace and help issuers account for the risk of all enrollees. And we're reaching out to marketplace consumers turning 65 helping them successfully transition to the—to Medicaid coverage, among many other actions we've taken.

CMS is committed to strengthening the growing marketplace as it matures. We have heard suggestions from stakeholders, issuers, States, Congress, and others, and we have responded. Working together, I know we can further our shared goal of improving the health care for America and making sure American families continue to have access to quality, affordable health coverage. Thank you.

[Prepared statement of Dr. Cohen follows:]

STATEMENT OF

MANDY COHEN, MD, MPH
CHIEF OPERATING OFFICER & CHIEF OF STAFF
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE AFFORDABLE CARE ACT

BEFORE THE
UNITED STATES HOUSE COMMITTEE ON
OVERSIGHT & GOVERNMENT REFORM

SEPTEMBER 14, 2016

U.S. House Committee on Oversight & Government Reform
Hearing on
The Affordable Care Act
September 14, 2016

Chairman Chaffetz, Ranking Member Cummings, and members of the Committee, 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, Americans' access to the health insurance market has fundamentally transformed in only a few years. Before the Affordable Care Act, consumers were frequently denied health care coverage or charged exorbitant rates if they had pre-existing conditions. People who managed to find insurance coverage often learned that it would not cover the care that they needed when they became sick—or that insurance companies could cancel their policies entirely. Annual or lifetime limits capped the value of coverage consumers had when they faced serious illness.

Since 2014, for the first time, we have a health insurance system that is providing access to quality care to all Americans regardless of their health or financial status. Millions who were previously denied or unable to afford coverage for chronic conditions or even routine care are now able to get the care they need. 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. As of earlier this year, an estimated 20 million more people have coverage because of the law,¹ and at 8.6 percent, the uninsured rate for Americans is the lowest on record.² We achieved these remarkable results at a lower cost than the Congressional Budget Office (CBO) originally projected, with coverage provisions

¹ <https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>

² <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>

costing 25 percent less than original estimates.³ And, despite concerns about rate increases, premiums charged by Exchange health plans remain well below what CBO initially predicted. Overall, independent experts calculate that Marketplace premiums are currently 12 percent to 20 percent lower than CBO predicted when the Affordable Care Act was enacted.^{4,5} If rates had come in as CBO predicted, and grown with medical trend, consumers likely would pay more next year than they actually will, even with this year's rate changes.

The changes the Affordable Care Act made to our health system are providing countless Americans with the security that comes from knowing they will have access to health care when they need it. At the same time, this fundamental shift—to a health insurance market that serves all consumers, regardless of their health history—is new for all involved—consumers, insurers, and state regulators, thus requiring all of us to learn from what has worked and build on these successes, while making refinements and adjustments when necessary. Health insurance issuers need to build new business models for the individual market, where they can be successful by providing the care people need and compete on cost and quality.

Many health plans are meeting this challenge with a variety of innovative approaches, with the Marketplace serving as a laboratory for innovations and strategies that are helping us build a better health care system. For example, Blue Cross Blue Shield in Florida closely analyzed its prospective Marketplace customers and learned that those purchasing coverage in the new market differ significantly from the consumers they served in the individual market before the Affordable Care Act. Based on this research, the company was able to tailor plans to meet the needs of different communities, including innovative care delivery through interdisciplinary teams that that focused on improving care for high-risk populations in particular communities. In Massachusetts, Blue Cross Blue Shield of Massachusetts is using a payment model that pays doctors and clinicians based on the quality, efficiency, and effectiveness of the

³ <https://www.cbo.gov/publication/51385>

⁴ <http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/>

⁵ <http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/>

care they provide. This approach is saving money while giving patients better care than similar patients in other states.⁶

While many issuers have adopted innovative, successful approaches to the significant changes in the market, it is not surprising that others have encountered more challenges. Many companies are adjusting their geographic coverage, provider network, care management, and pricing approach now that they have information about how Marketplace consumers are accessing care. The approaching fourth Marketplace Open Enrollment presents an opportunity to build on what we have learned and put the Marketplace on even stronger footing through a series of major outreach improvements and important policy changes.

Building on Successes in Open Enrollment Four

The Marketplace was designed to make it easy for individuals to comparison shop for health care plans that meet their needs, and research shows that the Marketplace is delivering on this goal. Consumers say they can now access primary care and prescription drugs they could not afford before the Affordable Care Act, and a majority are satisfied with their coverage.⁷ More than 80 percent of consumers selected plans with primary care visits covered below the deductibles, and on average, nearly seven services—beyond preventive services—were covered below deductibles in the HealthCare.gov states in 2015.⁸ J.D. Power and Associates found that consumers who bought coverage through the Marketplace in 2015 generally were more satisfied than those with other types of insurance, including employer coverage.⁹

Nonetheless, we know that premium increases are a challenge for families. Fortunately, as the market adjusts, the Marketplace is designed to insulate most consumers from large rate increases. As a result of financial assistance and the ability to shop around, the vast majority of

⁶ <http://www.nejm.org/doi/full/10.1056/NEJMsa1404026>

⁷ <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>

⁸ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html>

⁹ <http://www.jdpower.com/press-releases/2015-health-insurance-marketplace-exchange-shopper-and-re-enrollment-hix-study>

HealthCare.gov consumers could still choose plans for less than \$75 per month even if all plan premiums rose substantially next year.¹⁰ Premium changes typically vary from issuer to issuer and even across plans offered by the same issuer, so the lowest-priced plan one year may not be the lowest-priced plan the next year.

CMS is hard at work preparing for the fourth Marketplace Open Enrollment, beginning on November 1. Earlier this year, we finalized several policy changes and enhancements,¹¹ including provisions to: (1) help consumers with surprise out-of-network costs at in-network facilities; (2) provide consumers with notifications when a provider network changes; (3) give insurance companies the option to offer plans with standardized cost-sharing structures called “simple choice plans”; and (4) in a pilot program, provide a rating on HealthCare.gov of each Qualified Health Plan’s relative network breadth (for example, “basic,” “standard,” or “broad”) or quality rating to support more informed consumer decision-making.

We have learned more about what kinds of outreach are most effective as we seek to reach out to the remaining Americans who are uninsured and eligible to enroll in Marketplace coverage. Our outreach efforts will put a special emphasis on communicating with those Americans who paid the Individual Shared Responsibility Payment for 2015 and on facilitating 26-year-olds’ transitions from their parents’ plans to Marketplace coverage.

We are making it easier for issuers to conduct outreach to young adults moving off their parents’ 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.

We also are undertaking smarter, more timely, and targeted email and other outreach campaigns. These efforts will complement our successful in-person outreach and assistance

¹⁰ <https://aspe.hhs.gov/sites/default/files/pdf/206741/APTCMarketplace.pdf>

¹¹ <https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017>

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

Additionally, this year we will be able to email consumers with important proactive reminders in near-to-real time if they open accounts to start applying or finish applications to select plans, and we will send each consumer a reminder after selecting a plan to pay their first premiums 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 will act on this year.

Policy Changes to Build a Strong Marketplace for the Long-Term

CMS is committed to building a stable, sustainable Marketplace that serves consumers for years to come. One of the most significant things CMS is doing is making adjustments and refinements along the way. With the benefit of three years of data and experiences to analyze and inform our policies, CMS has proposed or taken a number of actions to: (1) better reflect the risk associated with high-cost enrollees; (2) better reflect the risk associated with enrollees who are not enrolled for a full 12 months; (3) strengthen the risk pool; and (4) support issuers in entering the Marketplace and in growing their Marketplace businesses. These actions, coupled with other related improvements already underway, will help to make the Marketplace an even more attractive market for consumers and health plans alike.

Supporting Issuers with High-Cost Enrollees and Updating Risk Adjustment

One of the core tenets of the Affordable Care Act has been that people with pre-existing conditions finally have access to the coverage they need. The law's risk-adjustment program plays an important role in providing issuers both the incentives and the financial support to design products to serve all Americans. By reducing incentives for issuers 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. Based on significant input from all marketplace participants, 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. CMS also recently proposed additional changes in the Proposed Notice of Benefit and Payment Parameters for 2018.¹² We are seeking comment on a number of approaches for addressing the costs of healthier enrollees. Our goal is to update risk-adjustment for all types of enrollees, to ensure that issuers can have confidence in the program as they design products to attract all types of consumers. These proposals could help to bring more certainty into the Marketplace, helping issuers account for the risk of all enrollees, while continuing to ensure that all Americans have access to the care they need.

Strengthening the Marketplace Risk Pool

Along with helping issuers cover enrollees with more serious health needs, we also recognize the importance of balancing the mix of enrollees in the Marketplace risk pool. CMS has undertaken a variety of efforts to help strengthen the risk pool, and is seeking comment on several additional proposed improvements.

Special enrollment periods (SEPs) exist to ensure that people who lose coverage or experience other qualifying events have the opportunity to enroll in coverage. We are committed to making sure that SEPs are available to those who are eligible and are equally committed to avoiding any misuse or abuse of SEPs. In 2016, we took a number of steps to ensure appropriate use of SEPs, such as introducing a confirmation process under which consumers enrolling through common SEPs are directed to provide documentation to confirm their eligibility.^{13,14} Recently, we announced that we are planning a pilot to evaluate a pre-enrollment verification process.¹⁵ Our intent in conducting such a pilot would be to evaluate the impact of pre-enrollment verification

¹² <https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>

¹³ For more information on SEPs, visit <https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/>

¹⁴ See <https://blog.cms.gov/2016/01/19/clarifying-eliminating-and-enforcing-special-enrollment-periods/> and <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html>

¹⁵ <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf>

of SEP eligibility on compliance, enrollment, continuity of coverage, the risk pool, and other outcomes. We continue to seek information on additional steps related to SEP outreach or policy we could take as soon as the 2017 plan year to strengthen the risk pool.

CMS also is reaching out to the small number of consumers enrolled in both Medicare and Health Insurance Marketplace coverage with financial assistance. We are doing this to make sure they end their Marketplace coverage with advance payments of the premium tax credit because they are receiving Minimum Essential Coverage (MEC) Medicare, and thus are not eligible for this financial assistance. In March 2016, we also added a pop-up to the Marketplace application with information about Medicare for Marketplace applicants aged 64 and over, to increase consumer awareness and understanding of the rules regarding Medicare enrollment and eligibility for Marketplace coverage. In summer 2016, CMS began sending email notices to existing Marketplace consumers who will turn age 65 the following month. This notice helps educate consumers about the eligibility rules pertaining to Medicare and Marketplace coverage with financial assistance and potential tax liability, and provides instructions on how and when to end a Marketplace plan with this assistance due to Medicare enrollment.

CMS is seeking information regarding concerns that some health care providers or third party entities may be inappropriately steering their Medicare and Medicaid patients into the individual market in order to receive higher reimbursement rates.¹⁶ CMS's request for information and letters to providers informing them of this announcement focus on situations where patients may be steered away from Medicare or Medicaid benefits, which can, among other concerns, result in beneficiaries experiencing disruptions in the continuity and coordination of their care as a result of changes to their network of providers. These actions reflect ongoing efforts by CMS to address possible issues in the Marketplace that could affect the integrity of the programs for both consumers and issuers, and the costs of the individual insurance coverage, while at the same time help ensure patients are enrolled in the right plan for them. CMS also is seeking comments on a

¹⁶ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-18-2.html>

coordination of benefits policy that similarly is intended to ensure individuals entitled to Medicare and Medicaid are appropriately enrolled in those programs.¹⁷

Removing Obstacles to Issuer Entrance, Growth, and Innovation

As we look forward, it is clear that the issuers that will be most successful in the long term are likely to be those with innovative approaches to this new Marketplace and its consumers. CMS recently proposed new policies that would give issuers additional flexibility and freedom to offer innovative products and to remove obstacles to issuers growing their businesses and entering more markets.¹⁸ For example, CMS proposed more flexibility for innovation around plan design by issuers, particularly around bronze plan offerings, while still protecting the coverage on which consumers rely. This proposal is intended to help ensure that issuers can offer bronze plans with at least one major service before the deductible, as well as offer high-deductible health plans (that can be paired with health savings accounts) at the bronze level of coverage. Enrollment data from the Federally-facilitated Marketplaces shows that consumers prefer plans that cover and pay for services below the deductibles.

We also have included proposals to give new and growing issuers more flexibility in calculating their medical loss ratios to be more accurately reflective of their experience, and to avoid instances where issuers who are adjusting their individual market or group market portfolios would inadvertently trigger bans on participating in the individual or group market. These measures generally would promote stability in the individual and small group markets, and would encourage issuers to enter or stay in the Marketplaces.

Moving Forward

Thanks to the Affordable Care Act, our country's health-insurance system has transformed from one that too often excluded the sick to a system that guarantees access to care for all, regardless of health status. This type of fundamental change rarely is easy, and from the outset, we knew

¹⁷ <https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>

¹⁸ <https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018>

that implementation of the Affordable Care Act would be a multi-year process. Every day we learn more to help us improve our operations and enhance the consumer experience by making the purchasing of health insurance easier and simpler for our customers.

As the Marketplace continues to grow and mature, our most important priorities include studying data, listening to a range of market participants, testing different approaches, and adapting to what we see and hear. We have a number of tools to make adjustments and are confident in our ability to make the Marketplace an even more attractive market for consumers and health plans alike. 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 that comes with health insurance coverage.

Chairman CHAFFETZ. Commissioner Redmer, you are now recognized for 5 minutes.

STATEMENT OF AL REDMER, JR.

Mr. REDMER. Thank you, Mr. Chairman, Ranking Member Cummings, and members of the committee. My name is Al Redmer. I'm the appointed commissioner of the Maryland Insurance Administration. I want to thank you for the opportunity to be here today representing the National Association of Insurance Commissioners.

I'd like to begin my comments by offering a short historical review of the health insurance market in Maryland, which I believe will add some context to our discussion regarding rate changes coming in January of next year.

In the early 1980s and early '90s, Maryland's health insurance market had conditions similar to those discussed during the debate of the Affordable Care Act. In 1993, the Maryland General Assembly passed small group insurance reform, which included provisions similar to those contained in the ACA, including such things as guaranteed issue, a ban on preexisting condition limitations, a standard benefit plan, and adjusted community rating. Initially, those changes created disruptions to the market, but it has evolved into a competitive market that is seeing moderate, single-digit premium increases. Given that experience, we knew that there would be considerable instability in the individual market when the ACA was enacted, but hopefully eventually that there would be some equilibrium to the small group market.

Unfortunately, due to a variety of factors, the instability in the individual market created by the ACA has now extended into the fourth year of implementation, and corrections are long overdue.

I recently attended a national NAIC meeting where regulators across country expressed serious concerns about the condition of the individual market in their States. Major insurance carriers have pulled out of the exchanges citing substantial losses in the individual markets, and some carriers have closed their doors or failed to meet solvency requirements. This means thousands of consumers will need to reenroll in a new health plan from a different carrier by December 15 or they will not have coverage on January the 1st.

In addition, in too many counties there are only one insurance carrier offering individual coverage on the exchange, and there could still be one or two without any plans at all on the exchange. Furthermore, many insurance carriers are only offering the HMO-style health benefits with very narrow provider networks in the individual market, which dramatically reduces the coverage options available for consumers and increases the pricing.

Finally, my colleagues have reported that individual market carriers are requesting premium increases of 30, 40, and in some cases more than 50 percent.

I and my colleagues take very seriously our responsibility under State law to ensure all rates are actuarially justified, nondiscriminatory, and sufficient to ensure solvency. Proposed rate increases are thoroughly reviewed, and under the ACA, they are more transparent than ever. In Maryland, for example, we had two public rate hearings. But individual market premiums continue to rise, and for

too many consumers, is still unaffordable and consumers want to know why. Rising health care costs remain the driving force behind rising health insurance premiums, and this must be addressed if health insurance coverage is ever going to be truly affordable for the broadest possible group of policyholders.

Another key factor we are seeing, as a result of the ACA and its implementation, is uncertainty. And as any actuary will tell you, insurance hates uncertainty. And the ACA has been—as implemented, has considerable uncertainty in three areas: risk pools, funding, and regulations.

The fact that far fewer younger, healthier consumers are enrollees than expected, even with increasing penalties means the risk pools are sicker than either we or the policy carriers expected. Other contributing factors at work are the uncertainty of Medicaid, abuse of special enrollment periods, which contributes to adverse selection.

We would urge Congress to consider legislative proposals to improve the risk of the pools and act before the market deteriorates further.

As far as funding, carriers receiving less with the—I'm sorry, the risk corridor payments have higher-than-expected risk adjustment bills and potentially receiving less reinsurance payments than expected.

And finally, to wrap up, I would like to point out that if the Department of Justice is successful in seeking precedence over policyholders, we will see even more carriers fail as regulators are forced to step in sooner to preserve those dollars for the benefit of policyholders. And I'll look forward to any questions you might have.

[Prepared statement of Mr. Redmer follows:]

Testimony of
Commissioner Al Redmer, Jr., on behalf of
The National Association of Insurance Commissioners

Before the
U.S. House Committee on Oversight and Government Reform

Regarding:
Rising Health Insurance Premiums under the Patient Protection and Affordable Care Act

September 14, 2016
2154 Rayburn House Office Building

Introduction

Good morning Chairman Jordan, Ranking Member Cartwright, and distinguished members of the subcommittee. My name is Al Redmer, and I am the appointed Commissioner of the Maryland Insurance Administration. I want to thank you for inviting me to speak today on behalf of the National Association of Insurance Commissioners (NAIC) about rising health insurance. The NAIC represents the chief insurance regulators of the 50 states, the District of Columbia, and five U.S. territories and we are the primary regulators of health insurance in the United States.

I would like to begin my comments by offering a short historical review of the health insurance market in Maryland, that I believe will add context to our discussion regarding the rate changes coming in January of 2017. In the late 1980's and early 90's, Maryland's health insurance market had conditions similar to those discussed during the debate on the Affordable Care Act (ACA). We had folks that were declined coverage because of pre-existing health conditions and were excluded from the competitive marketplace.

In 1993, the Maryland General Assembly passed small group insurance reform that included provisions similar to those contained in the ACA, such as, guaranteed issue, a ban on pre-existing condition limitations, a standard benefit plan, and adjusted community rating. Initially, those changes created disruptions to the market, but it has evolved into a competitive market that is seeing moderate, single digit premium increases.

With that experience and our knowledge of how health insurance markets work, we knew there would be considerable disruption to the individual market when the ACA was enacted. Adding

guarantee issue subscribers to a medically underwritten pool results in rate instability for a number of years, but eventually there would be equilibrium. Further, with the individual market being historically more transient than the employer sponsored market, with the difficulty in attracting young healthy prospective customers, and with the potential for adverse selection, we projected that the number of years to reach that equilibrium would be longer than it took in the small group market. Unfortunately, due to a variety of factors, that instability has now extended into the fourth year of implementation. Insurance commissioners have some serious concerns about the current condition of the individual health insurance markets in their states and action by Congress and the Administration to address the problems is long overdue.

Summarizing the Status of the Individual Markets in the Various States

I have recently returned from the NAIC National Meeting, a triennial meeting of state regulators, where, among other things, we share information on the condition of our insurance markets; discuss issues that are affecting, or have the potential to affect, insurance sold in our states; and consider model laws and regulations intended to improve market stability and protect consumers. At the National Meeting, state regulators across the country expressed serious concerns about the condition of the individual markets in their states. Major insurance carriers, such as Aetna and UnitedHealth, have pulled out of the Exchanges in several states citing substantial losses in the individual markets they serviced, and some insurance carriers have closed their doors or failed to meet solvency requirements. This means thousands of consumers will need to enroll in a new health plan from a another insurance carrier by December 15th of this year or they will not have coverage on January 1, 2017.

Another consequence of fewer carriers participating on the Exchanges is that in many counties across the United States, especially rural counties, there is only one insurance carrier offering individual coverage on the Exchanges, and there remains the possibility that a county or two may not have any insurance carriers competing on the Exchanges at all – we will not know for sure until the Qualified Health Plan contracts are signed later in September. Furthermore, many insurance carriers are only offering HMO-type health plans with very narrow provider networks in the individual markets, which dramatically reduces the coverage options available for consumers. Finally, my colleagues have reported that insurance carriers servicing the individual markets are requesting premium increases of 30 percent, 40 percent, and in some cases, 50 percent.

I and my colleagues take very seriously our responsibility under state law to ensure all rates are actuarially justified, nondiscriminatory, and sufficient to ensure the carriers remains solvent. All rates submitted by carriers are thoroughly reviewed and, under the ACA, they are more transparent than ever. But, premiums continue to rise, especially in the individual market, and for too many consumers coverage is still unaffordable.

Explaining the Forces that Drive Premium Increases

Rising health care costs, particularly hospital and pharmaceutical costs, are the driving force behind rising health insurance premiums and this must be addressed if health insurance coverage is ever to be truly affordable for the broadest possible group of policyholders.

Another key factor we are seeing, as a result of the ACA and its implementation, is uncertainty. As any actuary will tell you, insurance hates uncertainty. And in regards to health insurance,

particularly in the Federally Facilitated Marketplaces (Exchanges), there is uncertainty in three important areas: 1) risk pools; 2) funding; and 3) regulations.

Risk Pools: The fact that far fewer younger, healthier consumers are enrolling in health plans on the Marketplaces than expected, even with the increasing penalties, means the risk pools are sicker than policymakers and insurance carriers expected. The extension of transition plans through 2017 exacerbated this problem in many states, as these plans are not included in states' single risk pools. Other contributing factors at work here are the uncertainty of Medicaid expansion, the fact that fewer people than projected are moving out of group coverage and into individual coverage, and the frequency and potential abuse of Special Enrollment Periods, which contribute to adverse selection.

State regulators continue to work with the Administration to increase verification of Special Enrollment Period eligibility and to promote participation by younger, healthier consumers. But more must be done if the individual market is to remain viable into the future. There have been several legislative proposals to provide more affordable options for younger people; to encourage more participation in the individual market; and improve the overall risk of the pool. We urge Congress to begin a thorough consideration of these proposals before the market deteriorates further.

Funding: Over the past couple of years, many health insurance carriers have seen their risk corridor payments slashed, have received unexpectedly high risk adjustment bills, and are receiving reduced reinsurance payments, which may be reduced even further. Ironically, the very programs that were designed to bring stability to the markets have actually increased uncertainty,

which has contributed to premium increases in a significant way. In addition, carriers are now waiting for the courts to decide whether they will continue to receive reimbursement from the U.S. Treasury for the lower cost-sharing plans provided to low-income enrollees. They would still be legally obligated to provide these more costly plans, but the courts could prohibit Treasury from reimbursing them without an appropriation.

The NAIC does not have a position as to whether any or all of these changes or legal challenges are appropriate, but the impact on rates and the markets are real and should not be ignored. Uncertain funding streams lead to higher premiums. We need to work together to address these issues and provide more stability.

Regulations: Ever since the health insurance market reforms were put into place in 2014, insurance carriers have been forced to constantly deal with new regulations, annual and mid-year changes to regulations, and new interpretations of existing regulations. All of these changes create confusion and cost money, which in turn increases premiums. The latest example is the 2018 HHS Notice of Benefit and Payment Parameters, which is over 200 pages of proposed policy and process changes that will impact administrative and claim costs. In addition, there are new Mental Health Parity requirements, non-discrimination rules, certification requirements, and Essential Health Benefit benchmarks that must be implemented in 2017. On top of all this, carriers are facing more and more federal oversight that has led to more confusion and more costs. While some of the objectives here may be worthwhile, there appears to be little cost-benefit analysis, and nearly constant tinkering, which again contributes to uncertainty and directly impacts cost.

There must be more stability in the regulations, the interpretation of the regulations, and the oversight. We strongly believe that states are best suited to provide that stability and that every effort should be made to retain states as the primary regulator of insurance and to provide states the flexibility they need to protect consumers and promote stable and competitive markets.

Conclusion

It has been over six years since the ACA was signed into law, and the time is long past due for state and federal policymakers to move past the politics and come together and make substantive corrections to the law to bring about more stable risk pools, dependable funding and reasonable regulations for the individual health insurance markets. The markets are suffering. Let's roll up our sleeves and fix them.

Chairman CHAFFETZ. Thank you.
Mr. Carlson, you are now recognized for 5 minutes.

STATEMENT OF CHRIS CARLSON

Mr. CARLSON. Thank you, Chairman Chaffetz, Ranking Member Cummings, and distinguished members of the committee. Thank you for the opportunity to testify today on the premium rate increases for 2017 in the non-group health insurance market.

My name is Chris Carlson, and I'm a principal in the firm of Oliver Wyman Actuarial Consulting. I'm testifying today on behalf of America's Health Insurance Plans, the national trade association representing health insurance plans and the millions of Americans they serve across the country.

My testimony will focus on three main issues: the evolution of the premium rates on the exchanges, the current factors that are being considered in calculating premium rates for 2017, and policy options for making health insurance premiums more affordable in the long term.

The Affordable Care Act changed many of the rules regarding premium rating that existed prior to 2014, which has allowed for a broad increase in the number of individuals with health insurance and has significantly reduced the uninsured population.

As health plan actuaries, we were preparing the rate filings for exchange products back in 2013 and had limited information available to support the estimates for premium rates due primarily to the considerable amount of uncertainty about the characteristics of the population likely to enroll in the exchange market.

Further, the premium rates for 2015 were developed by actuaries in a manner consistent with 2014. In both cases there was limited amount of data available for the pricing assumptions. Premium rates for 2016 also followed a similar pattern. While there were a wide range of rate changes, both increases and decreases, the average increase for the second-lowest-cost silver plan was 7.5 percent, consistent with underlying medical trend.

To put it simply, health insurance is a reflection of medical care delivery and is priced accordingly. Underlying medical trend has always been the primary driver in the increased cost of health insurance. When costs of delivering medical care go up, so too does the cost of health insurance.

More specifically, some of the key components of the premium rate calculations being considered in developing rates for 2017 include: the underlying medical trend, the risk pool composition, the expiration of two of the three premium stabilization programs, and special enrollment periods.

Actuaries use the experience of the risk pool in setting the premium rates. However, as discussed earlier, the risk pool was relatively unknown when premiums were priced for 2014 and 2015. In general, the actual composition of the risk pool has been less healthy than originally expected.

Another significant factor is the expiration of the transitional re-entrance program, which forces insurers to build these costs into their premiums. Moreover, the temporary risk corridor program has not worked as designed and has led to upward pressure on premium rates.

Oliver Wyman reviewed the impact of special enrollment periods on health insurers and found that individuals that enrolled during SEPs had claim costs that were 24 percent higher during the first 3 months of enrollment than those that enrolled during the open enrollment period, leading to higher health care costs than were anticipated by insurers.

While health insurers are trying to utilize their best estimates of cost to provide health insurance, this continues to be a market in transition. To make health insurance premiums more affordable in the long term, additional action must be taken to address the factors that are driving underlying health care costs.

My written testimony discusses several areas where there are opportunities for legislative and regulatory action to provide relief from rising health care costs and to stabilize the market. I will just name a few, though: strengthening the risk adjustment program to promote greater payment accuracy, improving verification of special enrollment periods, and providing further relief from the health insurer tax. These changes and others will help deliver more affordable coverage and more choices in the marketplace. That's what consumers deserve and that's what health insurance plans are committed to delivering.

Thank you for this opportunity, and I look forward to answering any questions.

[Prepared statement of Mr. Carlson follows:]

Testimony of

Christopher Carlson

Principal and Consulting Actuary

Oliver Wyman Actuarial Consulting

On Behalf of America's Health Insurance Plans

House Committee on Oversight and Government Reform

"Examining the Affordable Care Act's Premium Increases"

September 14, 2016

Washington, DC

Chairman Chaffetz, Ranking Member Cummings, and distinguished members of the Committee, thank you for the opportunity to provide this testimony regarding the premium rate increases requested for 2017 in the non-group health insurance market.

My name is Chris Carlson. I am a Principal in the firm of Oliver Wyman Actuarial Consulting. I am testifying today on behalf of America's Health Insurance Plans (AHIP), the national trade association representing health insurance plans and the millions of Americans they serve across the country.

AHIP's members serve families and consumers in every insurance market, from health and supplemental benefits for businesses and their employees, to individual insurance, to public programs such as Medicare and Medicaid. AHIP advocates for solutions that deliver affordable coverage, more choices, and higher quality to all Americans.

My testimony will focus on three main issues:

- The evolution of the premium rates on the Exchanges;
- The current factors that are being considered in calculating premium rates for 2017; and
- Policy options for stabilizing the market and making health insurance premiums more affordable in the long term.

Historical Experience

The Affordable Care Act (ACA) changed many of the rules regarding premium rating that existed prior to 2014, including guarantee issue which allows individuals with pre-existing conditions to purchase coverage that otherwise would not have been available to them. This has allowed for a broad increase in the number of individuals with health insurance and has significantly reduced the uninsured population from 44.8 million during 2013¹ to the most recent estimates of 27.3 million during the first quarter of 2016.²

The large increase in individuals purchasing health insurance in the non-group market has come with challenges. Although carriers anticipated this growth, when the actuaries were preparing the rate filings for the Exchange products back in early 2013, there was very limited information available to support the estimates for premium rates. This made the initial rate requests very challenging, and we're still feeling the consequences today. Here I provide a brief history of the premium rates in the non-group market.

To begin, I start by looking back to the original expectations for premium rates in the Exchange marketplace. In 2009, the Congressional Budget Office (CBO) responded to Senator Evan Bayh with its expectations for the level of premium rates on the Exchange marketplace beginning in 2014. These estimates reflected the changes in the coverage requirements, the risk pool and rating restrictions required by the ACA. At that time, the CBO expected the average premium in the non-group market to be \$5,800 per year for a single policy which equates to \$483 per month.

It is important to recognize that in most cases I speak in regards to averages. However, the experience also varies greatly from state to state (and even within states). For example, while the average premium

¹ https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease201409_01.pdf

² <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>

rates were lower in 2014 than expected, the rates for the second lowest cost silver plan ranged from \$2,304 in Minnesota to \$5,688 in Alaska.

It was not until several years later that we again had an opportunity to see what kind of premium rates individual policyholders were going to pay on the Exchanges. In October 2013, individuals started enrolling in the Exchange marketplace for the first time. Carriers had developed their rates based on the market rules that had been established in preceding regulations. Many were surprised that the 2014 premium rates were far lower than had been projected by the CBO. A report from HHS's Assistant Secretary for Planning and Evaluation (ASPE) determined that the average cost of the second lowest cost silver plan was \$3,936.³ Not only did many carriers propose premium rates below the CBO estimates, consumers were noticeably cost-conscious and chose plans that offered the lower cost.⁴ However, after carriers were already enrolling individuals in coverage, the Administration announced in November 2013 its transitional policy which would allow consumers to remain on their pre-ACA coverage subject to state regulators and availability.

The premium rates for 2015 were developed by actuaries in a manner consistent with the 2014 premium rates. There was a limited amount of data available, especially in light of the difficulty in enrolling through Healthcare.gov and the extensions of the open enrollment period and the transitional policies. As a result, premium rates in 2015 reflected increases consistent with medical trend. The weighted average increase for individuals that were enrolled during 2014 was 7% assuming that they kept the same plan.⁵

Premium rates for 2016 followed a similar pattern. While there was a wide range of rate increases, from a reduction of 10.6% in Seattle to an increase of 38.4% in Nashville⁶, the average increase for the second lowest cost silver plan was 7.5% for plans on the Federal Exchange.⁷

2017 Premium Rates

The ACA Exchanges will soon begin enrolling individuals for 2017. There has been concern that premium rates will be higher in 2017. I will address the key components of premium rate calculations that actuaries considered in developing premium rates for 2017. These components include:

- Underlying medical trend
- Risk pool composition
- Market turnover
- The expiration of two of the ACA's three premium stabilization programs
- Special enrollment periods
- Health Insurer Tax

³ https://aspe.hhs.gov/sites/default/files/pdf/177626/ib_premiumslandscape.pdf

⁴ <http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-february-2014/>

⁵ http://healthcare.mckinsey.com/sites/default/files/2015%20OEP%20Emerging%20Trends%20-%20McK%20Reform%20Center_0.pdf

⁶ <http://kff.org/health-reform/fact-sheet/analysis-of-2016-premium-changes-in-the-affordable-care-acts-health-insurance-marketplaces/>

⁷ <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-26-2.html>

To put it simply, health insurance is a reflection of medical care delivery – and is priced accordingly. Underlying medical trend has always been the primary driver in the increased cost of health insurance. The trend reflects a number of factors including, but not limited to: increased cost of medical services, increased utilization of services, change in the type of services to more costly modalities (e.g., high-cost prescription drugs), and technological advancements. When the costs of delivering medical care go up, so, too, does the cost of health insurance.

Actuaries use the experience of the risk pool in setting the premium rates. However, as discussed earlier, the risk pool was relatively unknown when premiums were priced for 2014 and 2015, and to some extent in 2016. In general, the actual composition of the risk pool has been less healthy than originally expected. The two primary reasons are the extension of policies through the transitional plans, and lower enrollment than projected. The transitional plans, in states that allowed them, have led to many individuals that otherwise would have enrolled through the Exchanges keeping their non-ACA insurance. These individuals are likely to be healthier since they chose to maintain policies that likely provide less coverage than the benefit-rich plans on the Exchanges.

The annual open enrollment allows consumers to have the opportunity to change their plans to meet their needs. However, this frequent rate of transition is a drawback for insurers because of uncertainty regarding the enrollment in their plans. This uncertainty results in an inability to confidently rely upon the experience of the health plan and requires actuaries to be more conservative in their pricing.

The temporary reinsurance program functions to reduce premiums for consumers in the Exchange. The elimination of this program for 2017 will force insurers to build an additional 4% to 6% into their premiums to reflect that they will not receive any funding to offset large claims. Moreover, the temporary risk corridors program also has not worked as originally designed, which has led to upward pressure on premiums.

Oliver Wyman reviewed the impact of the special enrollment periods on health insurers.⁸ We found that individuals that enrolled during the special enrollment periods were higher cost than those that enrolled in the open enrollment period. Whether this was intentional by the consumers to take advantage of lax oversight, or endemic of those that required the special enrollment periods, it led to far higher health care costs than were anticipated by the health insurers.

While health insurers are trying to utilize their best estimates of the cost to provide health insurance, this continues to be a market in flux. The membership is fluid and continues to grow as more people sign up for non-group insurance. However, there is more that can be done to maintain a stable and affordable market for consumers. I discuss some policy decisions that could help move toward this goal in the next section.

Policy Options to Stabilize the Market

To make health insurance premiums more affordable in the long term, additional action must be taken to address the factors that are driving underlying health care costs. While the Administration has taken positive steps in key areas – tightening the rules for special enrollment periods (SEPs), improving risk

⁸ <https://www.ahip.org/wp-content/uploads/2016/03/Oliver-Wyman-Analysis-of-SEP-Enrollment-in-ACA-Nongroup-Market.pdf>

adjustment, and targeting outreach to the uninsured – much more needs to be done. Below I discuss several areas where there are opportunities for legislative and regulatory action to provide relief from rising health care costs and to stabilize the market.

Strengthening the risk adjustment program to promote greater payment accuracy: The ACA risk adjustment program plays an important role in promoting market stability, a level playing field, and affordable coverage for consumers in the marketplace – particularly for patients with chronic health conditions. Additional targeted changes to improve the accuracy and effectiveness of the model – such as better accounting for the effects of partial year enrollment and including prescription drug data in the model – can help strengthen the risk adjustment program so it can better fulfill its goals of promoting affordability and stability in the new marketplace. I appreciate that the Administration has addressed this in its proposed rule for the 2018 Notice of Benefit and Payment Parameters.

Improving verification of SEPs: While the Administration has taken steps to address the misuse of SEPs, more action is needed to assure appropriate use of SEPs – which is critical to assuring stability in the new Exchange marketplaces and promoting affordability for consumers. HHS has clarified the availability of certain SEPs – notably, tightening the eligibility requirements for most instances of permanent move by requiring prior coverage – to limit potential abuse. Earlier this year, the Administration also announced that it would conduct an assessment of enrollments made through SEPs. Additional policy steps include further streamlining and reducing the number of SEPs and implementing pre-enrollment verification for high-priority SEPs (such as permanent move and loss of minimum essential coverage). AHIP supports a House bill, H.R. 5589, which would implement a pre-enrollment verification process for SEPs.

Promoting stability and flexibility in benefit and network design to promote consumer choice and affordability: Benefit design flexibility is a hallmark of private sector coverage, and innovations in benefit and network design can help promote affordability and value for consumers in the new marketplace. Moreover, flexibility in network design – including the ability of plans to offer high-value network plans – provides consumers with a broader range of affordable health plan choices and providers that meet their own financial and health care needs.

Enhancing the effectiveness of outreach and enrollment strategies to build on coverage gains: Expanding participation in the new marketplace – including through more targeted educational and outreach efforts to subsidy-eligible individuals – can not only build on the progress made in reducing the number of uninsured, but can also help stabilize the risk pool and promote more affordable premiums.

Providing further relief from the health insurance tax: In December 2015, Congress approved bipartisan legislation providing for a one-year suspension, in 2017, of the ACA health insurance tax. An analysis by Oliver Wyman⁹, commissioned by AHIP, estimates the following per enrollee premium savings, for each market segment, that will result from suspension of the ACA health insurance tax in 2017: \$350 for Medicare Advantage enrollees; \$270 for small business employees; \$250 for employees of large businesses; \$210 for consumers who buy coverage in the individual market; and \$150 for state Medicaid programs. Looking ahead, Congress has an opportunity to further improve the affordability of coverage for consumers by suspending the health insurance tax for an additional year in 2018 and

⁹ Oliver Wyman, Estimated Impact of Suspending the Health Insurance Tax from 2017-2020, December 16, 2015

eventually taking action to fully repeal this tax. Under the ACA, the total dollar amount of the health insurance tax is set at \$14.3 billion in 2018. Unless Congress takes action, this massive tax bill will be passed onto consumers in the form of higher premiums. AHIP strongly supports a bipartisan House bill, H.R. 928, which calls for the full repeal of the health insurance tax. This bill has been cosponsored by 236 House members.

Allowing states to set their own age rating bands: AHIP supports a House bill, H.R. 5921, which would amend the ACA to allow states to set their own age rating rules. The flexibility granted to states under this bill would promote more affordable coverage and expand participation among younger, healthier individuals. The ACA established 3:1 age rating bands that led to higher premiums for certain younger consumers – particularly those who purchased individual market coverage prior to the ACA and/or are not currently eligible for subsidies. Providing flexibility for states to adopt wider age bands could encourage younger and healthier people to enroll in coverage. This, in turn, could improve affordability for consumers by promoting greater stability of the risk pool.

Recognizing fraud prevention programs as quality improvement activities: Health plans devote significant resources to fraud prevention and detection programs as part of a broad-based strategy for improving health outcomes and achieving the optimal use of health care dollars. These programs employ innovative techniques to identify fraud and halt practices that lead to substandard care – including the delivery of inappropriate or unnecessary services that may harm patients. The federal government also is refocusing its anti-fraud efforts to emphasize prevention, moving away from the “pay and chase” approach used in the past. Accordingly, the regulations for the ACA’s medical loss ratio (MLR) requirement should be revised to recognize investments in fraud prevention programs as quality improvement activities, rather than administrative expenses.

Aligning the grace period with state law and regulation: AHIP supports a House bill, H.R. 5410, which would align the current grace period for recipients of advanced premium tax credits (APTC) with existing state law and regulation. Under current law, Exchange enrollees who receive the APTC are provided with a three-month grace period before coverage is discontinued if they are delinquent on their premium payment, and health plans are required to pay health care claims during the first month of the grace period. Current law should be amended to make the grace period requirements consistent with existing state rules, most of which currently allow for a 30-day grace period. This legislation could help promote continuous coverage and consumer affordability by improving the stability of the risk pool.

Preventing third party payments that skew the risk pool: There is concern that the risk pool is skewed when pharmaceutical companies, providers and other organizations are allowed to pay premiums on behalf of Exchange enrollees or inappropriately steer high-cost Medicare and Medicaid eligible individuals to the private market to maximize their reimbursement. These practices result in a risk pool that is weighted more heavily with older and less healthy people – thereby driving up premiums for everyone and destabilizing the market. AHIP has urged CMS to issue regulations to prevent third party payments by, or on behalf of, entities with a financial interest in the payment of health insurance claims, and prevent the selective shifting of Medicare and Medicaid beneficiaries into private coverage.

Improving Health Savings Accounts (HSAs): AHIP supports a House bill, H.R. 5445, which proposes three important policy changes that would allow consumers to maximize the value they get from their HSAs: (1) increasing the annual limit on the amount account-holders are permitted to contribute to their

HSAs; (2) allowing consumers the flexibility to use HSA funds to pay medical expenses incurred in the 60-day period before the account was established; and (3) allowing both spouses to make “catch-up” contributions to the same HSA. These improvements would be beneficial to the growing number of Americans who rely on HSAs to accumulate savings for their future medical needs and take a more active role in making decisions about their health care.

These changes will help deliver more affordable coverage – and more choices – in the Marketplaces. That’s what consumers deserve – and that’s what health insurance plans are committed to delivering.

Mr. MEADOWS. [Presiding.] Thank you, Mr. Carlson.
Mr. Giesa, you are recognized for 5 minutes.

STATEMENT OF KURT GIESA

Mr. GIESA. Chairman Chaffetz, Ranking Member Cummings, and distinguished members of the committee, thank you for allowing me to be with you this morning to provide testimony related to the rising premiums in the Patient Protection and Affordable Care Act.

I'm here today on behalf of the Blue Cross Blue Shield Association. The association is a national federation of 36 independent community-based and locally operated Blue Cross and Blue Shield companies that collectively provide health care to more than 107 million members. Blue Cross and Blue Shield plans have an 85-year history of providing individual health insurance coverage in local communities across the United States.

Issuers and their actuaries face extraordinary challenges in setting premiums in the non-group market, which I described in my written testimony. Two thousand seventeen will be the first year that issuers are setting premiums in the non-group market based on a relatively thorough understanding of the health of that market, meaning the makeup of the people they are insuring.

But issuers have come to understand that the people they have enrolled are older and sicker than they had initially assumed. In its report titled "Health of America," The Blue Cross and Blue Shield Association found, for example, that the prevalence of HIV is four times higher and the prevalence of hepatitis C is twice as high as the prevalence of these diseases in the employer group market. Inpatient hospital admissions are 40 percent higher, and allowed costs per member are 22 percent higher.

In my written testimony I present data showing that almost half the enrollees in the exchange are ages 45 or older. That was in 2014, and that situation persists today in spite of the growth in the non-group market.

In order to create a viable and sustainable marketplace, younger, healthier individuals will need to enroll, which will require changing the value equation for younger people purchasing coverage. Congress and the administration could take steps to ensure the long-term viability of this market by improving the verification of eligibility for special enrollment provisions and making other changes to encourage continuous enrollment. In addition, Congress should make changes to the age band structure and the premium tax credits to encourage more and younger, healthier people to enroll.

Again, thank you and I look forward to the discussion this morning.

[Prepared statement of Mr. Giesa follows:]



Testimony before the Committee on Oversight and Government Reform
September 14, 2016

Kurt Giesa, FSA, MAAA

Rising Health Insurance Premiums under the Patient Protection and Affordable Care Act (ACA)

Introduction

Chairman Chaffetz, Ranking Member Cummings, and distinguished members of the Committee, thank you for allowing me to present this written testimony to you regarding premium increases under the ACA.

My name is Kurt Giesa. I am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries and I meet that body's qualification standards for providing this testimony. I am also a Partner in the firm of Oliver Wyman Actuarial Consulting, though this testimony reflects my views and opinions and not necessarily those of my employer.

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

My testimony will focus on the non-group market and will discuss some of the major changes the ACA brought to that market and some of the ways in which the ACA introduced significant challenges to issuers and their actuaries in setting premiums. I will also discuss the impact the actual morbidity of the single risk pool has had on issuers' premiums for 2017, and I will provide some thoughts on steps Congress and the Administration could take to stabilize the market.

Background

Issuers and their actuaries faced extraordinary challenges in setting non-group ACA premiums going into 2014, the first year of the major insurance rating reforms in the non-group market.¹ In most states prior to 2014, issuers were able to take an individual's health status, age, gender, and other relevant factors into account in setting non-group premiums. As a result, issuers were able to charge premiums based on expected costs. Matching

¹ Swenson-Moore, Karin, "Implementing the ACA: An Actuarial Perspective," The Actuary Magazine, December 2013/January 2014 – Volume 10, Issue 6

premiums to expected costs had several consequences. Underwriters were able to produce a relatively stable risk pool, and because actuaries had been accumulating experience on these relatively stable risk pools over time, they were able to set premiums at a level that was generally sufficient to cover actual costs. At the same time, prior to 2014, coverage was difficult to obtain in the traditional non-group market for those individuals with significant health burdens, although most states had mechanisms to assure these individuals had access to coverage through alternative sources, including state high risk pools.²

Beginning in 2014, the ACA required issuers offering coverage in the non-group market to make that coverage available to anyone during the open enrollment period, including those individuals who had obtained their coverage through state high risk pools, and to anyone qualifying for a special enrollment period.³ Premiums for new products in the non-group market can now only vary by family status, age, though not by more than 3:1 for adults, rating area, and tobacco use, though not by more than 1.5:1.⁴ The ACA requires all issuers to cover ten "Essential Health Benefits," and to offer coverage at one of four "metal" levels.⁵ In addition to greater transparency, these provisions of the ACA have resulted in consumers purchasing coverage that is generally more generous, and more costly, all other things equal, than had typically been purchased in the non-group market prior to these requirements.⁶

Challenges Associated with Setting Premiums in 2014, 2015, and 2016

Issuers had to prepare premium rates for calendar year 2014 in April of 2013. Because of the significant changes to the operation of the non-group market going into 2014, and the significant uncertainty around the size and health of the non-group risk pool, issuers and their actuaries made educated guesses regarding appropriate premium levels. Regulations were being finalized as issuers were working to develop premiums, and several events that occurred after premiums were submitted had significant, negative impacts on the adequacy of issuers' 2014 premiums. These included the difficulties individuals had enrolling through federal and many state exchanges,⁷ the Administration's decision to give states the authority to allow policies that had been issued prior to October 1, 2013 to renew in 2014, so that these insureds could remain outside of the single risk pool, Congress' decision not to fund the risk corridors program, and the expansion and lax enforcement of special enrollment

² In 2011, roughly 225,000 individuals were covered under state high risk pools. "Comprehensive Health Insurance for High-Risk Individuals: A State-by-State Analysis." National Association of State Comprehensive Health Insurance Plans

³ ACA, §1201

⁴ Ibid.

⁵ ACA, §1302

⁶ Gabel, R., et al., "More than Half of Individual Health Plans Offer Coverage that Falls Short of What Can Be Sold through Exchanges as of 2014," Health Affairs, June 2012, vol. 31, no. 6, 1339-1348

⁷ Pear, Robert. "Insurers Claim Health Website is Still Flawed", New York Times, December 1, 2013.
<http://www.nytimes.com/2013/12/02/business/white-house-praises-gains-on-health-site.html>

periods. If issuers had full knowledge of these developments when they were setting premiums in 2013, premiums would have certainly been higher.

Issuers were required to submit exchange premiums for 2015 in June 2014 in most states. Due to the lag between when claims are incurred and when they are processed and paid, most issuers were likely finalizing 2015 premium rates in May 2014 using actual claims experience through only March 2014. Given the difficulties individuals had enrolling through HealthCare.gov and some state-based exchanges, the potential for pent-up demand among the previously uninsured, and the fact that issuers had very limited knowledge of the impact that risk adjustment would have on their financial results,⁸ issuers were again forced to set premium rates for 2015 with very little relevant information.

For 2016, issuers had to submit exchange premiums by May 2015 in most states. Again, issuers were likely finalizing premiums in April using claims incurred through February 2015. In other words, issuers likely had full knowledge of a very turbulent 2014, and very little knowledge of 2015, but given emerging experience, and the losses issuers were reporting in 2015 on their 2014 non-group business, issuers were coming to understand that premiums in 2015 were likely to be understated.⁹

CMS required issuers to make other changes to their policies that caused premiums to increase for 2016, including the application of self-only maximum out-of-pocket limits to each member of a family and changes to prescription drug coverage. In addition, the Shared Responsibility Payment, or ACA penalty, for not maintaining coverage increased significantly in 2016.¹⁰ The effect of these changes on the cost of providing coverage and the make-up of the single risk pool was uncertain.

Health of the Single Risk Pool

2017 will be the first year that premiums in the non-group market will be based on a relatively thorough understanding of the make-up of the single risk pool. It is smaller than many initially thought it would be, and the enrollees are older, and less healthy than is needed for a stable pool.

Earlier this year, BCBSA released its *Health of America* Report on the cost of those insured under the ACA. BCBSA found that those non-group members who were newly insured under the ACA have a higher disease burden, use more services, and cost more to insure than those covered in the employer group market and also than those covered in the non-group

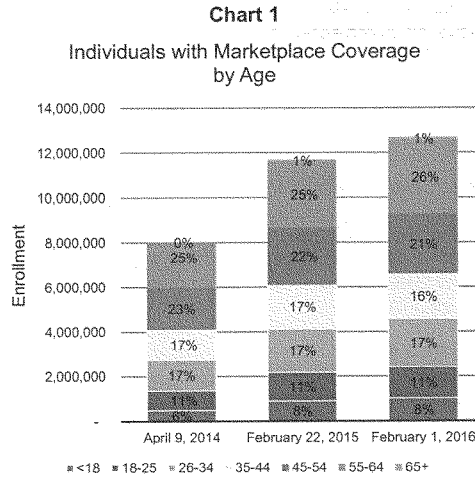
⁸ Actual risk adjustment transfers were made available to issuers on June 30, 2015. Risk adjustment transfer payments had a significant impact on issuer's financial results. The absolute value of risk adjustment transfers in the non-group market was equal to 10% of total premium.

⁹ Author's calculations based on annual statement information, ASPE reports on Exchange enrollment, and CMS data on the impact of the transitional policy on the risk corridors payments (http://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/rc_transitionaladjguidance_5cr_041715.pdf)

¹⁰ <http://obamacarefacts.com/individual-shared-responsibility-payment/>

market prior to the ACA. The report shows, for example, that the prevalence rates of HIV and hepatitis C that are roughly 400% and 200% higher respectively than those covered in the employer group market. Inpatient hospital admissions are roughly 40% higher for the newly insured than those covered in the employer market, and allowed costs per member are 22% higher.¹¹

In the chart below, we show that while there was significant growth in the Exchange market between 2014 and 2016, increasing from 8.0 million to 12.7 million in 2016, most of that growth came in 2015 and the growth slowed considerably in 2016. Further, the chart shows that in spite of this growth, the demographics of the population changed very little.¹² We note that the size of the non-group market is considerably lower than many analysts expected.^{13,14}



¹¹ BlueCross BlueShield and BHI, "The Health of America Report: Newly Enrolled Members in the Individual Health Insurance Market after Health Care Reform: the Experience from 2014 and 2015." March 2016. <http://bcbs.com/healthofamerica/>

¹² This chart is taken from the following article: Armour, Stephanie and Radnofsky, Louise. "Health Law Faces Key Time – Officials Look to Enroll More Healthy People During this Year's Critical Sign-up Period." The Wall Street Journal, September 8, 2016, page A3.

¹³ Jost, Timothy. "CBO Lowers Marketplace Enrollment Projections, Increases Medicaid Growth Projections (Updated)." Health Affairs Blog, January 26, 2016. <http://healthaffairs.org/blog/2016/01/26/cbo-lowers-marketplace-enrollment-projections-increases-medicaid-growth-projections/>

¹⁴ Haight, Randy and Aherns, John. "Cost of the Future Newly Insured under the Affordable Care Act (ACA)." Society of Actuaries. March 2013

Data from the U.S. Census Bureau shows that in 2013, individuals age 45 to 64 made up 29% of the uninsured population.¹⁵ In 2016, the chart above shows that this cohort made up 47% of the Exchange market.

Two provisions of the ACA work to produce an older risk pool. These are the Advance Premium Tax Credits ("APTCs," or subsidies) that lower-income individuals receive to offset the cost of purchasing insurance, and the 3:1 age curve. The APTCs are structured such that an individual's or family's cost for the second-lowest-cost silver plan is limited to be no more than a specified percentage of their household income, which is defined as a percentage of the Federal Poverty Level ("FPL"). The percentage of household income an individual or family must pay towards the cost of coverage decreases as household income decreases, but does not vary by age.

The structure of the APTCs and the 3:1 age banding alter the value equation for individuals to purchase coverage by making it more attractive for older individuals (who would naturally be motivated to purchase coverage because they generally have more health care needs) to buy coverage while making insurance less attractive for younger purchasers (who may not be inclined to purchase insurance in the first place because they are generally in much better health). In Table 1, we show the ratio of the value of the insurance being purchased to the net cost of insurance after APTCs by age and FPL.

¹⁵ Smith, Jessica and Medalia, Carla. "Health Insurance Coverage in the United States: 2013." U.S. Census Bureau. September 2014. <https://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-250.pdf>

Table 1
 Actuarial Premium Relative to Out-of-Pocket Cost of Coverage
 by Age and FPL

	Age		
	Age 24	Age 44	Age 64
Actuarial Premium	\$ 133.87	\$ 263.51	\$ 593.70
ACA Premium (3:1 Age Slope)	\$ 183.51	\$ 256.37	\$ 550.53
Out-of-Pocket Cost of Coverage after APTCs by FPL			
150% FPL	\$ 58.64	\$ 58.64	\$ 58.64
250% FPL	183.51	196.93	196.93
350% FPL	183.51	256.37	325.40
400%+ FPL	183.51	256.37	550.53
Actuarial Premium Relative to Out-of-Pocket Cost by Age and FPL			
150% FPL	2.28	4.49	10.12
250% FPL	0.73	1.34	3.01
350% FPL	0.73	1.03	1.82
400%+ FPL	0.73	1.03	1.08

At the top of Table 1, we show premiums that would be roughly representative of premiums in the market in 2015 if premiums were not restricted to 3:1 for age.¹⁶ In the next row, we show premiums using the same market wide average premium as in the first row, but now restricted to 3:1 for age using the HHS prescribed age curve. In the middle of the table, we show the individual's out-of-pocket cost for coverage after the APTCs based on the FPL and applicable percentages for 2015.

The 24 year-old at 150% FPL receives an APTC that lowers the cost of coverage to \$58.64, but because the applicable percentage of income for individuals at 250% of FPL and above is greater than the premium at age 24, 24 year-olds must pay the entire premium at the higher FPLs, as illustrated.

At the bottom of the table, we show the ratio of the age-specific actuarial premium (the actual cost of covered health care benefits for someone of that age) to the out-of-pocket cost of coverage to illustrate how the value equation changes for consumers at different ages and income levels.¹⁷ At 250% FPL, for example, the ratio for a 24 year-old is equal to 0.73. This means that for every \$1.00 they pay out-of-pocket for coverage, they receive \$0.73 in value. At age 64, the ratio is 3.01; for every \$1.00 a 64 year-old at 250% FPL pays towards coverage, they receive \$3.01 in value. Even above 400% FPL, where APTCs are not

¹⁶ The age slope for these actuarial premiums is taken from "Health Care Costs – From Birth to Death." Yamamoto, Dale. Society of Actuaries. June 2013. <https://www.soa.org/Files/Research/Projects/research-health-care-birth-death-report.pdf>

¹⁷ Note that we have not factored in the value of cost sharing reduction subsidies or the penalties for not maintaining coverage in this analysis to simplify the presentation.

available, 64 year-olds receive more value from purchasing coverage than the out-of-pocket cost of that coverage due to the 3:1 age banding.

While the subsidy structure and age bands are not the only provisions of the ACA that impact the price of insurance for younger people (benefit structure and other rating rules are also important), these examples illustrate why it has been more difficult for health plans and exchanges to enroll the younger, healthier population that is needed for a balanced risk pool.

Stabilizing the Single Risk Pool

Health plans have worked to better manage the cost of the population enrolled in the ACA risk pool by introducing new products and networks tailored to the exchange population. Given the rate of high cost conditions for new enrollees in the individual market, plans are using care coordination and medical management tools to help people with complex conditions get the care they need in the most effective and efficient manner. BCBS companies are expanding patient-focused care programs that emphasize prevention, wellness and coordinated care so that individuals get healthy faster and stay healthy longer. BCBS companies have engaged with more than 327,000 physicians and 2,000 hospitals that now serve 42 million members through these innovative care models.

Congress could help to stabilize the health of the single risk pools and assure the long-term viability of the markets by encouraging continuous coverage and adjusting the rating and subsidy structures to change the value equation for young people.

Specifically, Congress could pass legislation to accomplish the following:

- Ensure individuals are eligible for a special enrollment period before enrolling;
- Align grace periods for non-payment of premium with state requirements;
- Allow issuers to reward insureds for maintaining continuous coverage through benefit designs and other means;
- Make coverage more attractive to younger insureds by redesigning the subsidy structure to more accurately reflect younger consumers' lower demand for health insurance;
- Modify age variation in premium rates to 5:1 or a rate set by a state; and
- Repeal the health insurance tax (or at a minimum extend the moratorium) to prevent a 3% premium increase starting in 2018.

The Administration could help to stabilize the health of the single risk pool by improving its outreach efforts to younger, uninsured Americans, by working with plans to both avoid over-burdensome regulation and assure that appropriate premium increases are approved by state regulators, and by providing a stable regulatory environment.

The Administration could also take the following administrative action to help stabilize the market:

- Require upfront verification of special enrollment period eligibility prior to coverage;
- Require payment of outstanding premiums before re-enrolling on the exchange; and

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- Issue a final rule to stop the inappropriate steering of Medicare and Medicaid eligible individuals to private coverage.

I appreciate the opportunity to present this testimony and I welcome any questions you may have.

Thank you.

Mr. MEADOWS. Thank you.
Mr. Spiro, you are recognized for 5 minutes.

STATEMENT OF TOPHER SPIRO

Mr. SPIRO. Thank you.

When evaluating the status of ACA markets, context is important. Before the ACA, the individual market was volatile, and people in rural areas do not have much choice. The difference is that this market did not work at all for anyone who was sick. Even as the ACA put in place consumer protections, the average benchmark premium in 2014 was 10 percent lower than the average benchmark premium in 2013. The rate of the uninsured is now at historic low, giving more peace of mind to an additional 21 million Americans.

Contrary to popular perception, the ACA risk pool is stable and improving. From 2014 to 2015, the cost per enrollee in exchanges actually fell by .1 percent. So this begs the question, why are insurers increasing premiums substantially? Well, when the new markets launched in 2014, insurers significantly under-priced premiums. There was a lot of uncertainty about pricing, and some insurers under-priced premiums to establish a foothold. As a result, the average benchmark premium came in 15 percent lower than the CBO had projected.

Congress also constrained the risk corridor program, which was designed specifically to address pricing uncertainty in a new market. Congress did so after insurers had already priced their plans for 2015 and 2016. The resulting shortfall is responsible for about two-thirds of the financial losses incurred by insurers in 2014.

Premium increases in 2015 and 2016 were not sufficient to close the gap from 2014. Compounding the problem, the reinsurance program began to phase out in 2015. So it is not surprising that the markets are due for a correction in 2017. Although this correction will be significant, the ACA's subsidy structure will act as a stabilizing force. Even after the correction, premiums will still be 11 percent lower than average premiums would have been in the absence of the Affordable Care Act.

Even though ACA markets are not in crisis, policymakers should take additional actions to accelerate the transition to equilibrium. The administration should err on the side of caution, acting as urgently and proactively as possible.

First, the administration should verify eligibility for special enrollment periods, and in my written testimony I detail several important conditions and consumer protections that would be necessary.

Second, the administration should quickly prohibit providers from steering high-cost patients from Medicare and Medicaid to the exchanges.

Third, States should establish their own reinsurance programs. Under innovation waivers, the administration should offer States the Federal savings that would result from lower premium tax credits to help pay for this reinsurance.

Fourth, the administration and States should expand rating areas to cover larger geographical areas. In States that have a mixture of rural and urban areas, this policy option would provide greater choice in rural areas.

Fifth, States should require all plans to be sold through the exchange. Although there is a single risk pool for each insurer, insurers that sell plans only outside of the exchange steal enrollees who might help broaden the risk pools of other insurers.

Sixth, States that have not done so should expand their Medicaid programs. In States that expanded Medicaid, ACA market premiums are about 7 percent lower than in States that did not.

Seventh, the government should use active purchasing to get the best deal from insurers for all programs. Insurers that profit from participation in Medicaid and Medicare Advantage should be willing to participate in the exchanges.

Eighth, Congress should create a guaranteed choice plan. In perhaps less partisan times, Congress created a fallback option in the Medicare prescription drug program.

Ninth, Congress should tackle the high cost of specialty drugs, as Mr. Cummings mentioned. This is one of the biggest factors cited by large insurers for leaving ACA markets.

Tenth, Congress should increase cost-sharing subsidies to lower deductibles and increase premium tax credits for young and middle-income people.

But most of all, the administration, Congress, States, insurers, and other stakeholders should act in a constructive spirit to fix any problems that arise rather than root for failure or cut and run. Thank you.

[Prepared statement of Mr. Spiro follows:]

Affordable Care Act Markets Will Remain Viable After a One-Time Correction in 2017

Policy improvements can accelerate the transition to equilibrium

Testimony of Topher Spiro
Vice President for Health Policy, Center for American Progress
U.S. House of Representatives Committee on Oversight & Government Reform
September 14, 2016

Thank you for the opportunity to testify today about the status of Affordable Care Act (ACA) markets. Contrary to hyperbolic media coverage, the Affordable Care Act is not in crisis. As a result of underpricing by insurers in early years, and the phase-out of mechanisms to stabilize risk, the markets are undergoing a one-time correction in 2017. Even so, additional policy measures would be prudent to accelerate the transition to equilibrium.

Comparison with pre-ACA markets

When evaluating the status of ACA markets, context is important. Before the ACA, the individual market was volatile and people in rural areas did not have much choice.

The difference is that this market did not work at all for those who needed it. Insurers charged women, older people, and sick people much higher premiums; they restricted or denied coverage entirely for people with pre-existing conditions; they charged consumers much more in deductibles and other out-of-pocket costs; and they did not cover essential benefits such as prescription drugs, mental health care, and maternity care. People with pre-existing conditions were quarantined into severely underfunded high-risk pools.

Even as the ACA put in place consumer protections to address these issues, and enhanced the value of coverage, the average benchmark premium in 2014 was 10 percent *lower* than the average individual market premium in 2013.¹ In other words, people are getting more coverage for less money.

Millions more people have better financial protection. Although more work needs to be done to increase enrollment, more than 18 million people are enrolled in ACA markets as of March 2016.² This estimate is comprised of 11.1 million enrolled in ACA-compliant plans through exchanges and about 7 million people enrolled directly in ACA-compliant plans.³ Along with the ACA's expansion of Medicaid coverage, this enrollment has driven the rate of the uninsured to a historic low – giving peace of mind to an additional 21.3 million Americans.⁴

One-time correction in 2017

Contrary to popular perception, the ACA "risk pool" – the balance of healthy and sick enrollees – is stable and improving. From 2014 to 2015, the cost per enrollee in exchanges actually fell by 0.1 percent.⁵ The reason is that total enrollment increased by 66 percent in 2015, resulting in a broader risk pool. Although data is not yet available for 2016 and results vary by state, this data is a good sign.

This begs the question: why are insurers increasing premiums substantially or withdrawing from markets?

When the new markets launched in 2014, there were new insurers, new market rules, and a new consumer population. Insurers did not have experience or claims data to accurately price their products. In addition, the markets were hyper-competitive as insurers jockeyed to establish a foothold.

As a result of these factors, insurers significantly underpriced premiums in 2014. The average benchmark premium came in 15 percent lower than the Congressional Budget Office (CBO) had projected.⁶ According to a study by the Commonwealth Fund, insurers' actual costs turned out to be 6 percent higher than they had projected.⁷ The reinsurance program, which reimburses insurers for the costs of high-cost enrollees, helped to cushion this shortfall.⁸

However, the risk corridor program – which was designed specifically to address pricing uncertainty in a new market – did not.⁹ This is because Congress constrained the program and prevented it from operating as intended. Moreover, Congress did so *after* insurers had already priced their products (for both 2015 and 2016) under the assumption that they did not need to be overly conservative.¹⁰ The resulting risk corridor shortfall is responsible for about two-thirds of the financial losses incurred by insurers in 2014.¹¹

The average benchmark premium increased by only 2 percent in 2015 and 7.2 percent in 2016.¹² These increases were not sufficient to close the gap from 2014. Compounding the problem, the reinsurance program began to phase out in 2015 and 2016. As a result of these factors, the gap between actual premiums and expected premiums widened to 20 percent.¹³

Nonetheless, there are signs that insurer financial performance is improving. Whereas not-for-profit Blue Cross plans had an operating loss of 1.1 percent in 2015, they now have an operating profit of 1.5 percent as of the second quarter of 2016 – driven by improvement in their ACA exchange business.¹⁴

Which brings us to 2017. It is not surprising, given the context discussed above, that the markets are due for a correction.¹⁵ For 2017, the average benchmark premium is expected to increase by about 10 percent.¹⁶ Although this correction is significant, the ACA's subsidy structure will hold harmless many consumers and act as a stabilizing force.¹⁷ Even after the correction, premiums will be still be much lower than the CBO had projected and 11 percent lower than average individual market premiums would have been in the absence of the Affordable Care Act.¹⁸

The financial losses of insurers must also be viewed in context. Losses are normal and to be expected whenever a business enters a new market. As Aetna CEO Mark Bertolini explained recently, Aetna's losses are well below what it would have normally cost the company to expand its business.¹⁹ (In Pennsylvania, where Aetna is withdrawing, it is even profiting.²⁰)

Policy options to accelerate equilibrium

Even though ACA markets are not in crisis, with no risk of a death spiral, policymakers should take additional actions to accelerate the transition to equilibrium.

When evaluating policies to further stabilize the risk pool, the administration should err on the side of caution in the short term – acting as urgently and proactively as possible. For their part, to build trust and provide focus, insurers should refrain from opportunistically seeking policy changes that are not absolutely necessary. With this preface, the following menu of policy options should be considered:

The administration should verify eligibility for Special Enrollment Periods (SEPs).

There is some evidence that some individuals are enrolling in exchange plans through SEPs when they are not eligible. For instance, some individuals who applied through SEPs outside of the exchange, but who did not submit any proof of eligibility, subsequently enrolled through the exchange.²¹ Although there is no evidence yet that this sort of gaming is widespread, even a small number of high-cost individuals can affect the risk pool. Actuaries believe that verification of SEP eligibility could lower premiums by 2-5 percent.²²

In designing and implementing a verification process for SEP eligibility, the administration should adopt the following guidelines:²³

- Verification should only be required when the necessary documentation is easy to provide, such as a utility bill. In the case of the SEP for loss of prior coverage, when individuals leave a plan, insurers should be required to provide a notice that documents the loss of coverage and advertises the opportunity to enroll in exchange coverage through an SEP. If insurers are unwilling to provide this notice, verification for this SEP should not be required.
- Ultimately, verification should only be required when it can be carried out electronically (including through “real time” data checks where possible). Until this system is ready, insurers could be allowed to verify documents and submit a recommendation on eligibility to the exchange, which would retain responsibility for the eligibility determination and appeals.
- If insurers do not make a recommendation to the exchange within 15 days, the applicant is enrolled in coverage.
- Once an applicant’s eligibility is verified, coverage is effective when it otherwise would have been – retroactively if necessary.

With verification, insurers should have confidence that any gaming has been eliminated. For their part, they should then re-instate broker fees for enrollment through SEPs. The administration should enforce parity between broker fees paid for open enrollment and broker fees paid for special enrollment.

The administration should quickly enforce a prohibition against third-party payments from financially interested providers who are steering high-cost patients from Medicare and Medicaid to the exchanges.

For instance, dialysis providers are paying for their patients to receive coverage through exchange plans instead of Medicare. This is significant because dialysis can cost commercial insurance hundreds of thousands of dollars per patient per year.

The administration should continue to refine risk adjustment so that transfers accurately reflect actual costs.

Although costs per enrollee may be stable market-wide, insurers that suffered large financial losses may have attracted a greater share of sick enrollees. The administration has proposed several improvements to the risk adjustment methodology, such as including the cost of prescription drugs.²⁴

In 2014, CMS reported that its risk score model under-predicts actual costs for adults with the lowest costs (by 17 percent for silver plans and by 29 percent for bronze plans) and over-predicts actual costs for adults with the highest costs.²⁵ CMS should adjust its risk score model accordingly to remove this bias or explore retrospective reconciliation using actual claims data.

Because risk adjustment payments are based on the average premium, which includes administrative costs, the formula inflates the amount of transfers, penalizing more efficient plans with lower-than-average administrative costs. CMS should remove administrative costs from the formula.

Finally, CMS must speed up the timing of the process to release more information before insurers price their plans for the following year.

States should establish their own reinsurance programs, with help from federal savings.

In June, Alaska passed legislation establishing a new reinsurance fund.²⁶ This was necessary because Premera, the only insurer remaining in the state, paid out 24 percent of its claims for just 37 high-cost enrollees.²⁷ After enactment of the reinsurance fund, Premera lowered its proposed premium increase for 2017 from 40 percent to 9.8 percent.²⁸

Under Section 1332 Innovation Waivers, the administration should offer states the federal savings that would result from lower premium tax credits to help pay for reinsurance. The administration should quickly issue a template or guidelines to advertise this opportunity and assist states in carrying it out.

The administration and states should expand rating areas to cover larger geographical areas.

The decline in insurer participation and consumer choice is concentrated in rural areas.²⁹ In states that have a mixture of urban and rural areas, this policy option would provide greater choice in rural areas. Eleven states and the District of Columbia already either have a single rating area or limit variation in premium rates across areas.³⁰ The administration should set a minimum size of rating areas based on population.

States should prohibit insurers from selling plans exclusively outside of the exchange – or go further and require all plans to be sold through the exchange.³¹

Off-exchange plans have higher administrative costs than on-exchange plans.³² Although there is a single risk pool for each insurer, insurers that sell plans only outside of the exchange in effect steal enrollees who might help broaden and balance the risk pools of other insurers.

States that have not done so should expand their Medicaid programs.

In states that expanded Medicaid, ACA market premiums are about 7 percent lower than in states that did not.³³ This is because in states that did not expand Medicaid, people with income between 100-138 percent of poverty (a population with poorer health) are included in the exchange risk pool. It is no coincidence that the “states left with the most limited exchange participation as a result of 2017 market exits are likely to be in the south.”³⁴

The government should treat federal health care programs holistically and use active purchasing to get the best deal from insurers for all consumers in all programs.

ACA marketplaces are one small part of the nation's health insurance system. In a true partnership between the government and insurers, insurers would benefit financially across programs *and* the public's interest would be served across programs. Insurers that profit from participation in Medicaid and Medicare Advantage (which were not always profitable) should be willing to participate in the exchanges.³⁵

For instance, Nevada requires Medicaid managed care plans to offer at least one silver and gold plan in the exchange – perhaps why UnitedHealthcare is participating in Nevada's exchange while exiting nearly every other state.³⁶

Medicaid managed care plans are the most successful exchange plans and also ensure continuous coverage when enrollees switch eligibility.

Congress should create a "Guaranteed Choice Plan."

In perhaps less partisan times, Congress created a "fallback option" in the Medicare Part D prescription drug program.³⁷ In ACA markets, consumers should never be subject to the whims of insurer withdrawals or threats of withdrawals.

The lack of plan choices in rural areas is a problem that long pre-dated the ACA. The reason is that insurers' fixed costs must be spread over a small potential market population. Recognizing this reality means that private insurers, unless they are heavily subsidized, cannot be relied upon to increase plan choice in rural areas.

Congress should tackle the high cost of specialty drugs.

This is one of the biggest factors cited by large insurers for leaving ACA markets.³⁸ Yet to date the insurance industry has done little to push for meaningful reforms. The Center for American Progress is working with insurers and drug manufacturers in an effort to find common ground.

Congress should increase cost-sharing subsidies to lower deductibles and increase premium tax credits for young and middle-income people.

For instance, student loan payments should be deducted from income for purposes of determining tax credits and the cliff at the 400 percent eligibility threshold should be smoothed.

Insurers, too, can take actions to improve the markets.³⁹

For instance, insurers that are succeeding are very effective at controlling nonmedical administrative costs.⁴⁰

Conclusion

Most of all, the administration, Congress, states, insurers, and other stakeholders should act in a constructive spirit to make the law work and fix any problems that arise – rather than root for its failure or cut and run. As Bernard Tyson, CEO of Kaiser Permanente, said: "I view it through the lens of my mission. It obligates to us to figure it out, not to get out."⁴¹

Endnotes

¹ Loren Adler and Paul B. Ginsburg, *Obamacare Premiums are Lower Than You Think*, Health Affairs, July 21, 2016, available at: <http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/>.

² ACASignups.net, September 6, 2016, available at: <http://acassignups.net/16/09/08/steve-davis-robert-laszewski-confirm-what-ive-been-saying-all-along-appx-40-aca-indy-market>.

³ Because there is a single risk pool, and off-exchange plans must follow the same ACA rules as on-exchange plans, there is no reason to exclude enrollment in off-exchange plans from estimates of enrollment in ACA coverage.

⁴ Robin A. Cohen et al., *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January-March 2016*, National Center for Health Statistics, September 2016, available at: <http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf>.

⁵ U.S. Department of Health and Human Services, *Changes in ACA Individual Market Costs from 2014-2015: Near-Zero Growth Suggests an Improving Risk Pool*, August 11, 2016, available at: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-resources/Downloads/Final-Risk-Pool-Analysis-8_11_16.pdf.

⁶ Adler and Ginsburg, fn1.

⁷ Mark Hall and Michael J. McCue, *How Has the Affordable Care Act Affected Health Insurers' Financial Performance?* The Commonwealth Fund, July 20, 2016, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/the-affordable-care-act-and-health-insurers-financial-performance>.

⁸ In 2014, insurers' actual costs were only 2 percent higher than projected costs after factoring in reinsurance payments. Hall and McCue, fn6.

⁹ For the same reason, Congress created a permanent risk corridor program for the Medicare Part D prescription drug program. Yet Congress has not exhibited the same concern with respect to that program.

¹⁰ "Because the risk corridor program offered insurers financial protection against underpricing their marketplace products, the program may have resulted in insurers pricing their individual market products less conservatively than they otherwise would have in light of the substantial amount of uncertainty when setting rates." Milliman, *2014 commercial health insurance: Overview of financial results*, March 2016, available at: <http://us.milliman.com/uploadedFiles/insight/2016/2014-commercial-health-insurance.pdf>.

¹¹ "The risk corridor shortfall resulted in individual market composite underwriting results decreasing from negative 2.1% to negative 6.1%." Milliman, fn10.

¹² Adler and Ginsburg, fn1.

¹³ Adler and Ginsburg, fn1.

¹⁴ Goldman Sachs, *Blue Cross show further improvement in 2Q*, September 1, 2016, available at: <https://360.gs.com/research/portal/?st=1&action=action.binary&d=22341892&fn=/document.pdf&a=ae79c897e77147d290a10bf98d1351b2>.

¹⁵ Adler and Ginsburg, fn1: "...it is likely that premiums through 2016 have been *too low* to be sustainable in many cases given the financial difficulties many insurers are having, whether the result of underestimating the cost of serving new populations, loss leader strategies to build a customer base, or other reasons." Hall and McCue, fn7: "...improved financial performance will require increased premiums, especially as the ACA's reinsurance component phases out, starting in 2017. This reinsurance has played a crucial role in helping insurers transition."

¹⁶ Cynthia Cox et al., *Analysis of 2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, July 2016, available at: <http://files.kff.org/attachment/Issue-Brief-Analysis-of-2017-Premium-Changes-and-Insurer-Participation-in-the-ACA-Marketplaces>; Avalere, *Early Analysis Finds 2017 Proposed Exchange Premiums for Low Cost Silver Plans Increasing 8 Percent on Average*, July 13, 2016, available at: <http://avalere.com/expertise/life-sciences/insights/update-early-analysis-finds-2017-proposed-exchange-premiums-for-low-cost-si>.

¹⁷ McKinsey therefore concludes that "there is little risk of a market-wide 'death spiral' given stabilizing subsidies." McKinsey Center for U.S. Health System Reform, *Exchanges three years in: Market variations and factors affecting performance*, May 13, 2016, available at: http://healthcare.mckinsey.com/sites/default/files/Intel%20Brief%20-%20Individual%20Market%20Performance%20and%20Outlook%20%28public%29_vf.pdf.

¹⁸ Adler and Ginsburg, fn1.

¹⁹ Aetna (AET) Mark T. Bertolini on Q1 2016 Results – *Earnings Call Transcript*, April 29, 2016: "If we were to go out and buy those members, it would cost us somewhere around \$1.2 billion to acquire them. If we were to build out 15 markets, it would cost us somewhere between \$600 million to \$750 million to enter those markets and build out the capabilities necessary to grow that membership. So in the broad scheme of things, we are well, well below any of those numbers from the standpoint of losses we've incurred in the first two-and-a-half years of this program."

²⁰ Richard Mayhew, Balloon Juice, August 17, 2016, available at: <https://www.balloon-juice.com/2016/08/17/aetna-cynicism-and-pennsylvania/>.

²¹ Blue Shield of California, *Emerging CoHC Deep Dive*; John Bertko, *Emerging Potential Trends for Covered California Special Enrollment Period Enrollees*, Covered California Board Meeting, February 18, 2016, available at: <http://board.coveredca.com/meetings/2016/2-18/PPT-Covered%20California%20SEP%20Policy.pdf>.

²² Bertko, fn21.

²³ Washington State, Idaho, and Minnesota have implemented a pre-verification process similar in concept to these guidelines.

²⁴ U.S. Department of Health and Human Services, *HHS Notice of Benefit and Payment Parameters for 2018*, available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-09-06/pdf/2016-20896.pdf>.

²⁵ John Kautter et al., *The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act*, Medicare & Medicaid Research Review, Exhibit 7, available at: https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf.

²⁶ Alaska State Legislature, House Bill No. 374, available at:

<http://www.akleg.gov/basis/Bill/Text/29?Hsid=HB0374D>.

²⁷ Timothy Jost, *Alaska Reinsurance Plan Could Be Model For ACA Reform, Plus Other ACA Developments*, Health Affairs, June 16, 2016, available at: <http://healthaffairs.org/blog/2016/06/16/alaska-reinsurance-plan-could-be-model-for-aca-reform-plus-other-aca-developments/>.

²⁸ Kevin Counihan, *Building on Premium Stabilization for the Future*, The CMS Blog, August 11, 2016, available at: <https://blog.cms.gov/2016/08/11/building-on-premium-stabilization-for-the-future/>.

²⁹ Cynthia Cox, *Preliminary Data on Insurer Exits and Entrants in 2017 Affordable Care Act Marketplaces*, Henry J. Kaiser Family Foundation, August 28, 2016, available at:

<http://kff.org/health-reform/issue-brief/preliminary-data-on-insurer-exits-and-entrants-in-2017-affordable-care-act-marketplaces/>.

³⁰ Justin Giovannelli et al., *Implementing the Affordable Care Act: State Approaches to Premium Rate Reforms in the Individual Health Insurance Market*, December 2014, available at: http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/dec/1795_giovannelli_implementing_aca_state_premium_rate_reforms_rb_v2.pdf.

³¹ To date, only Vermont and the District of Columbia have adopted this policy. Henry J. Aaron, *How to rescue Obamacare as insurers drop out*, Washington Post, August 19, 2016, available at: https://www.washingtonpost.com/opinions/how-to-rescue-obamacare-as-insurers-drop-out/2016/08/19/edb038b2-6641-11e6-be4e-23fc4d4d12b4_story.html?utm_term=.3004fe5795a0.

³² Michael J. McCue and Mark A. Hall, *Comparing Individual Health Coverage On and Off the Affordable Care Act's Insurance Exchanges*, Commonwealth Fund, August 2015, available at: <http://www.commonwealthfund.org/publications/issue-briefs/2015/aug/comparing-coverage-on-off-aca-exchanges>.

³³ Aditi P. Sen and Thomas DeLeire, *The Effect of Medicaid Expansion on Marketplace Premiums*, Office of the Assistant Secretary for Planning and Evaluation, August 25, 2016, available at: <https://aspe.hhs.gov/pdf-report/effect-medicaid-expansion-marketplace-premiums>.

³⁴ Cynthia Cox, fn29.

³⁵ With regard to Medicare Advantage contracts with insurers, Section 1857(e) of the Social Security Act provides that: "The contract shall contain such other terms and conditions not inconsistent with this part...as the Secretary may find necessary and appropriate."

³⁶ Louise Norris, Nevada health insurance exchange/marketplace: All current carriers remaining in Nevada exchange in 2017, healthinsurance.org, August 20, 2016, available at: <https://www.healthinsurance.org/nevada-state-health-insurance-exchange/>.

³⁷ Social Security Act Section 1860D-11(g), available at: https://www.ssa.gov/OP_Home/ssact/title18/1860D-11.htm#act-1860d.11-g.

³⁸ Tim Mullaney, *How Gilead "Broke" Obamacare*, Marketwatch, August 21, 2016, available at: <http://www.marketwatch.com/story/how-gilead-broke-obamacare-2016-08-31>.

³⁹ McKinsey, fn17: "There are also specific actions carriers can take to improve near-term performance on the public exchanges and position their businesses for longer-term sustainability."

⁴⁰ Tim Mullaney, *Insurers Can Make Obamacare Work, But They Need Help From Congress*, FiveThirtyEight, August 31, 2016, available at: <http://fivethirtyeight.com/features/insurers-can-make-obamacare-work-but-they-need-help-from-congress/>.

⁴¹ The Dallas Morning News, *Let's root for those trying to make Obamacare work*, August 22, 2016, available at: <http://www.dallasnews.com/opinion/editorials/20160822-lets-root-for-those-trying-to-make-obamacare-work.ece>.

Mr. MEADOWS. Thank you, Mr. Spiro.

I am going to go to the gentleman from Michigan, Mr. Walberg, for a series of questions, but I would like to comment, Mr. Spiro. Some of your comments in your opening remarks defy reality, and so I look forward to some robust questioning as you make your premise and see if you can back those up.

So I will go to Mr. Walberg for 5 minutes.

Mr. WALBERG. Well, thank you, Mr. Chairman. I think you said it as well as I was going to say it. But it started with Dr. Cohen, as well as Mr. Spiro, some comments that defy credibility and reality. I mean, I know positions have been taken and we have to sell certain things, but my gracious, it is not dealing with reality and I am expecting Toto in the Land of Oz and we are not in Kansas yet.

And in Michigan I read in the Detroit Free Press, not an organ of conservatism, health plans sold on Michigan's insurance exchange could see an average 17.3 percent increase next year, and we are a Medicaid expansion State. It goes on to say that rate increases would mean a financial hit for taxpayers in general and the 345,000 Michiganders who buy their health insurance on the HealthCare.gov Web site.

It goes on to point out that of the 14 insurers with individual market plans, 10 are seeking increases exceeding 10 percent. They include a proposed 13.9 percent average increase by Priority Health, 18.7 percent by Blue Cross Blue Shield of Michigan, 16.8 percent by Health Alliance Plan, and 39.2 percent by Humana. The Avalere health analysis of 2017 rate increases for individual plans in 14 States, including Michigan, found that the average silver plan, the second-cheapest classed after bronze, would rise 11 percent in 2017.

We have got a problem, and we have to admit that. And I appreciate the hearing today to do that very thing and get away from simply selling something that was doomed to fail. And one of the providers says it has failed 2 years ahead of time and it is getting worse. And when I talked to my ratepayers back in my district, people who say yes, I have insurance but I don't have health care because when I go in to take care of my health, I find out that my out-of-pocket expenses, it precludes me caring for my health.

Having got that off my shoulder, Mr. Carlson, what impact has the rate filing process had on competition and insurance premiums?

Mr. CARLSON. Well, I think that the industry as a whole is fairly highly regulated, and certainly premium increases that are being requested are higher than anybody would like to see. And, you know, from the health plan perspective, you know, we certainly want to be able to justify the rates that are being asked for. And the regulatory process puts somewhat of a barrier but it—you know, it also puts a, you know, an opportunity for everyone to see exactly what is being requested.

And, you know, as far as making it more—you know, limiting the choice in the marketplace, you know, I can't speak directly to any specific plan but, you know, it is—you know, does make it more difficult for a health plan to make sure that they, you know, maintain

their solvency to be able to get these rate increases that are necessary for that fact.

Mr. WALBERG. Okay. Mr. Redmer, can you explain the rate process?

Mr. REDMER. Certainly. In—the law around the country is pretty specific. The law requires us to approve or disapprove rates to make sure that those rates are adequate to protect solvency. They cannot be excessive, they have to be actuarially justified, and they cannot be discriminatory.

So what happens is the beginning of May we receive the proposed rate increases from the carriers, along with all the supporting actuarial data. We have a team of actuaries. Some States use outside actuarial consultants to scrub the data, to challenge the data and the projections of the carriers.

In Maryland, we had not one but two separate rate increases where different stakeholders, consumer groups come in and provide their feedback and information, and at the end of the day we come out with our final rates. In Maryland as an example, if you look at the aggregate price increases and you look at what we ultimately approved, we approved aggregate rates that were about \$24.5 million less than were —

Mr. WALBERG. Let me ask a question quickly in the remaining seconds here. Some State regulators have said that they are put in the position of having to decide between agreeing to the price increases or have plans withdraw from the markets entirely. Is that what you are finding?

Mr. REDMER. Well, no. The end result is we're required to approve adequate rates, so if—the problem that some carriers have is they can't get the rates that they believe are sufficient to operate their business. Insurance 101 is you have to collect revenues to pay the claims, the administrative expense, and the reserves that government requires. The key is not necessarily the approval process but carriers being able to get sufficient rates in order to run their organizations.

Mr. WALBERG. Thank you. I yield back.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentleman from Tennessee, Mr. Cooper, 5 minutes.

Mr. COOPER. Thank you, Mr. Chairman. I would like to welcome this distinguished panel of experts.

And for most viewers of this hearing, it is about as exciting as watching paint dry, so let me try to put the cookies on a low shelf and simplify some of these issues.

Here, we have a distinguished panel of experts, and none of them are really echoing the political outrage that my friends on the other side of the aisle are trying to express. You know, we do not have the real chairman of the committee chairing this hearing, and the hearing is very sparsely attended, so they are not getting the political impact that apparently they were expecting.

I think the testimony is best summed up by the NAIC witness Mr. Redmer when he concludes in his final paragraph on page 7 and says this: "It has been over 6 years since the ACA was signed into law, and the time is long past due for State and Federal policymakers to move past the politics and come together to make

substantive corrections to the law to bring about more stable risk pools, dependable funding, and reasonable regulations for the individual health insurance markets. The markets are suffering. Let's roll up our sleeves and fix them." Well put.

Mr. REDMER. You said it better than I could.

Mr. COOPER. But here, we have a committee that literally has no jurisdiction over any fix. We are purely an investigative committee. And oftentimes that translates into pure political theater. Members of this committee, if they wanted to study the issues, couldn't do anything about them.

So let's review the bidding. The American Enterprise Institute, a conservative think tank, reported in their journal just last year that there still is no substitute Republican plan for the ACA. Now, there are band-aids here or there but really there is no alternative so it is not a question of if we had only done the Republican plan.

I was one of the supporters of the bipartisan plan, the alternative to ObamaCare, the so-called Wyden-Bennett plan, that would have solved many of these problems, but we had difficulty getting people to be constructive, to be for something. It is much easier to criticize.

So as you deal with these important issues and the most important lesson to learn is like who is hurt? Where are the victims?

Ms. Cohen pointed out in her testimony that still the vast majority of folks who are getting marketplace insurance are paying less than \$75 a month. That is a pretty awesome deal.

With marketplace subsidies, a lot of these large-looking rate increases in terms of percentage translate into \$2 or \$3-a-month increases in cost. And while that is regrettable, as Ranking Member Cummings pointed out in his opening testimony, spiraling insurance costs have been happening to America for some 40 years. And the costs under the ACA are actually less than expected. Let me repeat that for some of my friends who prefer not to live in a fact-based world, less than expected.

Now, no one knows if these trends will continue, but this is astonishingly good news, and yet we live in a political culture in which people don't want to talk about the facts, especially if they include good news for what might be happening.

So this is a time, I think, to focus on the details, understand how this is done. Most folks back home don't understand that Congress gave away jurisdiction on insurance in 1947 with the McCarran-Ferguson Act. Most of the regulatory power is really at the State level, and some States do a good job managing this, some not so much. So there is really not even a committee in Congress that has jurisdiction over insurance per se as most of the work is properly done at the State level.

But the fundamental issue of controlling rising health costs is a challenging one. And my friend from the State of Michigan, who has now already departed the hearing, when the big three auto-makers have their very nice health plans, some of those folks were considered to be one of the instigators of high health costs because when you have first-dollar coverage, no one questions pricing.

And I think it was former HEW head Joe Califano who pointed this out, that medical prices in the Detroit area were far higher

than the rest of the country because nobody was questioning the bills.

So we are moving into an era in which people are questioning the bills, they are paying close attention to deductibles and copays and coinsurance, and that is a good thing. And when you are comparing silver plans with bronze plans and things like that, we already have more clarity in the market than we had in previous generations, and most important, a better benefits package.

I am proud of Maryland for having instituted some of these reforms as far back as 1993, a guaranteed issue ban on preexisting conditions, things like that, that are necessary elements of a decent insurance market.

So there are ways to solve these problems, and let's all echo Commissioner Redmer's call for bipartisan action. Let's roll up our sleeves and fix the glitches that remain.

Thank you, Mr. Chairman.

Mr. CUMMINGS. Mr. Chairman?

Mr. MEADOWS. Yes.

Mr. CUMMINGS. Just one moment. I want to associate myself with everything the gentleman just said, but I also want to make sure, in all fairness to Chairman Chaffetz, of course he was here, and the fact that he is not here at this moment does not mean that he doesn't consider this very important.

Chaffetz and I have been in a lot of hearings and rarely does he or I miss one moment, but he has a bill on—a major bill that he is—his bill testifying in another committee. So I didn't want to let that—I wanted to make sure that is clear to all of us that he rarely misses a moment, but he does consider this an important hearing. We have talked about it many times. And I just wanted to straighten that out.

Mr. MEADOWS. I thank the gentleman. And as we go to the gentleman from Tennessee, Mr. Duncan, I do want to clarify one quick thing. Mr. Cooper said you are not outraged. Dr. Cohen, do you by your health insurance from HealthCare.gov?

Dr. COHEN. No. I'm a Federal employee.

Mr. MEADOWS. Okay. Commissioner, do you by your health care from HealthCare.gov?

Mr. REDMER. No, sir.

Mr. MEADOWS. All right. Mr. Carlson, do you buy your health care from HealthCare.gov?

Mr. CARLSON. No, I have employer coverage.

Mr. MEADOWS. Okay. Mr. Giesa, do you by your health care from HealthCare.gov?

Mr. GIESA. I have employer coverage as well.

Mr. MEADOWS. You have employer—and, Mr. Spiro, do you by your health care —

Mr. SPIRO. No.

Mr. MEADOWS. No? Well, so perhaps they are not outraged because they are not having to use the system.

I will recognize the gentleman from Tennessee, Mr. Duncan, for 5 minutes.

Mr. DUNCAN. Well, thank you very much, Mr. Chairman.

I want to read just a tiny portion of some of what I have received. Linda Mays, a registered nurse for 30 years, who decided

to retire this year at the age of 63, she says she was shocked at the price that she was quoted. The cheapest plan was \$586.23 and covered nothing with a \$4,000 deductible and \$6,350 out-of-pocket expenses and no medication coverage. She says, "I'm still looking for the affordable part of health care."

Les Gotto of Knoxville—and I don't know any of these people personally—sent me this email. "Blue Cross Blue Shield of Tennessee up 62 percent"—that is the percentage increase that Blue Cross Blue Shield requested in Tennessee. "Blue Cross Blue Shield of Tennessee up 62 percent after going up 39 percent last year, and these plans pay for nothing." And he's got "nothing" in all capital letters. "Where am I supposed to get another 6,000 bucks next year? I paid \$10,000 this year for premiums and four wellness exams? I also paid at least \$6,000 out of pocket for health care."

Christopher D. Bush, an average—it says an average, healthy 30-year-old male, and he said that his policy that he got 2 years ago, it is going up—it is now four times the original cost of the premium. Blue Cross Blue Shield cites ObamaCare as the cause for the increase.

Ann Kovaleski, a 61-year-old from Knoxville, is paying \$761 a month now, which was nearly a 63 percent over her prior premium the year before and included a \$3,000 in-network deductible, \$6,000 out-of-network, and said this is quite expensive since she will have paid down more than \$9,000 in premiums and \$3,000 in deductible before their policy pays out a cent. Now, she has been notified for the 62 percent Blue Cross Blue Shield increase. She said, "This would bring my monthly premium to \$1,234 a month, \$14,794 annually, this much out of pocket plus the \$3,000 deductible." And she says, "The President promised on many occasions that the average family's health insurance premiums will be lowered by up to \$2,500."

And finally, Mr. William H. Power of Knoxville sent a message about his premium increases, and he says "In reality, I feel what we are experiencing is the sellout of the Federal Government to pass along the issues that we were told would not happen as a result of the ACA."

My late mother was from Iowa. There was a public hearing out there where one individual testified that his policy would increase by \$4,000 from \$15,000 a year to \$19,000 a year.

That is what we are hearing not only from all over my district but all over Tennessee and all over the country. And I tell you, the people are really up in arms about this and we are going to have to make some major changes.

I went to a reception in the mid-1990s where the doctor who delivered me came and brought my records, and I asked him, I said, how much did you charge back then? He said he charged \$60 for 9 months of care and the delivery if they could afford it. Medical care was cheap and affordable until the Federal Government messed it all up, and the few people who know how to manipulate the system have been getting filthy rich.

And it makes no sense whatsoever because we have got more doctors, more nurses, more health care workers per person than any country in the world by far. And I really sometimes think that the people who foisted this so-called unaffordable care plan out on

us knew that it wouldn't work but that it would get so bad that people would then demand that we go to a single-payer plan, and then we will end up with shortages, waiting periods, lower quality of health care, and we will have this Russian/Cuban type of medical system.

I was on a congressional CODEL a few weeks ago, and the front page of the largest newspaper in Ireland had a front-page story while we were there and said they had 530,000 people on waiting lists in Ireland for medical care. You multiply that times 70 for the United States, you see where we are heading.

Thank you, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentlewoman from Michigan, Mrs. Lawrence, for 5 minutes.

Mrs. LAWRENCE. Thank you, Chair.

In the 6 years since Congress passed the ACA, we have found ourselves in this hearing again and again as it is being debated in some would call obsession with undoing and undermining this historic law. There has been more than 60 times that we voted to repeal and undermine the ACA. There have been lawsuits filed. They have cut critical funding. And the majority have held hearing after hearing just like today's using overheated rhetoric and claims that seem to be exaggerated.

It is not productive. It is really tiresome. Because when I came to this Congress, I recognized that the ACA was not perfect, and I am willing to work with the other side of the aisle to make it better. But I never get a chance to have that conversation on what to do to make it better because it is continuous, continuous attacks to repeal it.

So, Dr. Cohen, how many Americans have gained quality, affordable insurance coverage since the ACA has passed in 2010?

Dr. COHEN. Twenty million.

Mrs. LAWRENCE. I'm sorry?

Dr. COHEN. Twenty million.

Mrs. LAWRENCE. Twenty million. Twenty million people have gained insurance coverage. The ACA has also cut the uninsured rate nearly in half. It is now at a historic low of 8.6 percent according to the National Center on Health Statistic. Dr. Cohen, what was the primary goal of ACA?

Dr. COHEN. To increase access to affordable, quality coverage.

Mrs. LAWRENCE. Then I would say we are well on our way to reaching that goal. Just imagine how much we could accomplish if Republicans and Democrats would work together instead of against this. I can understand differences of opinion, but it is unacceptable to have a stalemate on an issue that is so important to the American public. And if we can sit here today and clearly identify the areas that we should address so that we can make it better, then why don't we do that? Why don't we come together and work to make this plan? Because we have changed 20 million people in America? We have affected 20 million people, and we have increased—the goal of ACA—we are on our way and we have increased that number.

And I am speaking today—the facts are the facts, and I will not say the ACA is perfect, but I can tell you it is the foundation for

us to build on. And we waste time hearing after hearing after hearing where we refuse to come to the table and say let's fix what is wrong with this so we can continue to make this country competitive with other countries who are providing health care for all of the citizens of that country to make it affordable.

With that, I yield back my time.

Mr. MEADOWS. I thank the gentlewoman.

The chair recognizes the gentleman from Arizona, Mr. Gosar, for 5 minutes.

Mr. GOSAR. Thank you, Mr. Chairman.

Now, before being elected to Congress, I owned and operated a dental practice in northern Arizona for more than 25 years, so I know a few things about health care and how it really works in the real world. In fact, one of the primary reasons I ran for Congress in 2010 was out of the frustration in the way that Washington was damaging health care with ObamaCare.

Now, sadly, another ObamaCare failure is hitting Arizonans. Ms. Cohen, I am coming right at you. Last month, health insurance provider Aetna pulled out of the growing list of insurers that have announced their intention to pull out of Arizona due to the heavy losses introduced by ObamaCare regulations. This move is leaving my constituents in Pinal County without access to any—without any insurance place marketplace plan. The Pinal County marketplace is the first, but I am afraid it won't be the last to be abandoned and wrecked by the ObamaCare regulations.

So, Dr. Cohen, was leaving Pinal County residents with zero marketplace options, exactly what President Obama meant when he told them that if you like your plan, you can keep your plan?

Dr. COHEN. I think you may have seen last week Blue Cross Blue Shield of Arizona did announce that we—they will be staying in that county.

Mr. GOSAR. Good. Once again, you can keep your plan?

Dr. COHEN. So, again, I think what the Affordable Care Act is meant to —

Mr. GOSAR. There is absolutely no —

Dr. COHEN.—do is to give access to affordable coverage by providing financial —

Mr. GOSAR. That is not what he meant. That is not what he meant.

Dr. COHEN. Okay.

Mr. GOSAR. The President's health care law is a quagmire of bureaucratic red tape, regulatory hoops, and cost-shifting tax increases that has left tens of thousands of Arizonans scrambling to find health care insurance for 2016. So, Dr. Cohen, the administration seems to know the bill is inherently flawed and unworkable as it was passed. As a result, the administration has decided to delay many aspects of the law, isn't that correct?

Dr. COHEN. We have said, as we do with the Medicare program, we want to continue to make improvements —

Mr. GOSAR. Once again —

Dr. COHEN.—to the marketplace —

Mr. GOSAR.—answer the question. Answer the question.

Dr. COHEN. Yes, it's —

Mr. GOSAR. You have delayed implementation? Thank you for answering.

How many individual changes have been made in the law since it was passed to try to make it workable?

Dr. COHEN. How many congressional actions have been taken?

Mr. GOSAR. How many actions have you taken —

Dr. COHEN. To make improvements to the —

Mr. GOSAR. Seventy.

Dr. COHEN.—to the —

Mr. GOSAR. Let me answer that for you. Seventy. Now, in my first three terms, I have now represented over 85 percent of the geography of Arizona, most of the rural aspects. So for every person I hear that has been helped by the program, I can give you two that have been hurt. You can make statistics say anything you want to make statistics. I have got a pretty good background in statistics.

So, Mr. Giesa, I am going to come back to you. So if we took this highly regulated industry and we streamlined the process, we have money to people for their ability to buy in the marketplace and came up with the industry coming up with a different idea and competitive advantage, do you think that we could actually come up with a fairly—industry solution to this problem?

Mr. GIESA. I'm afraid, Congressman, that question is a little beyond what I'm prepared to talk about today. It's certainly possible, but I can't say with any sort of certainty that the answer is yes.

Mr. GOSAR. So when you are looking at this marketplace, I mean, we are seeing fewer and fewer options. Is the whole intention a single payer?

Mr. GIESA. I can't, again, speak to the intention, but I can say that with certain changes, the changes that we've—that are in my written testimony, I think the marketplace can continue and can continue to improve.

Mr. GOSAR. A vibrant marketplace has lots of entries and opportunities and options, is that true?

Mr. GIESA. That is true.

Mr. GOSAR. So are we shrinking in options and opportunities?

Mr. GIESA. We are shrinking in options and opportunities going into 2017, yes.

Mr. GOSAR. Now, you know, I want to make a comment. You know, we also made it even worse in health care. So my wife on election day in Arizona ends up being in the emergency room with a neck injury that we can't figure out. It is going to be 3 months before she sees her primary care doctor. She has been in the emergency room twice, and they won't take an MRI because she doesn't have her authorization from her primary care doctor. It is pretty incredible that that is what exists today in Arizona. It is pretty incredible that that is what is happening.

So it is causing a deformation of the marketplace. It is causing a deformation in regards to the way care is being applied. And I think the marketplace and the industry has an opportunity that we could reset that bar. I am one of the people that has looked at different options outside that in an evolutionary process, and I have got to say I am pretty sad with what I see my folks on the other side of the aisle complaining about.

So I yield back.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentlewoman from the District of Columbia, Ms. Eleanor Holmes Norton.

Ms. NORTON. Thank you very much, Mr. Chairman.

Mr. Chairman, it has been 6 years since Congress passed the Affordable Care Act, and the majority has been the majority for that entire time. All they have done is to propose to repeal it 60 times. They could have come forward with their own bill. The closest they have come is no bill at all. It is a recently unveiled proposal from Speaker Ryan that he calls the "Better Way."

It is terribly short on specifics after all this criticism of the ACA, but it does recycle a lot of bad ideas. For example, it rolls back the ACA's vital consumer protections, and if you can imagine this, would allow companies once again to discriminate by charging higher premiums based on race and sex and health status. I cannot believe that any Member of Congress would want to go back to those bad old days.

Mr. Spiro, what effect would repealing these consumer protections have on those who have gained coverage under the ACA?

Mr. SPIRO. Well, in general it would shift costs to consumers—back to consumers. And I think the way to think about it is that the goal of the ACA was to spread risk broadly, and some of the alternatives that have been floated to replace the ACA, what they in effect do is quarantine the sick instead.

And so what they do is repeal essential health benefits so you are not guaranteed coverage for prescription drugs, for maternity care, for mental health care, which I think we would all agree are essential, eliminate out-of-pocket—limits on out-of-pocket costs, and most critically, reduce the value of coverage. I mean, one Congressman was talking about how the constituents have written in about the high deductibles.

So the answer is not to actually reduce the value of coverage back to the way it was before, to rely on health savings accounts and high-deductible plans. That is going in the exact wrong direction. And it seems to me that there are obvious constructive solutions to address that issue.

Ms. NORTON. Yes. Any large piece of legislation, this is a work in progress. It is amazing the progress that has been achieved on its first iteration.

You mentioned the cap on out-of-pocket expenses. Let me ask Dr. Cohen. How important have the premium tax credits been in helping people afford health care?

Dr. COHEN. We've seen them be essential on the marketplace. Eight-five percent of consumers do qualify for some sort of financial assistance. And we put out an analysis earlier this year that goes State by State so folks can see for their own State, even with significant increases, that consumers are protected because if premiums do go up, the financial assistance goes up as well. So the majority of consumers can purchase a plan for less than \$75 a month.

Ms. NORTON. Imagine that, less than \$75. And I know that is important out here. The majority of these consumers can be protected for less than \$75 a month. If it were not for these tax credits, they

obviously wouldn't be in the market at all. And Mr. Spiro's notion about what insurance is all about, spreading the risk, and that is essential to this or any insurance program.

Which leads me to a question about the option for turning Medicaid into a block grant, here be the options: block grant program, which would say to the States do whatever you want to do; or imposing a per-capita cap on benefits that would not keep up with the growth of health care costs. So both of those options would leave States with less funding and take away care from those who can least afford it, the poor and the elderly.

Mr. Spiro, do you think that the Speaker's proposed changes to Medicaid would have a negative effect on the private insurance market?

Mr. SPIRO. To—Medicaid would have a negative effect on the private insurance market? Yes, because they would roll back the Medicaid expansion. And as I mentioned in my testimony, States that have done Medicaid expansion, their premiums in the private markets are 7 percent lower, and that is because the population from 100 to 138 percent of poverty would be in the Medicaid risk pool instead of the exchange risk pool.

Mr. MEADOWS. The gentlewoman's time is expired.

Ms. NORTON. Thank you very much. I think my questions have been aimed at showing the benefits and showing that the majority has filed on its option to not propose but to come forward with a bill.

Thank you very much, Mr. Chairman.

Mr. MEADOWS. All right. I thank the gentlewoman.

The gentleman from Texas, Mr. Farenthold, is recognized.

Mr. FARENTHOLD. Thank you very much.

And I can't get started without questioning some of the characterizations of the Speaker's and the House Republicans' plan. I am not sure that our panelists or the gentlelady from the District of Columbia has actually reviewed the very detailed plan outlined on the Better.GOP Web site, and I would encourage them to do that.

But at this point I am going to go ahead and ask some of my questions. Dr. Cohen, I am going to start with you. In your testimony you said that the CBO estimates said that we were actually below the CBO estimates for what this plan would cost. How does that jibe with everybody's health insurance is going to go down \$2,500? It seems like you knew with the CBO estimates you referred to in your testimony the time the Affordable Care Act was enacted we knew they were going to go up.

Dr. COHEN. So I think we're talking about two different groups of folks. Both—I mentioned—one are the 150,000 million Americans, all of these panelists who get our health insurance through our employers. And if you look at the cost of those premiums, it has actually been the slowest growth in the last —

Mr. FARENTHOLD. But, ma'am, wouldn't you say —

Dr. COHEN.—4 or 5 years.

Mr. FARENTHOLD.—the benefits have gone down? I will just use an anecdotal example. My daughter's employer, based on the increased cost of coverage, was forced to take her from a very generous first dollar plan to a \$3,000 deductible plan that when she

had to visit the emergency room earlier this year wiped out her savings account.

Dr. COHEN. So we very much agree with you that high-deductible plans are challenging for folks, which is why the Affordable Care Act has limit on out-of-pocket costs, and for folks who have incomes below 250 percent of poverty, they have limits and they have ability to do cost-sharing—

Mr. FARENTHOLD. All right. Now, under the Affordable Care Act, as a Member of Congress, I am required to purchase my insurance on the D.C. exchange. I pay over \$1,000 a month for that insurance. With these premium increases that we are talking about of double digits, I could see as much as a \$2,000-per-year increase in my premiums. That doesn't sound affordable to me either.

Dr. COHEN. So the important part about the Affordable Care Act is now that you know—you know what you're buying when you buy that insurance. It covers those essential health benefits, prescription drug costs, and such. In addition, if you had any preexisting conditions before, you have options. You can now have —

Mr. FARENTHOLD. No, I was better off under FEHB, I will tell you that. And again, I am also concerned about the lack of coverage options that are available.

Mr. GIESA, I am going to go to you, and I am going to go Texas-specific since I am a Texan. We are seeing projections for 2017, rate increase for your company, just phenomenal. I mean, what do you see going and happening with those rate increases for people forced to buy through the exchange? Microphone, please.

Mr. GIESA. First, please understand that the Blue Cross Blue Shield Association that I am here representing is a federation of 36

Mr. FARENTHOLD. Right.

Mr. GIESA.—independently run plans. The strategy and pricing decisions of any specific plan are —

Mr. FARENTHOLD. All right. I will go to Mr. Redmer for a second. One of the complaints I am hearing out of my hometown of Corpus Christi and the areas that I represent is if you wanted to buy a PPO plan now in cities like Houston—and we are getting there in Corpus Christi—there simply isn't one available. You are stuck with an HMO where you have things like with Mr. Gosar. You have a gatekeeper before you can get the care. Why are we losing all these choices?

Mr. REDMER. That's one of the problems that we're seeing all around the country. In some parts of the country, we're seeing folks only have an option of a PPO. In other parts of the country, other counties, they may only have an option of an HMO. So the shrinkage of competition and carriers is a real problem.

Mr. FARENTHOLD. All right. Thank you very much.

And, Dr. Cohen, one last question for you as my time is about to expire. When Dr. Gosar asked the question about was the intent all along to move to a single-payer system, you smiled. Is that because you believe that to be true or what is your take on that?

Dr. COHEN. No, it is because we work so collaboratively with the State Departments of Insurance and the many private issuers to provide Americans access to affordable coverage through private insurance, so I think my smile was we work so closely with folks in

the private sector that I don't see how that intent could be read into what we are doing —

Mr. FARENTHOLD. It certainly seems to be the end result with premiums going so high and deductibles skyrocketing and choices going down. The American people are incredibly dissatisfied, and it seems like if you to create a system designed to wreck what I consider to be the best health care system in the world, you have done it.

I see I am out of time, and I will yield back.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentlewoman from Illinois, Ms. Duckworth, for 5 minutes.

Ms. DUCKWORTH. Thank you, Mr. Chairman.

I am very concerned about the significant premium increases that we have been discussing, especially the ones that are going to be going up in 2017 on the Illinois health insurance exchange. Of course, the ACA's premium tax credits will shield the vast majority of the 335,000 Illinois residents who shop for insurance on the Illinois exchange with significant increases in premium rates, but as the Chicago Tribune reported recently, even if the premiums increased by 50 percent, the ACA's premium tax credits would ensure that nearly two-thirds of Illinois enrollees could still enroll in plans that cost them \$100 or less per month.

I am concerned, however, about the impact of this increase on the 84,000 Illinois residents who don't qualify for tax credits, and I would like to know what steps we can take to empower these consumers to be smart shoppers in the exchange and what reforms are needed to ensure regulators effectively protect these people from unreasonable rate hikes.

With that, Dr. Cohen, I would like to address this idea of falling health care rate increases. I understand that all States are required to file health care rate increases of 10 percent or greater with CMS. Each State determines whether or not to reject or modify these rates, even though they have to file them with the CMS.

So am I correct in understanding that the State review programs are not created equal? Some regulators are weak and some are strong?

Dr. COHEN. I think that'd be correct in that there are a number of States in which we, CMS, do that process but in the majority of States the Department of Insurance does do that process. But I agree with you that—variable in terms of the authorities that they have.

Ms. DUCKWORTH. Okay. So while some States are empowered to provide relief from the skyrocketing rates for their citizens, others like Illinois, we don't have to enable regulators to reject these astronomical rate increases. I am hearing the term file-and-use for States like Illinois. So long as insurers properly file the rates with their regulators, they can use them, is that correct? Can you explain that, file-and-use term a little bit?

Dr. COHEN. Yes. I mean, I think my colleague from the Department of Insurance can probably speak to this in addition, but yes, those are—depending on what State you're in that there are different authorities, and Illinois has one where they can review them but essentially can't change them.

Ms. DUCKWORTH. Okay. Is it Mr. Redmer who—do you have a comment on that?

Mr. REDMER. I will not speak to Illinois. I can tell you that Maryland is not file-and-use when it comes to health insurance, but other parts of the insurance market are file-and-use. But just because it's file-and-use does not mean that we lose our regulatory authority over those rates —

Ms. DUCKWORTH. Okay.

Mr. REDMER.—in Maryland.

Ms. DUCKWORTH. Okay. Back to you, Dr. Cohen. Can you tell me, do we need to change policies for regulators in Illinois and other States so they can do more to stop these rate increases that make the care unaffordable? Or what could potentially be done?

Dr. COHEN. Well, if you look across the country—and I think Congress—what you're seeing in States that do have the ability to do rate review, you are seeing folks look at those rates and make changes to them.

I think what we've been talking about for this year is that there are some one-time upward pressures on those rates, but we have been working very closely with the State Departments of Insurance and, you know, when they are working closely with their insurers to make sure that those rates are appropriate.

Ms. DUCKWORTH. So is this a State-by-State issue or is there anything that can be done at the Federal level?

Dr. COHEN. That's correct, State by State.

Ms. DUCKWORTH. State by State. Is there any type of coincidence or matching with the States that are more file-and-use and have less enabled regulators versus the States who, for example, have refused Medicare expansion?

Dr. COHEN. So we have seen that in Medicaid expansion States that the —

Ms. DUCKWORTH. Okay. Yes —

Dr. COHEN.—private market—the marketplace has seen premium increases that are about 7 percent less, so we definitely are seeing where Medicaid expansion is having an impact on marketplace premiums. And I could get back to you where—I don't have at my fingertips, but I know that there are cities that have shown where rate—where States are effective rate reviewers, that there is more engagement on the rate process, they do these open public hearings, and they are able to do some additional work on understanding and justifying those rates.

Ms. DUCKWORTH. Do you have the public hearings in Maryland? How does that work?

Mr. REDMER. In—I discussed this earlier. In Maryland we have—the rates—proposed rates are given to us May 1. We receive all the actuarial documentation and data. We have a team of actuaries that scrub the data. They challenge the projections and the experience. In Maryland this year, we had two public hearings, and then we ultimately approved rates that in aggregate were about \$24.5 million less than was originally requested.

But you bring up a great point and that is the—as is always the case, the vast majority of the middle class that does not have access to Medicaid, they don't have access to subsidies, and they really are being hurt by these rates. And my concern is that it is the

business death spiral. In other words, as the rates increase and folks have to pay 100 cents on the dollar of these increases without a subsidy, it's going to be the folks that are healthier and younger that are going to choose to leave the market, pay the penalty, and the experience will deteriorate further.

Ms. DUCKWORTH. Thank you. I am out of time. Thank you, Mr. Chairman.

Mr. MEADOWS. I thank the gentlewoman.

The chair recognizes the gentleman from Florida, Mr. DeSantis, for 5 minutes.

Mr. DESANTIS. Dr. Cohen, Congress has imposed limitations on appropriations vis-a-vis the risk corridor program in recent years, is that correct?

Dr. COHEN. That's correct.

Mr. DESANTIS. And I think that obviously reflects the will of the Congress who controls the purse. But I was wondering because this memo that CMS issued on September 9 said about these risk corridor payments and the prospect of lawsuits from the insurers "We know that a number of insurers have sued in Federal court seeking to obtain the risk corridor amounts that have not been paid to date. As in any lawsuit, the Department of Justice is vigorously defending those claims on behalf of the United States. However, as in all cases where there is litigation risk, we are open to discussing resolution of those claims. We are willing to begin such discussions at any time."

So was the purpose of that to basically invite lawsuits and try to provide the risk corridor payments through the judicial process rather than through the appropriations process?

Dr. COHEN. So I think we—as we had said last year and we said again this year, these payments are an obligation of the Federal Government. That is not new. There are ongoing lawsuits and DOJ represents us in those suits and continues to work through a legal process.

Mr. DESANTIS. Can you say whether anybody with HHS has encouraged lawsuit settlements for risk corridors?

Dr. COHEN. Again, I think DOJ would be the one that would need to answer questions about ongoing litigation —

Mr. DESANTIS. Well, no, I mean, if there are people in your department who were encouraging this either in conversations with insurers or others, that would be something that would be noteworthy. So can you say whether that has happened?

Dr. COHEN. So what I could say is that we are—you know, that the process of litigation has been moving forward, and DOJ is doing their work as they would in any other cases.

Mr. DESANTIS. But nobody in HHS has done anything to try to point in this direction where you would have lawsuit settlements

Dr. COHEN. What I —

Mr. DESANTIS.—is that what you are saying?

Dr. COHEN. What I think HHS has done is said, as we said last year, that this is an obligation of the Federal Government and —

Mr. DESANTIS. I understand that, but the question is, as Congress has not saw fit to provide that money in the appropriations process. Obviously, you disagree with that, but the question is is

knowing that Congress has expressed its intent and has refused to provide the funds, can you now try to use the judicial process to get around an expressed prohibition that Congress enacted? Can you provide the committee with any documentations on your end where people are discussing these lawsuits?

Dr. COHEN. So, you know, we have just been doing at HHS is focusing on implementing the law and —

Mr. DESANTIS. So you have—so there are no documents that we would get correspondence involving the lawsuits?

Dr. COHEN. So the lawsuits are handled by the Department of Justice.

Mr. DESANTIS. So the answer to that is no?

Dr. COHEN. So I could refer you to the Department of Justice

Mr. DESANTIS. I am not asking about the Department of Justice. I am asking whether you and anyone in your agency has correspondence about facilitating lawsuits for risk corridor payments.

Dr. COHEN. So obviously —

Mr. DESANTIS. Can you answer the question?

Dr. COHEN. So obviously we are the client, right? They—DOJ is representing us. And so our general counsel does correspond with DOJ —

Mr. DESANTIS. What about outside actors?

Dr. COHEN. Our general counsel is the one that interacts with DOJ on our behalf because we're the client.

Mr. DESANTIS. But not outside actors?

Dr. COHEN. Outside actors?

Mr. DESANTIS. Well, just, I mean if our—is there interaction between either general counsel or people at HHS trying to bring people along to see that the litigation track is the track that the administration would like to see?

Dr. COHEN. I think it's been very public that the litigation has moved forward. A judge in the—one of the cases related to—one of the first cases moving forward asked for all motions to be submitted by September 23. So the—everything is evolving sort of in the normal —

Mr. DESANTIS. Well —

Dr. COHEN.—course of litigation —

Mr. DESANTIS.—we may do then—we may have to send a request for some of these documents to just see so this is transparent.

Let me ask you this. Does the Department of Health and Human Services agree with the Department of Justice's Office of Legal Counsel, which has stated in analysis that judgment funds cannot be used to circumvent a prohibition on appropriations enacted by Congress?

Dr. COHEN. I'd have to talk to my lawyers on that so I can't speak to that.

Mr. DESANTIS. Okay. Well, we'd like to get an answer to that.

Mr. DESANTIS. Do you know, did your counsel or anyone at HHS confer with DOJ before the September 9 memo was issued, do you know?

Dr. COHEN. So, like I said, our counsel does interact with the Department of Justice as we are the subject of those litigation, and so—and DOJ —

Mr. DESANTIS. Do you know if DOJ reviewed the memo?

Dr. COHEN. So I know that they are working towards whatever legal process is unfolding, as they would in any —

Mr. DESANTIS. Well, no, no, that is not the issue. This issue is this conflicts with a 1998 OLC opinion about whether you can use judgment funds in this way. DOJ has been on record as saying that is illegal and improper, and my question to you is was that shown to the Justice Department for their advice or consent on that?

Dr. COHEN. I wouldn't be able to speak to that.

Mr. DESANTIS. Okay. So is it the position of HHS's general counsel that using judgment funds in that manner is appropriate and legal?

Dr. COHEN. So I'd have to have our lawyers get back to you on that.

Mr. DESANTIS. Okay. Well, we will—but the general counsel of HHS did approve the memo of September 9? Do you know if the general counsel reviewed it?

Dr. COHEN. They did review it, yes.

Mr. DESANTIS. Okay. Thanks. I am out of town. I yield back.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentleman from Massachusetts, Mr. Lynch, for 5 minutes.

Mr. LYNCH. Thank you, Mr. Chairman. And I want to thank the witnesses for helping us with our work.

So we have this article in the Boston Globe of September 9, and it really does in a very concise way explain the problem we are having. So we have one subsidized network plan that offers access to the Mass General Hospital and Brigham and Women's Hospital, two of really the finest hospitals with the best docs in the country. They are a teaching hospital, do a lot of important research for us.

But the neighborhood health plan that would allow enrollees who are subsidized to go to those hospitals has just pumped up their premiums by about 21 percent. So a lot of people, thousands of people are faced with the fact that—one of the big fears of the Affordable Care Act when it came out—and I want to confess I voted against it. I voted against it for a number of reasons that I will go into. And my opinion and my vote would not change if it were held again today.

But we were worried that we might end up with two systems, two health care systems, one for the people who could afford it and then everybody else who is on the subsidy. They can't get access to the good docs. That is exactly what is happening here or is threatened here. We have got one subsidized network, and if this goes away, if people can't pay that 25 percent increase, then the doors are locked to Mass General, the doors are locked to Brigham and Women's, two of the finest hospitals in the country. And I am worried about that.

The basic idea behind the Affordable Care Act was, as it was presented to Congress, was that since we were paying multiples of what other countries were paying in terms of trying to provide health care for their citizens, if we could just squeeze the cost, get that cost down, we could use the savings and the cost curve, use the savings to cover the people who were uninsured. That was the idea.

But as we have seen and as Jonathan Gruber—I know people use that as a punch line, but he actually is a very smart man, testified before the Senate, and he even admitted, he said we punted on cost containment. We punted on that. We have very strong incentives to get coverage, very low incentives to actually squeeze the cost down.

And there were several other items in the Affordable Care Act that caused me to vote against it. One was an antitrust exemption. So in the Senate version we gave back the antitrust exemption to companies under the Affordable Care Act so that they could act in restraint of trade so that one insurance company can cover an entire State and squeeze out competition because they have got everybody signed up. We allowed that. We put that into law. It was taken out in the House, put back in the Senate, and then it was part of the final bill.

The other piece, we eliminated the public option. So we were relying on the public option, even a State-run public option to put out a bare-bones plan to compete with some of these private plans so that by competition, if the State put out a bare-bones plan at low cost but reliable and providing adequate health care, people would buy that, and it would be up to the private insurers to compete with that. We took out the public option, so we eliminated a lot of competition that would have otherwise occurred.

And then lastly, we put in a Cadillac tax, a so-called Cadillac tax. So you have these good employers, a lot of them union employers who sat down with their employees and worked out a plan because health care was not taxed back then. So a lot of these union employees said, okay, rather than take money in our envelope, rather than take pay raises, we are going to take good health care, which would help their families. Now, we turned around after they did that, to those employers and those unions that sat down and worked together, we punished them. We put in a Cadillac tax. Now, Congress in its wisdom has postponed that.

But what has—eliminating the antitrust exemption, the Cadillac tax, and eliminating the public option, Mr. Spiro, what impact has that had on moving forward here? And we are trying to meet the goals of the Affordable Care Act, the original goals.

Mr. SPIRO. Thank you for the question. I think if you look at the hospitals in Boston, that is a unique situation and we shouldn't judge hospital quality based on reputation alone. I would refer you to your —

Mr. LYNCH. These are the best docs, though, just so you know.

Mr. SPIRO. Okay.

Mr. LYNCH. I live in the city. I know where the best doctors are. That is where my wife goes. And, look, I think it is generally accepted that those are the best hospitals.

Mr. SPIRO. But I would refer you to your own State's cost commission, which has identified growth in hospital prices as the main driving factor in the rise of health care costs. So that's an issue that needs to be addressed.

Mr. LYNCH. We are also teaching hospitals, though, right? So the benefit is benefitting the rest of the country by—it costs more obviously to deliver health care when you are a teaching hospital than if you are not.

Mr. SPIRO. Well, again teaching hospitals are heavily subsidized without much transparency or accountability. But that's a different issue from, I think, the thrust of your question, which is on antitrust and the public option. On antitrust, the ACA did not change the law on the antitrust exemption.

Mr. LYNCH. Right. We changed it in the House version. We did. We changed it in the House —

Mr. SPIRO. Sure.

Mr. LYNCH. We took out the antitrust exemption but —

Mr. SPIRO. But I just want to clarify that that was —

Mr. LYNCH.—the ACA put it back in.

Mr. SPIRO.—preexisting the ACA, the antitrust exemption. I would support removing it, but —

Mr. LYNCH. All 300 Members of Congress voted to change it, Republicans and Democrats.

Mr. SPIRO. I don't think it's fair to blame the ACA for changing the law. It didn't change the law —

Mr. LYNCH. Well, we put it back in.

Mr. SPIRO.—it actually —

Mr. LYNCH. It included an antitrust exemption —

Mr. SPIRO. No, the —

Mr. LYNCH.—so —

Mr. SPIRO.—House bill never became law.

Mr. LYNCH. Right.

Mr. SPIRO. So the ACA—the Senate bill—the ACA did not change the law on the antitrust exemption. On the public option I said in my testimony I support—I would call it the guaranteed choice plan, and I think the President has voiced support for that idea.

Mr. LYNCH. Okay.

Mr. SPIRO. I think it's important —

Mr. MEADOWS. The gentleman —

Mr. SPIRO.—to add to the law —

Mr. MEADOWS.—is out of time, so I appreciate it. I am sorry to cut you off, but as we go, we have got a few other members.

So the chair recognizes the gentleman, Mr. Hice, from Georgia.

Mr. HICE. Thank you, Mr. Chairman.

I have really some comments here. I am kind of just amazed, shocked at some of the things I have heard here today. You would literally think—in fact, it has been implied that ACA has somehow reduced cost and increased coverage. In fact, I believe I heard someone actually say something along the lines of we now have the lowest health care cost in our nation's history. I am trying to wrap my head around this kind of nonsense.

Now, look, it is not the Federal Government's responsibility to take over the health care industry in the first place. And I am as concerned as anyone with health care costs, but government intrusion is the problem, not the solution. And if ObamaCare is as great as it is, I am curious why none of our witnesses here participate. I mean, we all know that this is a disaster.

And, Mr. Chairman, what sets this hearing apart from other hearings on the ACA is that now we have a track record that we are able to look back on and see where this thing has been taking us. We have a track record to look at what the President and his

administration originally told us versus what has come to fruition, things like what has already come up today. If you like your health care, you can keep it. If you like your doctor, you can keep your doctor. We now have the track record to know that was totally false.

And, you know, as we look at these kinds of things, we have got to face reality. Now, we are facing the fourth enrollment period, and this whole thing is coming off the tracks. It is a national disaster. It is a health care disaster. It is an economic disaster. We have got the—Ms. Cohen, you mentioned 20 million people have been enrolled. You are including the Medicaid people. The real numbers are 12 million actual people enrolled in ObamaCare, just over half of what was predicted.

And all this contributes to the problem. I mean, many of you know firsthand we have got insurers that are leaving. It wasn't long ago UnitedHealth backed away. A couple weeks ago Aetna backed out. And why? Why are these insurance companies—because they are hemorrhaging in their costs. They cannot survive, despite the fact that billions of taxpayers' dollars are subsidizing this thing. Insurance companies are still losing their shirts, and it can't continue.

And for those insurance companies that remain, premiums going up and up and up and up and up just to cover the costs, this year, going up again in 2017. I think looking at a national average, a 25 percent increase this year. My State of Georgia we are expecting double-digit increases, more and more increases. Blue Cross Blue Shield going up over 20 percent in Georgia this year just to cover costs.

And, you know, we talk about all these people, all these millions of people, Ms. Cohen, getting insurance coverage. Let's face reality. We have 20 million perhaps who think they have insurance, but in reality—and I have heard this—if I have heard it once, it has been dozens and dozens of times, particularly rural hospitals across my district—people go to the hospital thinking they have insurance only to find out they have got 5, 10, 15 whatever thousand dollars of deductible. They can't even make the deductible payment. So the hospitals don't get paid. We have got rural hospitals on the verge of collapse because nobody is paying for the coverage they are getting.

And the problem goes up and up. This year, what, 65 percent of Americans are actually going to have the higher deductible option in this thing. This is not affordable for anybody. It is not affordable for our entire nation, and yet we have people continuing to try to defend it.

I think it is clear to anyone watching and anyone experiencing this, which none of you are experiencing it because none of you participate, but people who are experiencing the horrors of ObamaCare, they know what it is doing to their families, they know what it is doing to their health care options.

And I think it is time, Mr. Chairman, that we get honest with this whole reality and face the facts that this is a disaster and we need to get rid of this thing and let the free market enterprise and individuals with their doctors determine what is best for them

rather than government getting involved in this. And with that, I yield back.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentleman from Virginia, Mr. Connolly, for 5 minutes.

Mr. CONNOLLY. I thank the chair.

And I couldn't disagree more with my friend from Georgia and his characterization. I find it ironic. Mr. Spiro, was not the ACA absolutely modeled on a Republican Governor's health care bill in Massachusetts?

Mr. SPIRO. Yes, Mitt Romney's.

Mr. CONNOLLY. Right. Was not the scheme here rather than having a single-payer system but the idea of stakeholders having skin in the game so they become cost-conscious, a Republican think tank idea?

Mr. SPIRO. The Heritage Foundation, in fact, came up with the idea for the individual mandate.

Mr. CONNOLLY. Right.

Mr. SPIRO. So a lot of —

Mr. CONNOLLY. Not a Democratic idea, a Republican idea, absolutely heart and soul incorporated into this so-called government takeover my friend from Georgia just mischaracterized.

Mr. SPIRO. Correct.

Mr. CONNOLLY. Dr. Cohen, when I had to face voting, I told my voters there are three things I am going to measure a bill by: Is there a meaningful basket of reforms that protect consumers? Does it address the long-term cost curve so we have some hope of reducing the growth in costs in terms of health care in America? And does it address the problem, the crisis, the scandal of huge numbers of uninsured Americans? Does it reduce the number of uninsured Americans? In your opinion did we address those three things or not, and are they working or not today?

Dr. COHEN. So let me take them in reverse. Obviously, on the uninsured we have talked about the historic lows in uninsured. On the consumer —

Mr. CONNOLLY. Let's just stop there for a second —

Dr. COHEN. Sure.

Mr. CONNOLLY.—uninsured because I don't know what the Legislature in Georgia has done. I do know what they have done in my State in Virginia. The Republican majority, against the wishes of the Democratic Governor, have refused to take advantage of the provision on Medicaid. Medicaid would cover 400,000 uninsured Virginians, and the scandal of not taking advantage of that has cost Virginia billions of dollars of Federal money that we are entitled to but we are not taking advantage of, and every year we have a voluntary clinic in a rural part of our State where thousands of people without health insurance line up overnight to get basic medical care, highlighting the need.

My friend talked about hospitals closing. We have had hospitals close in rural areas because of the fact that we are not taking advantage of that Medicaid provision for political reasons, not out of concern for patients. If we really want to do something, that is money waiting to be taken advantage of, and some Republican Governors have, such as John Kasich of Ohio, is that not correct?

Dr. COHEN. That is correct, sir.

Mr. CONNOLLY. Okay. Please continue with the other two.

Dr. COHEN. So on the consumer protections, I think now we have been talking about essential health benefits so that folks know that they have quality health insurance when they are purchasing it, but also important to note the preventative services that everyone has access to without cost-sharing, that is not just in the marketplace but that is across the market in—that we're able to take advantage of through our employer-sponsored coverage as well.

Other consumer protection, given that we're talking about premiums today, is the medical loss ratio. That is a consumer protection in and of itself. We have paid—insurance companies have paid back \$2 billion to consumers when they've overcharged them, and that's an important backstop for what we've been talking about related to costs and could—insurers increase their costs. Well, now there's a backstop which protects consumers as well.

And on your third point about cost containment, that is some place where, wearing my other hat related to what we're doing in the Medicare world, we're really thinking about cost containment every day. We're moving towards alternative payment models, and we've been making great progress, as well as thinking about drug costs.

Mr. CONNOLLY. And final question, either to you or Mr. Spiro, but one of the criticisms at the time of the debate about ACA was we were going to kill Medicare Advantage. And my friends on the other side of the aisle just scared the bedevil out of seniors that that was going to happen.

So what happened, Mr. Spiro, to Medicare Advantage? Did premiums go up or down? Did benefits get expanded? And what happened to enrollment? Certainly, it is dead today, right, Medicare Advantage?

Mr. SPIRO. Enrollment has been increasing substantially, despite the cuts in the Affordable Care Act to eliminate the subsidies that those plans were getting, the extra subsidies. So the system is much more efficient and is not cutting enrollment as scaremongers

Mr. CONNOLLY. And in fact, premiums stayed pretty stable?

Mr. SPIRO. Yes.

Mr. CONNOLLY. Yes. And benefits actually expanded?

Mr. SPIRO. I can't speak to that. I don't know.

Mr. CONNOLLY. Other than that, we killed it. I mean, at some point the critics have to take responsibility for charges they made that have in fact not been borne out. The opposite has been borne out.

Mr. MEADOWS. All right. The gentleman's time —

Mr. CONNOLLY. My time is up.

Mr. MEADOWS.—is expired, so the chair recognizes the gentleman from Georgia for 5 minutes.

Mr. CARTER. Thank you, Mr. Chairman. And thank all of you for being here. And let me preface my remarks by saying that I totally disagree with my friend from Virginia. I am not going to speak for my partisan view. I am going to speak as a health care professional. And I want to ask you some very serious questions here.

Mr. Giesa—is that correct, Giesa?

[Nonverbal response.]

Mr. CARTER. In the State of Georgia where I have practiced pharmacy for the last 30 years, the regulators have approved a 21.4 percent increase over the average premium, a 21.4 percent average premium increase for Blue Cross and Blue Shield for the 2017 exchanges. Is this taking into account the fact that you are going to be picking up 70,000 to 90,000 more customers from Aetna because they have exited the market? And that, as I understand it, leaves Blue Cross Blue Shield as being the only plan that covers all the counties in the State of Georgia, is that correct?

Mr. GIESA. Well, as I said, I'm here on behalf of the association, and I can't comment on the situation for any specific plan.

Mr. CARTER. Well, let me assure you that what I just said is true, okay, 21.4 percent because of the fact that they are having to pick up 70,000 to 90,000 more customers because the insurance plan with Aetna, they exited the market. And that is understandable. And before they ask for the 21.4 percent, they were only asking for a 15.1 percent. Do you think a 21.4 percent increase is a significant increase?

Mr. GIESA. I would characterize that as a significant increase.

Mr. CARTER. Anybody disagree with that on the panel?

Dr. Cohen, do you think a 21.4 percent increase is a significant increase?

Dr. COHEN. Yes, it is significant.

Mr. CARTER. Anyone disagree? Please shake your head no if you disagree.

Mr. Spiro, you look a little bit contemplating this. You don't think a 21.4 percent increase is a significant increase?

Mr. SPIRO. I do. I think you have to look, though, whether it's the average premium or the premium for the silver plans, and I'm not sure—having not looked at your—the data in your State, I'm not sure what you're referring to.

Mr. CARTER. Well, let me assure you, it is the average premium.

Mr. SPIRO. Well, you'd want to look at the silver premium because that's what subsidies are tied to.

Mr. CARTER. You know, I don't care whose idea it was. I don't care if it was Republicans. I don't care if it was Democrats. It was a bad idea. I am just telling you. It has been—the one thing it has not been is affordable. Don't we see that? You know, one of the first things they taught us when I entered the Georgia Legislature over 12 years ago—I served for 10 years—they said when you are in the hole, quit digging. Well, guess what? We are in the hole and we keep digging. More plans keep going out. And what happens? We keep digging.

The co-ops, I mean how ridiculous can we be? Twenty-three and 17 have gone bankrupt? Duh. Man, we are here from the Federal Government and we are here to help you. Well, guess what? We ain't helping health care, a profession that I have practiced for over 30 years. We are ruining it. The Affordable Care Act is ruining health care in American. Don't we get that?

Until we put the free market back into the health care system, until patients have control, doctors have control, pharmacists, health care professionals have control over health care decisions, it is not going to work. It is not affordable and it is not quality. I

don't care if it was a Republican idea, and I don't care if it was a Democratic idea. It was a bad idea.

Dr. Cohen, let me ask you a question. In July of this year our President said too many Americans are still straining to pay for their physician visits and prescriptions, cover their deductibles, or pay for their monthly insurance bills. Do you agree?

Dr. COHEN. I think what he went on to say is that with increased subsidies that we could address a lot of those issues.

Mr. CARTER. There you go, increase subsidies, that is what we need to do. Haven't we tried that?

Dr. COHEN. And it is working pretty well, 20 million new covered.

Mr. CARTER. It is working pretty well? What health care system are you practicing in? Obviously —

Dr. COHEN. The one that —

Mr. CARTER.—not the same one that I am practicing in, Dr. Cohen.

Dr. COHEN. Well, I'm practicing in the one where folks can get coverage for less than \$75 a month.

Mr. CARTER. What good does it do them to get coverage if they are going to have 21.4 percent increase year after year?

Dr. COHEN. I think that —

Mr. CARTER. Some places are having —

Dr. COHEN.—when you look at 25 —

Mr. CARTER.—a 50 percent increase. Dr. Cohen, some places are having a 50 percent increase. Whatever you do, just go back to your offices and say we are going to take that affordable part off. That is all I am asking you to do is just take the affordable part off. Just take that out of the title, okay? Just say you are doing it for this poor pharmacist from Savannah, Georgia.

Mr. Chairman, I yield. I am going to take my blood pressure medicine.

Mr. MEADOWS. I thank the gentleman from Georgia.

The chair recognizes the gentleman from Maryland, the ranking member, Mr. Cummings.

Mr. CUMMINGS. On that note, I hope that the gentleman will be able to afford the blood pressure medicine.

Let me ask this, Mr. Spiro. You said something that I think we need to stick a pin in. You said that in those States that took advantage of the Medicaid provisions of the Affordable Care Act, the premium increases are 7 percent lower. Is that what you said?

Mr. SPIRO. Yes, correct.

Mr. CUMMINGS. And so we have people now, Dr. Cohen, who if we did not have the Affordable Care Act, would not have insurance because of things like preexisting conditions. In other words, if somebody had a breast cancer scare, wouldn't be able to get insurance, is that right?

Dr. COHEN. That's right. Before the Affordable Care Act, pre-existing conditions could have a—caused you to have absolutely no options for —

Mr. CUMMINGS. So they are just out of luck?

Dr. COHEN. Out of luck.

Mr. CUMMINGS. And so they have—if they were like my mother-in-law, who sadly died from breast cancer, they would be in a treat-

ment—I guess they would—well, what would they do? Have to depend on charity? I mean —

Dr. COHEN. Charity care.

Mr. CUMMINGS. That is the real deal. See, we are the United States of America, and this is about trying to make sure we take care of our own. And when I think—I tell you, I have said it many times. When I look at the States that do not take advantage of the Medicaid provisions of the Affordable Care Act, to me, to me that is a very, very sad thing because you have got a situation where literally people are left to get sicker and in many instances die early. That is real.

And so when we talk about experiences, the experiences of being ill and not being able to get the care one needs, that is something that I think we need to go back to as a nation.

Now, we know that the ACA has significantly expanded the individual insurance market, and 11 million people did not have coverage before the ACA now have marketplace insurance. We also know that some insurers have been more successful in adapting to the ACA's new marketplaces. Mr. Carlson, it seems that the smaller regional insurers that have more experience in the Medicaid market seem to be doing relatively well while larger legacy insurers have struggled. Why do you think some of these insurance members have fared better than others in adapting to this market?

Mr. CARLSON. Well, you know, I understand that there are companies that are doing well and others that are not doing well. And, you know, I can't speak to any specific company, but I can tell you that health care is a very—health care insurance is very local markets. So the ones that are doing well are probably the ones that have the ability to negotiate with providers and have authority over, you know, the ability to manage their costs well.

And, you know, there are other factors in health care trends that they can't affect such as the great increase in prescription drugs lately —

Mr. CUMMINGS. I am glad you said that. You went exactly where I wanted you to go. Tell me what effect does the high price of prescription drugs have on insurance premiums, if any?

Mr. CARLSON. Well, it is a significant issue. You know, the—I mean, when you look at a 40 percent rate increase that we've seen in some States, it's hard to pin prescription drugs exactly on that. However —

Mr. CUMMINGS. I am not saying the whole thing.

Mr. CARLSON. Right.

Mr. CUMMINGS. I am saying but a contributing factor. People are getting rich. They are charging these unreasonable prices. EpiPen is a perfect example. It costs pennies to produce, pennies, and they go in a few years from I guess, what, about \$100 to \$600. And I was just telling my staff that in talking to reporters, I talked to about 10 reporters over near the Floor, and eight of them use EpiPens.

Mr. CARLSON. And I would add that EpiPens is not a unique case. There are plenty of other —

Mr. CUMMINGS. Oh, believe me, I know. Martin Shkreli sat right in the seat that you are sitting in and thumbed his nose at us, called us imbeciles because we wanted to know why his company

could raise the price of a pill from \$13.50 to \$750. And so nobody can tell me—and that is happening all over the pharmaceutical industry. So it has to have an impact. I am not saying it is everything, but it is major.

And so what do you all suggest? You all are experts. What do you all suggest we do about that? Do we just sit back, Dr. Cohen, and just let that happen?

Dr. COHEN. So we've definitely been taking steps forward there. I think you know we proposed earlier this year some demonstration projects to work on costs in the Medicare program and the Part D program, so we are certainly making sure that we are looking at that, as well as what we think about the total cost of care, the work that we're doing in trying to do alternative payment models. Prescription drug costs are part of that, so we want to make sure that all folks are thinking about the total costs for all the care that they're providing and thinking about the quantity and the quality.

Mr. CUMMINGS. Redmer, are we doing anything in Maryland? This is a great man. He is from my State.

Mr. REDMER. Yes, I appreciate that. I'm not going to get into what we are or are not doing regarding pharmaceutical costs. That's certainly outside the —

Mr. CUMMINGS. But this comment on whether it has —

Mr. REDMER. Oh, certainly —

Mr. CUMMINGS.—an impact on —

Mr. REDMER.—it has a significant effect on —

Mr. CUMMINGS. Would you like to see us do something about it?

Mr. REDMER. Absolutely. Particularly specialty pharmaceuticals are having a significant increase.

Mr. CUMMINGS. I see my time is up, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman.

Obviously, as we look at the market for affordable drugs, it is something that we have to address, but we also have to look at affordable health care. And I can tell you, as someone who is part of the Affordable Care Act, I have seen increased premiums with higher deductibles and less benefits than when I was purchasing in the private sector.

So with that, we will go to the gentleman from Alabama, Mr. Palmer, for 5 minutes.

Mr. PALMER. Thank you, Mr. Chairman.

Dr. Cohen, so far Aetna, UnitedHealthcare, Humana, and there may be others that will likely be coming down the pipeline, have announced they are leaving the exchanges. We have all heard the clip of the President famously saying "If you like your doctor, you can keep him," which, as it turns out, was completely untrue.

Hundreds of thousands of people participating in the exchanges will have to find new coverage at the beginning of the year, and this will likely mean new doctors. What kind of comfort can you give these individuals and families that believe the President but are now experiencing the exact opposite of what he promised?

Dr. COHEN. Well, what I think we've talked about today is that before the Affordable Care Act for folks with preexisting conditions, there were no options —

Mr. PALMER. I am not talking about the people with preexisting conditions. I am talking about the promise the President made to

the people who already had insurance that people who were doing business with some of the companies represented right here who are dropping out of the exchanges, who are losing hundreds of millions of dollars. So if you would structure your answer to the question.

Dr. COHEN. Sure. In the employer market we actually have seen very little change in what employers are offering in terms of the number of employers offering coverage. That's one of the reasons when folks talk about, you know, CBO projections of who would enroll into the marketplace are actually seeing less erosion of the employer market, which is a good thing —

Mr. PALMER. Well, that is interesting in light of the fact that of the 20 million people who have insurance, Medicaid's enrollment is now at a record level, 72.5 million, and there have been 15 million additional people since ObamaCare's open enrollment began. So it looks like the majority of the people who are being insured are being insured in the government plan. There are 4.5 million people who had private insurance, employer-based insurance who have lost their insurance.

So I think for all of the political speak and the hemming and hawing around, the bottom line is is that it hasn't worked the way it is supposed to work. There are millions of—hundreds of thousands, not millions of people who have lost access to the health care that they had prior to this. And, unlike my colleagues across the aisle. I would like to have a constructive dialogue about it to reform this and correct it and get it back to where it works.

Mr. Giesa, Blue Cross Blue Shield of Alabama requested a rate increase for small group plans of 4 percent, yet they requested an increase of 39 percent for individuals plans on the exchanges. Can you give me an idea of what accounts for this disparity?

Mr. GIESA. Well, again, I apologize to answer the questions the same way, but the Blue Cross Blue Shield Association is a national federation of independently run plans, and the pricing and strategy decisions those plans make I am not privy to.

Mr. PALMER. Well, I would expect that you would have some concern about the losses. I mean, Blue Cross Blue Shield of Minnesota has lost \$500 million. Health Care Services Corporation, which owns the Blue Cross affiliates in Illinois, Montana, New Mexico, Oklahoma, and Texas, they lost \$1.5 billion. Blue Cross Blue Shield of Tennessee lost \$300 million. Highmark Group, which owns Blue Cross in Pennsylvania, Delaware, and West Virginia, lost \$266 million. Can the companies you represent sustain those kind of losses and stay in the market?

Mr. GIESA. No, and that's the primary reason for the rate increases we've been seeing, I would say.

Mr. PALMER. Well, Mr. Chairman, I would like to point out that not only does this impact individuals and families, it is impacting the economy. We now have companies that are restricting their expansion of employment. They have cut back hours. It is having a devastating impact.

I just left a budget hearing with former CBO director Douglas Holtz-Eakin in looking at our economic growth and how overregulated the economy is, and I think the health care law is a major contributor to that.

They are now projecting that over the next 10 years the economy, maybe over the next 30 years might only grow at 2 percent when the 70-year average was 3.2 percent. And I attribute a lot to the economy being overregulated, but a substantial part of it has to do with what we have done with health care. It is having a devastating impact on the economy. It is having a devastating impact on individuals and families, and it is driving companies out of the marketplace. Employers, people who provide insurance—I have gotten my insurance from Blue Cross Blue Shield for years.

My time is almost expired. I have one last thing. I was listening to Mr. Spiro's opening statement, and it reminded me of the old liberal view of communism, that it failed because no one had done it the right way, and I kind of thing that is the arguments for the Affordable Care Act. I yield back.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes the gentleman from South Carolina, Mr. Mulvaney, for 5 minutes.

Mr. MULVANEY. Thank you, Mr. Meadows.

Dr. Cohen, I have just got a couple follow-up questions, nothing major, but following up on what Mr. DeSantis was talking about, which is this memo that CMS sent out—actually, it was a public memo; it wasn't sent to anybody—regarding the risk corridors. You mentioned a couple times, and I think you are right, that the DOJ is your lawyer in these disputes and you are the client. It makes sense. You are not a lawyer. You are a doctor. I get that.

Why would you send this out? Why wouldn't your lawyer tell you not to talk to the people that might be suing you? It's general advice. Whenever lawyers advise their clients, don't talk to the people who are going to sue you. Let me do that. So why did you send this out?

Dr. COHEN. So I think the rest of the document describes what was happening in this year's program, as well as reiterating our commitment to the program. And I think what it's saying there is that whenever there's litigation risk, as it says right there, that you can always go talk to our lawyers.

Mr. MULVANEY. Right, but that is not what it says. In fact, you don't have to say what it says; we can read what it says. "We know that a number of issuers have sued in Federal court seeking to obtain the risk corridor amounts that have not been paid to date. As in any lawsuit, the Department of Justice is vigorously defending those claims on behalf of the United States. However, as in all cases where there is litigation risk, we are open to discussing resolution of these claims. We are willing to begin such discussions at any time." It doesn't say call the DOJ. It doesn't say don't call us. Has anybody called you on this, by the way?

Dr. COHEN. So I think folks know that the Department of Justice represents us in this, and so I'm sure they're going —

Mr. MULVANEY. Yes, they do. Yes, they do. So why send it?

Dr. COHEN. Again, it is normal course of business here —

Mr. MULVANEY. Can you tell me, was it ordinary course of business?

Dr. COHEN. Yes. So as litigation is moved through the —

Mr. MULVANEY. Have you all ever sent out a notice before saying we are getting sued and we know you all can sue us, do us a favor,

call us now and we can talk settlement without DOJ here? Have you ever done that before?

Dr. COHEN. So what I think the paper is saying is that we said last year, which is we have an obligation here and we have always said that. And —

Mr. MULVANEY. Did you send out a similar memo last year?

Dr. COHEN. We sent out a similar memo, yes, with our obligation here, but what has —

Mr. MULVANEY. Did it have —

Dr. COHEN.—transpired —

Mr. MULVANEY. Did it have an invitation at the end to please have people call you to begin discussions on settlement resolution?

Dr. COHEN. So at that point a year ago we had no litigation. And so what we're acknowledging this year is that time has evolved and folks are now suing us in Federal court, as it says.

Mr. MULVANEY. All right. Then skip ahead to my other question, which is has anybody contacted you as a result of this memo going out?

Dr. COHEN. Again, I imagine that conversations are happening with DOJ, but we are—I'm not —

Mr. MULVANEY. I imagine a lot of things, Ms. Cohen, but that is not really my question. Has anybody contacted you —

Dr. COHEN. No, has not contacted me.

Mr. MULVANEY.—about this yet? They might have contacted DOJ and you wouldn't know that.

Dr. COHEN. Correct. DOJ handles —

Mr. MULVANEY. But DOJ hasn't told you anybody has called you about this yet?

Dr. COHEN. DOJ handles these matters on our behalf.

Mr. MULVANEY. What is the deadline just so everybody who might be able to sue HHS over the risk corridor payments? When is the deadline for them to contact DOJ so they can file their lawsuits or begin negotiation discussions?

Dr. COHEN. I couldn't answer—I don't know if there's a—I would have to ask lawyers. I don't believe there's a deadline.

Mr. MULVANEY. Not the end of September or something like that?

Dr. COHEN. No.

Mr. MULVANEY. Is it the end of this term? Is it the end of this administration?

Dr. COHEN. There—as we've said, this is a 3-year program. We've said that all along. We've said that there is an obligation here. I think this is, again, nothing new that we hadn't said last year.

Mr. MULVANEY. I want to go back because Mr. DeSantis talked on this, and this would be more for the lawyers in the audience, not the doctors. But he mentioned briefly whether or not the judgment fund could be used to pay this, because I think that is HHS position right now is that there is no money in the appropriations. We got rid of that. I think that was Senator Rubio's amendment in the last appropriations bill. So there is no money left in appropriation for risk corridor payments. It apparently is the opinion of HHS or DOJ or both that the judgment fund might be available to make those payments.

But I want to read what I thought that Mr. DeSantis was going to read and, you know, he ran out of time. And this is a quote from the Department of Justice. “The judgment fund does not become available simply because an agency may have insufficient funds at a particular time to pay a judgment. If the agency lacks sufficient funds to pay a judgment but possesses statutory authority to make the payment, its recourse is to seek funds from Congress. Thus, if another appropriation or fund is legally available to pay a judgment or settlement, payment is otherwise provided for and the judgment fund is not available. This is the Clinton administration’s decision in 1998.”

So for the folks who are watching this today who got their little memo who are thinking about calling you folks, I think they should know that it is the opinion of at least some lawyers, some of whom are Republicans in Congress, others of who were Democrats in the administration of Bill Clinton, that the judgment fund is not available for these payments. And in order for these payments to be made, folks are going to have to make the argument to both parties in Congress that Congress should appropriate that money and that it is not proper for this administration to be paying any awards out of the judgment fund.

Thank you, Mr. Chairman.

Mr. MEADOWS. I thank the gentleman.

The chair recognizes himself for a series of questions.

Mr. Spiro, let me come to you. I told you I was going to do that, so let me come to you. In your testimony you said “There are signs that the insurer financial performance is improving.” Do you stand by that statement that the insurers’ financial conditions are improving?

Mr. SPIRO. Well, I was citing a Goldman Sachs report on the not-for-profit Blues plans, which said that their —

Mr. MEADOWS. You may be quoting that. So is the insurance industry improving as a result of the ACA?

Mr. SPIRO. I was just citing a report so you’d have to ask —

Mr. MEADOWS. Well, okay. So maybe you were. That was your testimony and I am —

Mr. SPIRO. Yes.

Mr. MEADOWS.—asking you to clarify it. Is the insurance industry’s financial condition improving?

Mr. SPIRO. I think it will improve after this price correction. As I mentioned in my testimony —

Mr. MEADOWS. So what you are saying is —

Mr. SPIRO. There was under-pricing in 2014 and the phase-out one time —

Mr. MEADOWS. Well, so let me —

Mr. SPIRO.—of these transition programs —

Mr. MEADOWS. Let me go with that.

Mr. SPIRO. After that, once the —

Mr. MEADOWS. But hold on. Let me go with that.

Mr. SPIRO. I think that we will see —

Mr. MEADOWS. It is my 5 minutes, Mr. Spiro. It is my 5 minutes.

Mr. SPIRO. I was just answering your question.

Mr. MEADOWS. No, you were pontificating. You were not answering the question. I asked you a very simple question. So, Mr. Spiro,

let me ask you this. If you are saying a one-time adjustment is what will fix the ACA, it is because they under-priced things because of the risk corridor, is that correct?

Mr. SPIRO. Well, as I mentioned in my testimony, there will be a transition to an equilibrium. How fast that happens depends on whether Congress can take additional action, whether States take additional —

Mr. MEADOWS. Well, let's assume that Congress —

Mr. SPIRO.—action and whether the administration takes —

Mr. MEADOWS.—is not going to take additional action.

Mr. SPIRO. Why is that?

Mr. MEADOWS. Because the risk corridors in the bill and the law that I guess you helped work on, isn't that correct? Weren't you part of the team that wrote the ACA?

Mr. SPIRO. I worked for the Senate HELP Committee in 2008

Mr. MEADOWS. Well, according to your bio that you put out, it says that you were part of the team that actually drafted the Patient Protection and Affordable Care Act, is that correct?

Mr. SPIRO. Correct, I worked with —

Mr. MEADOWS. Okay.

Mr. SPIRO.—the Senate HELP Committee.

Mr. MEADOWS. So is it working the way that you intended it to work?

Mr. SPIRO. It's insuring a lot more Americans —

Mr. MEADOWS. That is not what I asked.

Mr. SPIRO.—and the costs have come down —

Mr. MEADOWS. That is not what I asked.

Mr. SPIRO.—further than expected.

Mr. MEADOWS. Is it working the way that you intended it to work?

Mr. SPIRO. The transition to equilibrium is taking longer than I had expected it would take.

Mr. MEADOWS. All right. Well, that is fair enough. Well, let me ask you, how does your statement of a one-time fix and an adjustment correspond with your sworn testimony that you gave in 2013—and I will quote you—“emerging evidence,” which is the word that you just used, emerging—“Emerging evidence indicates that the exchanges are working as intended. The competition among plans and providers are already lowering premiums.” Now, that was your testimony in 2013. Now, you have testimony now that says, well, it is not working as intended. We may have to do a one-time fix or adjustment. How do you reconcile the two of those?

Mr. SPIRO. I think what's becoming clear now is that actually competition was too competitive and that rates came in too low in the initial years.

Mr. MEADOWS. All right. So you base this—you don't have a degree in economics, do you?

Mr. SPIRO. No.

Mr. MEADOWS. Okay. So you don't have a degree in finance?

Mr. SPIRO. No, but I encourage you —

Mr. MEADOWS. Well, the reason I ask —

Mr. SPIRO.—to ask your expert witnesses —

Mr. MEADOWS.—is because you say too much competition actually is what created this?

Mr. SPIRO. What's becoming clear is that —

Mr. MEADOWS. I want to find the —

Mr. SPIRO.—both premiums —

Mr. MEADOWS.—economic principle that you are going to grab that would suggest that. What economic principle would you grab

Mr. SPIRO. The markets were hypercompetitive, which encouraged insurers to under-price their premiums in 2014, so we're finding now that a correction is due in 2017 for that under-pricing.

Mr. MEADOWS. All right. So you are suggesting—and so when the government gets involved and creates false markets with subsidies, that has no effect whatsoever on the financial viability of an insurance company?

Mr. SPIRO. I don't understand the question.

Mr. MEADOWS. When you have a subsidy that comes in and a guaranteed of picking up and having to pay for preexisting conditions and having the unintended insurer that you may have to pick up, would that not make the market react in unusual ways?

Mr. SPIRO. It was a new market. There was a lot of uncertainty about pricing. There was a new consumer population —

Mr. MEADOWS. And your sworn testimony here today is the whole reason this happened is because we had too much competition?

Mr. SPIRO. We had —

Mr. MEADOWS. That is your sworn testimony.

Mr. SPIRO. We had too much pricing uncertainty, and yes, premiums came in too low as it was also —

Mr. MEADOWS. And you base that—well, you know, you are a lawyer. I guess you have a degree in, what, public policy, is that correct —

Mr. SPIRO. I have a law degree.

Mr. MEADOWS.—from Princeton?

Mr. SPIRO. I have a law degree, yes.

Mr. MEADOWS. You have a law degree from University of Virginia. You have an undergraduate from Princeton, is that correct?

Mr. SPIRO. Correct.

Mr. MEADOWS. Okay. Has any of it allowed you to do Jonathan Gruber kind of models?

Mr. SPIRO. No.

Mr. MEADOWS. All right. So most of your testimony—here is the reason I am concerned. UnitedHealthcare has lost over \$1 billion on exchanges in the last two plan years. Aetna expects to lose \$650 million on exchanges and lost \$475 million in 2015. Health Care Services Corporation, which is kind of a bundle of some of the Blue Cross Blue Shields in five States has lost \$1.5 billion in exchanges. Now, are you saying that this is caused by too much competition?

Mr. SPIRO. It's caused by under-pricing and Congress stepping in and constraining the risk corridor program, the one-time phase-out of reinsurance program, and it's all coming to a head in 2017.

Mr. MEADOWS. All right. Now, you are saying that it is Congress' fault but you drafted the law?

Mr. SPIRO. Congress came in and amended the law after it was passed.

Mr. MEADOWS. So it is whoever voted for the law's fault that this is happening, is that correct? Is that your testimony?

Mr. SPIRO. No, I said—my testimony was that Congress, by constraining the risk corridor —

Mr. MEADOWS. Well —

Mr. SPIRO.—program —

Mr. MEADOWS.—for the record —

Mr. SPIRO.—and is responsible for —

Mr. MEADOWS.—did any Republicans on the House side vote for that law? You were here. You know. Did any Republicans —

Mr. SPIRO. I don't believe so.

Mr. MEADOWS.—vote for it?

Mr. SPIRO. I don't believe so.

Mr. MEADOWS. Okay. So is your sworn testimony that it is the Democrats' fault that it is not working?

Mr. SPIRO. No.

Mr. MEADOWS. Then whose fault it is? You drafted it—you know, I am just trying to figure out where the —

Mr. SPIRO. I think it's the—I think —

Mr. MEADOWS. Let me just tell you, your testimony doesn't line up with the facts and that is my concern. Are you aware that out there on the Internet there is a way to game the system that says what you do is you actually quit paying your premiums in the fall and then you come back and you reapply in January? Are you aware that that is on the Internet?

Mr. SPIRO. No, I was not.

Mr. MEADOWS. Okay. Are the health insurers—Blue Cross Blue Shield, are you aware that some people tried to game the system as it relates to quit paying premiums because you are required to continue to cover them even though they are not paying the premium?

Mr. GIESA. Yes. The Blue Cross Blue Shield Association plans are familiar with that problem.

Mr. MEADOWS. How about you, Mr. Carlson? Are you familiar with that?

Mr. CARLSON. Yes. I think we would like to see some kind of action to prevent that from happening.

Mr. MEADOWS. All right. Dr. Cohen, don't you think that would be a good idea to not allow people to game the system and actually fix that particular problem?

Dr. COHEN. So we have a program integrity unit that is focused on gaming related to the marketplace in various facets, and so we very much are focused on that.

Mr. MEADOWS. So how many people have been denied coverage when they applied in January under your program integrity program?

Dr. COHEN. So when someone applies through HealthCare.gov, they —

Mr. MEADOWS. How many people? Do you have a number?

Dr. COHEN. I'm sorry, a number for —

Mr. MEADOWS. How many people have you stopped from gaming the system who quit paying in the fall and go and apply at any of

these other insurers? How many of them have you actually worked with the insurer to say, oh, by the way they are gaming the system? How many people have you found?

Dr. COHEN. So obviously those are two different systems, so the issuers are the ones who know are the folks who haven't paid —

Mr. MEADOWS. But they can't do anything about it. That is the whole problem. I have talked to them. They can't do anything about it. What they are doing is people were getting 3 months of free insurance and every year reapplying. And the problem is they can't do anything about it. They need your help.

Dr. COHEN. Absolutely. And that's why through the Fraud Prevention Partnership we do activities like this where we have information —

Mr. MEADOWS. That is great. How many people have you caught

Dr. COHEN. We haven't —

Mr. MEADOWS.—in fraud —

Dr. COHEN. We haven't —

Mr. MEADOWS.—and prosecuted?

Dr. COHEN. We haven't gotten there yet, but we are definitely

Mr. MEADOWS. So the answer is zero?

Dr. COHEN. So—fair enough.

Mr. MEADOWS. No, I am asking you.

Dr. COHEN. Fair enough.

Mr. MEADOWS. What is the —

Dr. COHEN. So, again —

Mr. MEADOWS. How many have been prosecuted for fraud?

Dr. COHEN. Zero.

Mr. MEADOWS. Thank you, Dr. Cohen.

I recognize the ranking member.

Mr. CUMMINGS. If there is fraud, we need to get to the bottom of it. And I am sure we will, Dr. Cohen, won't we? Dr. Cohen, we will get to the bottom of that, right?

Dr. COHEN. Absolutely. That's our—you know, we are focused on making sure that the market is solid for the future, and that includes making sure that folks are taking the rules seriously, and we work closely with OIG, State regulators, and others to make sure that folks are following the rules of the road. And again, the program continues to mature. We will continue to do that.

Mr. CUMMINGS. Sadly—you know, I haven't practiced law for many, many years. I have noticed that in all walks of life if people can find a way to get around something, they do. It kept me practicing law for many years, getting people out of trouble where they had tried to get around a system. That does not mean that the system gets thrown out.

Dr. COHEN. Correct.

Mr. CUMMINGS. It doesn't mean that you deny people health coverage. It doesn't mean that you just allow them to get sicker and die. And die. So I say to—you know, I appreciate that, but when we find fraud, we need to go after it —

Dr. COHEN. Absolutely.

Mr. CUMMINGS.—and deal with it, and so I agree. We need to deal with it. All right.

Dr. COHEN. And I would add that on other avenues of fraud where we've seen that in the marketplace, we have taken action and whether it's taken action to rescind coverage and—proper authorities are taking action there. Obviously, we are not that authority, but we pass that along to those that can —

Mr. CUMMINGS. I am sure the word will get out after today, am I right, Dr. Cohen?

Dr. COHEN. Absolutely.

Mr. CUMMINGS. All right. Thank you.

Mr. MEADOWS. Dr. Cohen, I think what you are hearing is that in a very bipartisan way —

Dr. COHEN. Absolutely.

Mr. MEADOWS.—we need to address this very real problem because it is affecting —

Dr. COHEN. Understood.

Mr. MEADOWS.—the insured.

And so the chair recognizes the gentlewoman from New Mexico, Ms. Lujan Grisham.

Ms. LUJAN GRISHAM. Thank you, Mr. Chairman.

And actually, this was not my intended question but I am going to take the privilege of having my 5 minutes and follow up on the fraud issue. I mean, in fact, under the Affordable Care Act I can tell you one instance where we so robustly dealt with fraud and the credible allegations of fraud that the HHS and CMS allowed the State of New Mexico, by virtue of that provision, to cancel 100 percent of our behavioral health care provider contracts under Medicaid. The following AG review finds no credible allegations of fraud. Oh, and guess what? Now, we have no access to a required insurance coverage for behavioral health parity.

So this is a very important question that the chairman and the ranking member are identifying, that we have to find how to root out real fraud and how to be careful that these mechanisms are not used by folks who really don't understand those provisions. And this really does lead me to my questions.

Here is my opinion. I think that the Federal Government and State governments are ill-equipped to deal with insurance companies. And prior to the Affordable Care Act, given that I ran the high-risk pool and also navigated health care for constituents, I can tell you countless underutilization, overutilization, denying of coverage, narrowing of networks, contracts that are inappropriate, poor parity, inappropriate discharge and transfer, inappropriate billing, surprise billing, transfer billing. I could spend 20 minutes just on the issues that insurance companies are dealing with and have been dealing with, and I can tell you about lots of profits, including the profits on the Affordable Care Act through the Medicaid and Medicare components. So when we talk about losses, I am not so sure that we are talking about them in the context that is fair if you look at the entire health care system.

The problem is is that Congress—we want to repeal it or do nothing to it, and in a health care system as complicated as this is with groups and policymakers who are ill-equipped to deal with the system as it is and particularly insurance companies, it is untenable.

And so, in fact, I think people are paying more, and I think in many ways, particularly in my State, are getting less even though the baseline for the Affordable Care Act was to provide consumer protections so that navigating and providing access to insurance markets would be fairer, but we have just cost-shifted outside of premiums and subsidies to out-of-pocket costs and narrow networks where people don't have choice.

So, Dr. Cohen, I do think that CMS—so take this back to CMS because, Mr. Chairman, they rarely hear this from me. Here are some things that I think have worked. I do think that adjusting the enrollment periods and making some changes to the risk adjuster were helpful. They are not enough.

What more can you be doing without us? What more can you be doing?

Dr. COHEN. I appreciate that, that we are taking steps within our authority to strengthen the marketplace. I think even just last week we announced taking an additional step related to special enrollment periods and that we will be looking at a process for pre-verification before —

Ms. LUJAN GRISHAM. Got it. I want more than that. So what else outside of those can you do?

Dr. COHEN. So we are also encouraging States to discuss with us, for example, thinking about using the 1332 pathway if they want to create within the State a high-risk pool, for example, so to come to us and have a discussion about what folks can do at the State level for —

Ms. LUJAN GRISHAM. I actually really like that idea, and it is an issue because the Affordable Care Act really wanted you to move away from high-risk pools. And the States that did not do that—New Mexico didn't, although we are in trouble if you look at our finances, given our Medicaid expansion and related issues, we are in trouble. So high-risk pools, I think, are something that this committee, Mr. Chairman, ought to look at again, and I would like more information.

Given that I have only got a minute left, I am going to move to Chris Carlson. If you have heard, I don't think that insurance companies have done their share of trying to address this issue in a fair and productive way, and in fact I think the ACA gives you many supports to do this.

Since March 5, 2009, since we began the debate that preceded the passage of the Affordable Care Act, Aetna's stock price has increased by more than 200 percent, despite the increased profits that insurers are seeing in a variety of markets, and the fact that we don't talk about the private market versus the marketplace exchanges. And I keep reading about carriers, which is also including my State where we are pulling out of exchanges, leaving consumers without the guaranteed access that they were promised under the Affordable Care Act, I think that Congress did the health insurance, a huge industry, a huge favor giving you thousands more enrollees, thousands of opportunities to decide what kind of marketplace you want to play in, and it maintained your access to the Medicaid pool through managed care.

As a result of that, I am very interested in some of the ideas that are emerging like in the Medicaid and Medicare managed care op-

tion that we might think that certain minimum participation is required in the exchanges if you are going to keep those managed care protections. How do you feel about that idea?

Mr. CARLSON. Well, I'm not familiar with those specific things that have been discussed so, you know, it's beyond kind of my ability to comment on them. You know, I think from a premium standpoint, which is what we're here to discuss, you know, the actuaries are setting the premiums based on what a cost to deliver the care under the exchanges. And, you know, that's what we're focusing on.

Ms. LUJAN GRISHAM. Well, I would like you to look at that.

And, Mr. Chairman, I am out of time, but the reality here is that our population wouldn't be as sick as they are in the context in which you are providing care if they were getting care through insurance companies in the first place.

Mr. MEADOWS. I thank the gentlewoman.

The chair recognizes the gentleman from Wisconsin, Mr. Grothman, for 5 minutes.

Mr. GROTHMAN. I remember years ago reading that the Japanese were the leaders in the world in consuming pharmaceuticals, but I look at a chart right now, and it looks like the Americans have blown by them like we are something like, what, 30, 35 percent more and Japan is second. Any of you guys give me a shot as to why we are spending so wildly more on pharmaceuticals than other countries? They are all looking at each other. It's like that old show "What's My Line?"

Mr. SPIRO. I'll go.

Mr. GROTHMAN. Okay, good.

Mr. SPIRO. I think in this country drug companies charge high prices because they can.

Mr. GROTHMAN. Isn't part of it, though, that we are prescribing more drugs than other countries?

Mr. SPIRO. I think most of the increase in drug spending is driven by price increases.

Mr. GROTHMAN. Anybody else here comment on it, any other wildly intelligent people? And when I look at people, you know, the number of prescription drugs that they are taking is just shockingly high compared to what they took to me subjectively 20 years ago. Is that true, all you smart people?

Dr. COHEN. So I'll say as the one physician on the panel —

Mr. GROTHMAN. Good.

Dr. COHEN.—that medicine has evolved and it's miraculous. I mean, we have cures for things that we can use pharmaceuticals for that we never did before. But I think prices for those pharmaceuticals are a real issue. I'm—I think we need to find a place where we can both innovate as well as make sure that we can have access to those lifesaving drugs that I want to give as a doctor.

Mr. GROTHMAN. You don't believe physicians are overprescribing drugs?

Dr. COHEN. So I think that physicians are trying to do best by their patient that is in front of them. I think that prices are not something that are in the physician's control. I think they are wanting to use the tools that are in front of them. I will say as a doctor I want to help my patient that's in front of me, and pharmaceuticals are one way to do that.

Mr. GROTHMAN. Okay. And I will give you some more questions, Dr. Cohen, since you spoke up.

Dr. COHEN. Sure.

Mr. GROTHMAN. All those guys were dithering and dathering and Dr. Cohen grabbed the mic.

Dr. COHEN. Yes.

Mr. GROTHMAN. Dr. Cohen, for the Affordable Care Act-complying plans, after a consumer pays their premium, what services is an insurer required to provide for no additional charge?

Dr. COHEN. So with no additional charge they are certainly required to provide preventative services both for the deductible with no cost-sharing. Certain plans decide to offer more as sort of a benefit to the consumer, and we're seeing folks do that to attract different types of populations.

Mr. GROTHMAN. Okay. Is the Affordable Care Act required to cover EpiPens?

Dr. COHEN. So formularies are decided by each of the individual products. Obviously, they're required to cover prescription drugs, but they are—you know, there are some very specific rules about how those things are covered. So epinephrine is covered. I couldn't say whether EpiPen is covered and how it's covered by any individual plan.

Mr. GROTHMAN. Okay. Well, do you know why it isn't covered, why it wouldn't be automatic because it seems like something that is pretty mandatory for people —

Dr. COHEN. Yes, and again, I'd have to go back and look at our rule. Again, epinephrine is covered. It's a matter of the mechanism of delivery, I think, so that I would need to—and I'm happy to follow up with additional details. But again, that would probably need to come from the plans themselves about how they are covering. We do set the rules of the road in terms of the benchmark plan and what they require in terms of pharmaceuticals for coverage.

Mr. GROTHMAN. Okay. Well, we will throw this out to the guys, too. Do you believe some parents would rather have the option of choosing a plan that provides EpiPens at no additional charge?

The answer is yes. It is almost a rhetorical question, right? Yes.

Would you agree that this is a good example of letting a consumer decide what kind of health care they need versus Washington bureaucrats?

It is almost a rhetorical question, too.

Mr. SPIRO. Well, if I could just point out, Congressman, in the markets that existed before the Affordable Care Act, prescription drug coverage was not a guarantee, and I can give you a stat on that. About 20 percent of plans did not cover any prescription drugs. So the Affordable Care Act, by including essential health benefits and coverage for prescription drugs, is actually increasing access to things like EpiPen.

Mr. GROTHMAN. Any other comments? No. I guess not. Okay. I will yield the final 10 seconds to my chairman.

Mr. MEADOWS. I thank the gentleman from Wisconsin. I thank each of you for your testimony.

Dr. Cohen, you have been here before, and I appreciate your testimony. And hopefully, in light of some of the questions today that

you see that there are a number of things that are bipartisan in terms of our desire to get you to address.

Dr. COHEN. Yes.

Mr. MEADOWS. The loophole as I see it, it may have been intentional. I don't know what it is, but the 90-day what I would say is it does not allow the insurers to do what they normally have done in the past is if you are not paying your premium, then your coverage quits. The ranking member and I are committed to making sure that you address that, and I sense from your comment that, other than your normal fraud prevention, that you are willing to address that, is that correct?

Dr. COHEN. Within the confines of the statute in which we are required to offer folks a 90-day grace period, we definitely want to make sure that folks aren't gaming it beyond what is —

Mr. MEADOWS. But you know that they are, right?

Dr. COHEN. So that's what we want to understand, and that we can't do until we put, as you're mentioning, the data together.

Mr. MEADOWS. Okay. So let me ask it—here is my concern is is that the front end, whether it is under HHS or CMS, it looks like a car but when you open the hood, all the parts are not in there. You know, sometimes there is not an air-conditioning compressor. To give you a prime example, you know, you are looking at fraud. We had somebody that actually contacted us and said they were actually able to enroll through HealthCare.gov on the exchange with a birth date of October 30 of 1124. That means that they were getting insured and they are 891 years old. Now, if they are able to do that under our system right now, fraud prevention is less than robust, wouldn't you agree?

Dr. COHEN. Well, so what I'd say is that fraud —

Mr. MEADOWS. How do we insure someone who is 891 years old?

Dr. COHEN. Well —

Mr. MEADOWS. Now, that is not quite as old as Methuselah —

Dr. COHEN. You know, that's pretty old.

Mr. MEADOWS.—but, you know, I don't know who they might be.

Dr. COHEN. You know, I think we—we're balancing things here. We don't want to make—we want to make sure that someone who maybe had a fat thumb or a fat finger when they were typing something in doesn't —

Mr. MEADOWS. Well, but that is what —

Dr. COHEN.—does not get insured.

Mr. MEADOWS.—I am saying. HealthCare.gov —

Dr. COHEN. Yes.

Mr. MEADOWS.—should say this says you are 891 years old. There is a high probability that you are not. Would you think that there is something automated —

Dr. COHEN. Yes. There is. There is. So —

Mr. MEADOWS. Then how could they enroll?

Dr. COHEN. So when—well, when someone puts their information into HealthCare.gov, we immediately do a check to the data sources that we have. We go to SSA and say is this person's Social Security number there? Is it right —

Mr. MEADOWS. I know and I am real —

Dr. COHEN. And if it's not —

Mr. MEADOWS.—familiar because I am kind of dug in, Dr. Cohen

Dr. COHEN. I know. I know you are.

Mr. MEADOWS.—and you know I have —

Dr. COHEN. I know.

Mr. MEADOWS.—and so as we do that—the problem is it doesn't go from you to the insurers. You know, there is this huge wall between HHS and CMS and the insurers when it comes to fraud, when it comes to enrollment. You know, there is a policy decision and then there is an implementation decision, and the two of you don't talk. And from what I am hearing, the insurance companies want you to talk to them, they want you to actually engage, and when they inquire, they get crickets. You know, they hear nothing.

And so I guess in the nicest way, Dr. Cohen, I am asking you on that 90-day issue that if they are seeing fraud —

Dr. COHEN. Absolutely.

Mr. MEADOWS.—or anticipating —

Dr. COHEN. We want to hear about it.

Mr. MEADOWS.—I need you to go with the full power of the Federal Government and say we are not going to tolerate this.

Dr. COHEN. Absolutely.

Mr. MEADOWS. I think it is also appropriate for—perhaps you probably can go in and figure out who is going to these sites and how they are navigating the sites. You are aware that it is on the Internet, right?

Dr. COHEN. We're very aligned in wanting to make sure we —

Mr. MEADOWS. You know it is on the Internet, right, Dr. Cohen?

Dr. COHEN. About how to get around the —

Mr. MEADOWS. Yes.

Dr. COHEN.—programs?

Mr. MEADOWS. Yes.

Dr. COHEN. Isn't everything on the Internet these days? Yes, I believe you that it is there —

Mr. MEADOWS. Okay. All right.

Dr. COHEN.—and I—we are aligned —

Mr. MEADOWS. But you have seen it, right?

Dr. COHEN. We are here—we're aligned.

Mr. MEADOWS. You have seen it? Somebody on your staff has seen it?

Dr. COHEN. Well, so we have a partnership where folks, you know, and the insurers are often —

Mr. MEADOWS. Just yes or no. Has anybody on your staff seen the site —

Dr. COHEN. I don't know. I don't know —

Mr. MEADOWS. So you have not seen it?

Dr. COHEN. I have not. I'd be happy for you to share with me

Mr. MEADOWS. Well, I am shocked. We will be glad to show it to you.

So with that, if there is no further business before the committee, the committee stands adjourned.

Dr. COHEN. Thank you.

[Whereupon, at 11:39 a.m., the committee was adjourned.]

