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HEALTH REFORM AND HEALTH INSURANCE PREMIUMS: EMPOWERING STATES TO SERVE CONSUMERS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

EXAMINING HEALTH REFORM AND HEALTH INSURANCE PREMIUMS, FOCUSING ON EMPOWERING STATES TO SERVE CONSUMERS

AUGUST 2, 2011

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C O N T E N T S

STATEMENTS

TUESDAY, AUGUST 2, 2011

HEALTH REFORM AND HEALTH INSURANCE PREMIUMS: EMPOWERING STATES TO SERVE CONSUMERS

TUESDAY, AUGUST 2, 2011

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10:03 a.m. in Room 430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Hagan, Merkley, Franken, Blumenthal, Enzi, Hatch, and Murkowski.

Also Present: Senator Feinstein.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Committee on Health, Education, Labor, and Pensions will come to order. This morning our hearing is on Health Reform and Health Insurance Premiums: Empowering States to Serve Consumers.

In the decade before the Affordable Care Act was passed, relentlessly increasing health insurance premiums imposed a heavy tax on families and small businesses. Over those 10 years, premiums for family, employer-sponsored coverage more than doubled. Small businesses simply couldn't afford it anymore and began dropping coverage. Congress had to act, and we did. In passing the Affordable Care Act, we enacted reforms to tame this runaway premium growth. Today's hearing will explore how those reforms are already protecting consumers.

It's basic economics that one of the surest ways to bring down prices is through open and tough competition. For the first time in our history, health reform applies this basic principle to the health insurance market. In 2014, Americans in every State will be able to buy health insurance in a one-stop shop called an insurance exchange. Small businesses will be able to shop there also. Just a couple of weeks ago, the Administration released guidance that gives States great flexibility in designing the exchange to suit the unique needs of their citizens.

The exchange will bring transparency and competition to markets which in many areas of the country have become stagnant and non-competitive, with high prices to show for it. From 1998 to 2006, just the consolidation of insurance markets alone accounted for overall premium increases of about $34 billion each year, equiv-

alent to a $200 annual rate hike per person. That's due to a lack of competition.

If insurers have to compete on price, rates will come down. Indeed, the non-partisan Congressional Budget Office projects that premiums in the small group market will be as much as 2 percent lower in 2016, about $350 less per family, in a market where premiums have increased 5 percent or more annually since 2005.

Employer spending on premiums is estimated to decrease by almost 4 percent, about $20 billion in this year's dollars. By 2019, businesses will save approximately $2,000 per family they insure. And by 2014, families buying in the individual market could save an estimated $2,300 a year if they buy health insurance in a new affordable insurance exchange.

Now, health reform also gives State insurance regulators unprecedented new resources to fight for consumers. The law allocates $250 million in grants for this purpose, almost $50 million of which has been awarded to 45 States and the District of Columbia.

We are releasing a report today from the Government Accountability Office that I requested, along with Senator Feinstein, which demonstrates the extraordinary work State regulators have done using these grant funds. These improvements, enabled by Federal grants, will empower States to rigorously enforce health reform's rate review requirements. As of September the 1st of this year, just next month, regulators will review proposed rate increases of more than 10 percent in the individual and small group markets. The insurer must publicly disclose and justify the rate increase, and if the regulator finds that the increase is unreasonable, the findings will be publicly posted.

Finally, health reform's medical loss ratio provision is a powerful deterrent against confiscatory premium increases, requiring insurers to provide fair value in return for consumers' premiums. Specifically, the law requires insurers to return to consumers 80 cents of each premium dollar in the individual and small group market, and 85 cents on the dollar in the large group market.

If insurers fail to return these amounts to consumers, either as payments for health care services or investments in quality of care, the company has to make up the difference in cash. It's estimated that next year, when rebates are due, 5 million Americans will receive between roughly $160 and $300 per person. Even those who don't receive rebates will benefit, since insurers will have to control premiums to stay above the threshold.

Some have argued that insurers can't meet these requirements, that holding them accountable would cripple their businesses. Insurers have been reporting their quarterly earnings over the last few days. Let's take a look at that.

For the second quarter of this year, United Health Group's net earnings, net earnings, before taxes, were $1.9 billion. That's for the quarter. That's not a year. That's for one quarter. And its net profit for that quarter was more than $1.2 billion just for that quarter.

Executives issued this announcement, and I want to quote from it.

> "In the first half of 2011, the number of people United Health Care serves with medical benefits grew by 1.2 million,

> on top of nearly 1 million people added over the course of 2010. This six-quarter addition of 2.2 million more people, almost entirely through organic means, places this among the strongest growth periods for our company."

I think that United Health Care can muddle through a rate review.

I'll just close with a letter I received from an Iowa constituent who just received notification of a 19 percent rate increase by United Health Care. She writes,

> "I am a self-employed professional with no pre-existing conditions. I now will pay $276 per month with a $5,000 deductible. I changed from a $2,500 deductible last year when the premiums were just getting too costly. At least this hasn't been a repeat of 2008, when my premium was increased twice that year. That was a 48 percent premium increase in 1 year."

So I believe these reforms are long overdue. I'm glad our witnesses have agreed to discuss them. I'll thank them for coming to Washington today, looking forward to their testimony.

With that, I'll yield to Senator Enzi.

STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you. Thank you, Mr. Chairman.

Today's hearing is to examine how the government can better regulate health insurance premiums. This is an unfortunate but entirely predictable response to the passage of the new health care law. As many of my colleagues and I predicted, the new health law is already driving up health insurance premiums. So now the authors of the law are attempting to shift the blame. The authors of the new health care law do not want to acknowledge the reason premiums are going up is because of the law they enacted. They would much rather point their fingers at the insurance companies and lay all the blame for these increased premiums on them.

Unfortunately, this story line ignores the basic facts. Insurance premiums are going up because health care costs are going up, and health care costs are going up, at least in part, because of the new health care law. Don't take my word for it. The Administration's chief actuary at the Centers for Medicare and Medicaid Services released a report last week that said that insurance premiums are estimated to increase by 9.4 percent in 2014. According to the actuary, this increase was 4.4 percent higher than would have otherwise been as a result of the new health care law.

This result should come as no surprise to anyone. More than 2 years ago, the Congressional Budget Office told us that the new health care law was going to increase premiums for individuals and families by 10 to 13 percent. This equals a $2,100 increase for families. These results were confirmed by several private studies which all projected even higher premium increases.

We're also seeing the validation of those statements in the insurance market. The *Wall Street Journal* reported last September that several insurers had already requested premium increases between 1 and 9 percent specifically to pay for the cost of the new benefits required under the new law. Rather than confronting the reality they created by enacting the new health care law, it appears that

its authors now want to find a scapegoat that can take the blame for these increasing insurance premiums. Unfortunately, blaming the insurance companies for these premium increases will do nothing to address the problems that are driving up the costs of health insurance.

Giving States or the Federal Government the authority to deny premium increases will do nothing to address the expensive new benefit mandates, billions of dollars in taxes on drugs and medical devices, and unsustainable cuts to Medicare payments, which are all part of the new health care law and which all drive up the private sector health care costs. Anyone who thinks that insurers will not pass these costs along to individuals and small businesses in the form of higher premiums is deluding themselves. As a former business owner myself, I can assure you no business can sell their product below their cost for very long. To think they can simply because the government mandates it is a recipe for disaster.

Rather than wasting our time on another hearing that tries to shift the blame for the entirely predictable results of the new health care law, we should instead be focusing on how to address the causes of these premium increases. We need to examine how the specific provisions in the new law are increasing premiums and determine how to replace those provisions with measures that could actually lower costs for individuals and small business. We also need to enact several provisions that will actually lower health care costs, help employers, and allow Americans to keep the plans they want rather than being forced to buy the plan that a government bureaucrat thinks best meets their needs or apply for waivers.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Enzi.

First we'd like to welcome our colleague, Senator Feinstein from California, chair of the Intelligence Committee, who does such a superb job there of keeping us advised as to terrorist threats and what's going on. We thank you very much for your service as chair of that committee.

Senator FEINSTEIN. Thank you.

The CHAIRMAN. Senator Feinstein also was very active in the passage of the Affordable Care Act. She did a lot of work on that, and one area in which Senator Feinstein had done a lot of work was in this whole area of rate reviews and making sure that consumers have information, good information. Senator Feinstein and I together asked the GAO to do a report on State Rate Review Activity. We're releasing that today. Senator Feinstein has long championed consumer protections and insurer accountability.

[Note: The report referred to may be found at *www.docstoc.com/docs/152435280/GAO-Private-Health-Insurance-State-Oversight-of-Premium.*]

So I thank Senator Feinstein for coming here today and for her great work in this area. I see you do have a prepared statement. It will be made a part of the record in its entirety, and you can proceed as you so desire.

STATEMENT OF SENATOR FEINSTEIN

Senator FEINSTEIN. Thank you very much, Mr. Chairman, and Senator Enzi, Senator Franken, Senator Murkowski.

I have, for a number of years now, been concerned about the affordability of health insurance. And, of course, as you look at health insurance around the world, you see that no country has the size of large, for-profit medical insurance companies that the United States of America does.

If you go further, you see that since 1999 the average premium for family coverage has risen 131 percent, while medical inflation, which should guide this, rose just 31 percent. Two years ago, in 2009, 57 percent of people attempting to purchase insurance in the individual market found it difficult or impossible to afford coverage. Now, that's before the health care plan.

While the cost of health insurance continues to rise for individuals, insurance companies, particularly the 10 large for-profit companies, enjoy unprecedented profits. In the first quarter of this year, 2011, the five largest for-profit health insurance companies recorded a net profit, in a quarter, of $3.9 billion. That's an average 16 percent increase from the same quarter the year before.

CEO pay for the 10 largest for-profit health insurance companies was $228.1 million in 2009, up from $85.5 million the year before, 2008. This is a 167 percent raise in just 1 year, and this doesn't include the tens of millions of more dollars in exercised stock options, and means that these CEOs received nearly a billion dollars in total compensation, dollars—and here's the key—that could have been used to provide health benefits. I mean, this raises the question to me as to whether America's health insurance should be controlled by for-profit companies rather than by non-profit companies.

And here's the rub: At the same time these insurance companies were reducing the amount they spend on actual medical care, the GAO report shows State insurance practices now vary widely, even within different markets in the same State. To me, the GAO report shows just how fractured the health insurance market continues to be and how consumers are not uniformly protected from egregious rate increases.

I believe that what should be standardized is the authority to block or modify unjustified, unreasonable premium rate increases. I strongly believe that each State insurance commissioner or regulator should not only be able to look at insurance rate filings and evaluate them thoroughly prior to implementation, which this GAO report dealt with, but that he or she should also possess the authority to block or modify those rates that are egregious.

To evaluate the rates and have no authority to reduce or stop those found to be unjustified makes the State insurance commissioner simply a paper tiger. The Department of Health and Human Services reports that as of December 2010, less than half of States and territories had the legal authority to reject excessive rates. The Kaiser Family Foundation reports in at least 17 States, including my own, California, State regulators do not possess the authority to block or modify premium rates prior to implementation.

The health reform law actually takes critical first steps to help control premium increases and ensures that companies spend more on medical care, not profits. The grants provided to States to improve rate review processes have helped ensure more information is available about all rate increases.

However, the health reform law does not grant explicit authority to modify or block egregious rate increases. This is a loophole, which is why during health reform I introduced legislation to authorize the Secretary of Health and Human Services to block or modify unjustified premium increases in States where the regulator does not have that authority.

The Health Insurance Rate Review Act of 2011 is pending in this house, and a like bill is also pending in the House of Representatives. These bills create a Federal fallback rate review process that grants the Secretary of Health and Human Services authority to block or modify rate increases that are excessive, unjustified, or unfairly discriminatory in those States where there is not appropriate authority. This legislation is a simple, commonsense solution, and we almost got it included in the bill, but we did not.

And so since then, what's happening is these big for-profit companies are raising rates wherever they can, sometimes once a year, sometimes twice a year, and sometimes three times a year. In 2010, I received over 1,700 letters from constituents pleading with me to help them with their skyrocketing insurance rates. Now, in California, the State insurance commissioner has reviewed some filings. They disapproved 14. They were withdrawn or negotiated to lower rates. So 6 percent were modified. I suspect that if California regulators had an appropriate legal authority, many more than 14 rate filings would have been modified or withdrawn in 2010.

Let me give you an example of why the review of rate filings is not sufficient, and why I believe authority to block or modify is necessary. Just about everyone I think is familiar with the increases that Anthem Blue Cross was set to impose in February 2010, as much as 39 percent for 800,000 policyholders in California. And in California, I should say, a couple of these companies essentially control the major medical insurance markets. So that as you spoke, Mr. Chairman, there isn't the competitive competition that there might be otherwise.

And Anthem was not an aberration. Insurance companies in California have continued to propose 30, 40, and even 80 percent cumulative premium increases. We have a very strong insurance commissioner. We have a bill pending. His name is David Jones. He's been successful in getting some of these big companies to reduce or cancel their premium increases. Recently, a number of insurance companies were set to impose premium increases in my State, some as much as 80 percent cumulatively. Commissioner Jones requested a delay of these increases until he had a chance to review them, and the insurance companies complied.

After review and pressure from him, Anthem Blue Cross agreed to scale back planned rate hikes from 16.4 percent to 9.1 percent for 600,000 individual policies in the Department of Insurance, and to delay implementation of these hikes. But here's the catch. Anthem Blue Cross also serves individual policyholders through the Department of Managed Health Care in California. For over 120,000 Californians that receive their Blue Cross insurance through this department, rates rose an average of 16 percent on May 1 of this year. The Department of Managed Health Care deemed these increases unreasonable, but they don't have the au-

thority to block them. This means that the same companies scaled back rates for some individual policyholders but not others, and I don't think that makes sense.

Now, on page 43 of the GAO report, in the appendix are general comments of the Department of Health and Human Services on the Government Accountability Office's draft report, which is this report. What they say is,

> "For too long, insurance companies in many States have increased health insurance premiums with little oversight, transparency, or public accountability. Health insurance premiums have doubled, on average, over the last 10 years, much faster than wages and inflation, putting coverage out of reach for millions of Americans.
>
> "As recently as December 2010, fewer than half of the States and territories had the legal authority to reject a proposed increase if the increase was excessive, lacked justification, or failed to meet other State standards. Additionally, many States that had authority lacked the resources needed to exercise it meaningfully. This lack of authority and resources for States has contributed to unjustified premium increases."

And then it announces,

> "Starting in September of this year, 2011, HHS is requiring that all non-grandfathered insurers seeking rate increases of 10 percent or more in the individual and small group markets publicly disclose the proposed increases and their justification for them. Disclosing proposed increases along with the insurer's justification sheds light on industry pricing practices that some experts believe have led to unnecessarily high rates.
>
> "This transparency in the health insurance market will help promote competition, encourage insurers to work toward controlling health care costs, and discourage insurers from charging unjustified premiums."

Then it goes on to talk about the Affordable Care Act.

I think this is a major step forward, Mr. Chairman. We worked with the health department to try to get them rate review authority as part of the bill. We failed. The lobbying by the big insurance companies obviously was intense, but I think suffice it to say we have a problem that's out of control, and we have a lot of people suffering for it, and we have a reduction in the number of people covered by this insurance because people can no longer afford the premiums.

Now, whether they're doing this just because they know in 2014 the health insurance law goes into play, and therefore they want to recover as much as they can before that, or simply because they're going to raise rates as best they can to flush up that bottom line, I think it's just as simple as that.

Let me conclude with this. A man by the name of T.S. Reid wrote a book about health care all over the Nation. Probably members of this committee have read it. And he concludes that no nation on earth has really been able to reform health insurance with a large for-profit insurance industry. That may continue to be a problem. But I just want to thank you for watching this carefully, because our people have to be able to afford to be covered.

I wish we could get this rate review through. I thank you for your support of it, and I wish the other side of the aisle—and Ranking Member Enzi has always been fair. We've worked together on other matters. But this one really cries out for watching and for taking action to see that premium rates are truly justified.

I thank you for the opportunity to testify.

The CHAIRMAN. Senator Feinstein, thank you very much for a very eloquent presentation. I'd just say that I quoted a constituent of mine who had written in about her increases. One might just ask, well, why doesn't she just shop around and buy something else? Two companies have over 80 percent of all of the market in Iowa, and in some places in Iowa only one company, United Health Care. There are no other options. It's called monopoly.

Senator FEINSTEIN. In the Los Angeles metropolitan area, too, one company dominates, and it's a 16-million person market, huge.

The CHAIRMAN. Yes. Thank you very much.

Senator ENZI. That's why I was pushing for the small business health plans so the associations could group together and possibly form their own insurance company to increase it. But by having those groups we would have had some people who would have been on a par with the insurance companies for doing any of the negotiating, and I think that would have brought down prices.

And, yes, I read that book, but I think the author missed Switzerland.

Senator FEINSTEIN. No, he was in Switzerland.

The CHAIRMAN. He did Switzerland.

Senator FEINSTEIN. I'll send you the chapter.

Senator ENZI. OK.

Senator FEINSTEIN. He was in Switzerland, and he found the care pretty good there.

Senator FRANKEN. I read the book. In Switzerland, he interviewed—they had a battle there several years ago to regulate the insurance companies, and the conservatives fought it, but now they're very happy with it. He interviewed a conservative and said, "since this reform, has any Swiss citizen gone bankrupt because of a health care issue," and as you know, in this country, about 50 percent of bankruptcies, or more, are in some part caused by health care challenges. And he asked, "has anyone in Switzerland since these reforms gone bankrupt," and he said, "no, that would be a shame, that would be a disgrace." And, you know, they've made these reforms in Switzerland.

The CHAIRMAN. Senator Feinstein, thank you very much. I know you have other obligations. Thank you very much for being here, appreciate it.

Now we'll welcome our panel, Steve Larsen, just Steve Larsen on the first panel. Mr. Larsen is director of the Center for Consumer Information and Insurance Oversight within the Centers for Medicare and Medicaid Services. He comes with a distinguished insurance background, has held a number of senior positions with Amerigroup, a managed health care company, spent 6 years as a Maryland insurance commissioner. We last saw Mr. Larsen here in March, when he shared his expertise on the implementation of health insurance exchanges.

Mr. Larsen, we welcome you back to the committee. Your statement will be made a part of the record in its entirety, and if you could sum it up in—the clock says 5, but if it goes to 7, that would be fine—5 to 7 minutes, we'd sure appreciate it.

STATEMENT OF STEVE LARSEN, DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, BALTIMORE, MD

Mr. LARSEN. Thank you very much, Chairman Harkin and Ranking Member Enzi, and members of the committee. Thank you for the opportunity today to discuss the positive impact of the Affordable Care Act on the affordability of health insurance premiums for American families and businesses, including small businesses.

The Affordable Care Act reforms the health insurance market for the benefit of health care consumers, both individuals and businesses. One important goal of the reforms in the Affordable Care Act is to make sure that people and businesses receive value for their health insurance premium dollars. The need for this focus is clear. Over the last 10 years, health insurance premiums have risen dramatically, and these increases in health care costs outpace the rise in medical costs and the rise in wages during the same period.

We know that this is not only a burden on individuals, who often have seen their rates increase 20 percent a year or more, but on small businesses as well. The rate at which small businesses are offering coverage to their employees has dropped in the last decade.

The Affordable Care Act helps to make health insurance coverage more affordable in three key ways. First, it provides States with unprecedented resources to strengthen the existing processes that they have in place today to review proposed rate increases by insurance companies. I know from my experience as an insurance commissioner for 6 years how important the process of bringing an independent review of proposed rate increases can be for consumers.

But although the rate review process is important, we also know that the resources and expertise for rate reviews varies significantly across the States. The Affordable Care Act provides $250 million in grants to assist the States and territories in enhancing their health insurance rate review processes. Since enactment of the bill, $48 million has been awarded to 42 States, the District of Columbia, and the territories. In February, the availability of approximately $200 million more in additional grant funding was announced to support the continuation of these efforts.

The grants are already having a major impact on State rate review processes. As of June 2011, 18 States had proposed legislation to increase their ability to review rates, 25 States had hired additional staff to review rates, 37 were engaged in rate review contract activity, 33 States were enhancing their IT capabilities, and 35 States were working to enhance their consumer transparency and provide education to consumers on the rate review process.

The second important tool that the ACA provides to ensure that consumers receive value for their premium dollars are the rate review provisions, which we've heard about. As Senator Feinstein in-

dicated, and you did, Mr. Chairman, beginning in September, insurers seeking rate increases of 10 percent or more for most plans in the individual and small group market are required to publicly disclose the proposed increases and provide basic information to consumers about the reasons for the increase. These increases will then be reviewed by States that have an effective rate review process, or by CMS as a backstop to determine whether these rates are unreasonable.

We recently concluded an evaluation of State review processes and found that almost all States will have an effective rate review process and will be reviewing rate increases beginning on September 1st. Many States, as I said, enhanced their existing processes in order to meet the standards for an effective rate review and drew on grant funds as part of that process.

We know effective rate review works. Rhode Island's insurance commissioner was able to use its rate review authority to reduce a proposed increase by a major insurer in that State by 6 percent, and I think actually today there was a blurb that he had reduced a proposed increase by United Health Care. Nearly 30,000 consumers in North Dakota faced a proposed increase of 23 percent on their premiums that were reduced to 14 percent, and I think we'll hear about some of the great review activity that the State of Oregon has done.

Finally, to ensure consumers receive value for their premium dollars, the ACA established minimum standards for spending by health insurance issuers on clinical services, medical costs, and quality improvement activities for their members, known as the medical loss ratio or MLR provisions. The new MLR protections effective this year require that insurers spend at least 80 percent or 85 percent, depending on the market, of premium dollars on actual health care services and quality improvement efforts rather than on administrative expenses. Insurance companies that don't meet the standards will be required to provide rebates to their customers.

Recognizing State flexibility, the law allows for a temporary adjustment in the individual market MLR standard if a State requests it and demonstrates to HHS that the 80 percent MLR standard may destabilize its individual health insurance market. We're already seeing indications that the MLR and rate review provisions are benefitting consumers. We know from the States that insurance companies are pricing to the 80 percent standard for the benefit of consumers and have announced that they will moderate future increases in order to meet the 80 percent standard.

States play a critical role in the implementation of the Affordable Care Act, and we've worked actively with governors, with insurance commissioners, Medicaid directors, and State stakeholders to implement these programs. It's been our priority to work collaboratively with our State partners as the provisions of the Affordable Care Act go into effect.

So in conclusion, the Affordable Care Act includes a variety of provisions designed to promote accountability, affordability, quality, and accessibility in the health care system for all Americans, and to make sure the health insurance market is more consumer friendly, transparent, and responsive.

Thank you for the opportunity to testify today, and I look forward to answering questions that you might have.

[The prepared statement of Mr. Larsen follows:]

PREPARED STATEMENT OF STEVE LARSEN

Chairman Harkin, Ranking Member Enzi, and members of the committee, thank you for the opportunity to discuss steps the Affordable Care Act takes to help make health insurance premiums more affordable for American families and businesses.

The Affordable Care Act reforms the health insurance market in a way that puts American consumers back in charge of their health coverage and care, ensuring they receive value for their premium dollars. Further, by focusing greater attention on justifications for insurance rate increases at the State and Federal level, we are already seeing positive results.

The need for these actions is clear. Over the past 10 years, health insurance premiums have risen dramatically. According to a 2010 survey of employee benefits, premiums for average family coverage are up 114 percent and worker contributions are up 147 percent when compared to 2000.[1] Further, these increases in premiums outpace the rise in medical costs and wages during the same period. As a result, families and businesses saw many of their gains in earnings wiped away by the increased cost of insurance.

MAKING COVERAGE AFFORDABLE

The Affordable Care Act helps make coverage more affordable by providing States with unprecedented resources to improve how States review proposed health insurance premium increases and hold insurance companies accountable for unjustified premiums increases. These resources for States to strengthen their insurance premium review procedures work in tandem with other policies in the Affordable Care Act to create a powerful tool to help keep health insurance premiums more affordable. These policies include:

- **Review of Insurance Rates** brings an unprecedented level of scrutiny and transparency to health insurance rate increases. The Affordable Care Act ensures that, in any State, large proposed increases will be evaluated by experts to make sure they are based on reasonable cost assumptions and solid evidence. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for significant rate increases, as well as publicly justify and post on their Web site any unreasonable rate increases. These steps will allow consumers to know why they are paying the rates that they are.
- **Affordable Insurance Exchanges** can, beginning in 2014 exclude health plans that show a pattern of unjustified premium increases.

These new provisions will help moderate premium hikes and provide those who buy insurance with greater value for their premium dollar. For example, consumers in North Carolina are already feeling the benefits of the Affordable Care Act, as Blue Cross and Blue Shield of North Carolina refunded $155.8 million to 215,000 customers, in response to provisions in the law.

PARTNERING WITH STATES ON RATE REVIEW POLICIES

States play a critical role in the implementation of the Affordable Care Act. Since enactment, we have worked actively with Governors, insurance commissioners, Medicaid directors, and other stakeholders to implement programs to help consumers and businesses. It has been our priority to work collaboratively with our State partners as the provisions of the Affordable Care Act go into effect.

In recognition that States are the principal regulators of the private insurance market, the Affordable Care Act empowers and supports States to review unreasonable rate increases within their State, while CMS serves as a back-up to review rates only if a State lacks the authority or resources to do so. The Affordable Care Act provides $250 million in grants to assist States and Territories enhance their health insurance rate review process. Since enactment, $48 million has been awarded to 42 States, the District of Columbia, and the 5 Territories. In February, the availability of approximately $202 million in additional grant funding was announced to support the continuation of such efforts. The applications for the additional grant funding are due on August 15, 2011, with awards planned for the end of fiscal year 2011.

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[1] *http://ehbs.kff.org/pdf/2010/8085.pdf*.

The Government Accountability Office (GAO) report *Private Health Insurance: State Oversight of Premium Rates* shows that State insurance departments are already making good use of the rate review grants. In response to a survey conducted by GAO, 41 respondents from States that have been awarded rate review grants reported that they are making changes to enhance their health insurance premium oversight activities. States are using these grant funds to support rate review by hiring new actuarial staff, engaging in consumer transparency initiatives and developing improved information technology infrastructure to collect and analyze more robust rate filing data.

Specific examples of how States are improving their rate review processes with grant funds include:

• Tennessee is expanding the scope of rate review to small and large group policies and granting the Department of Commerce and Insurance prior approval authority and the authority to disapprove rates.

• New York is standardizing rate filing applications and expanding the information collected across all product types when reviewing rates.

• Kentucky created a new consumer-friendly Web site with Frequently Asked Questions (FAQs) on the rate review process and an email box to collect consumer comments. Kentucky also hired six new full-time employees to assist with reviewing rates.

• Utah surpassed their goal of reviewing 50 percent of individual and small group rate filings by reviewing 100 percent of all submitted rate filings with the assistance of grant resources.

The Affordable Care Act establishes additional protections from unreasonable insurance rate increases. Starting September 1, 2011, insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets are required to publicly disclose the proposed increases and the justification for them. Such increases will be reviewed by either State or Federal experts to determine whether they are unreasonable. States with effective rate review systems will conduct the reviews, but if a State lacks the resources or authority to conduct actuarial reviews, HHS will serve as a backup. Starting September 1, 2012, the 10 percent threshold will be replaced with a State-specific threshold, using data that reflect insurance and health care cost trends particular to that State. For those States in which a State-specific threshold is not established by that time, the 10 percent threshold will continue to apply. If an issuer wishes to implement an unreasonable rate, it will have to publish a justification for that increase on its Web site and on *www.Healthcare.gov*.

After reviewing and considering more than 60 stakeholder comments, CMS issued a final rate review regulation (CMS–9999–FC) on May 19, 2011. The final rule makes certain that potentially unreasonable health insurance premium increases will be thoroughly reviewed, and ensures that consumers will have access to clear information about those increases. This analysis is expected to help moderate premium hikes and provide those who buy insurance with greater value for their premium dollar. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for significant rate increases, as well as publicly justify and post on their Web site any unreasonable rate increases. These steps will allow consumers to better understand why their premiums are increasing.

The regulation (CMS–9999-–FC) finalizes the proposed rule (OCIIO–9999–P) that was issued on December 23, 2010. The final rule includes several additions to the proposed rule that reflect feedback received through the comment process. For example, the final rule includes a requirement that States and CMS provide an opportunity for public input in the evaluation of rate increases subject to review. This will strengthen the consumer transparency aspects of the new rule. The change from a 10 percent threshold in 2011 to a State-specific threshold in 2012 was also based on public input. CMS will work with States to develop State-specific thresholds that reflect the insurance and health care cost trends in each State. In the final rule, due to comments received from State regulators and other stakeholders on the proposed rule, we requested further comment from the public on applying the rate review rule to individual and small group coverage sold through associations.

IMPACT OF RATE REVIEW

CMS is committed to supporting the States as the primary regulator of the private health insurance market. This new system has already begun to help States strengthen or create rate review processes. As of May 2011, 18 States had proposed legislation to increase their ability to review premium rates, 25 States had hired additional staff to review rates, and 34 were engaged in rate review contract activity.

In addition, 33 States were enhancing their IT capacity for rate review and 34 States were working to enhance consumer transparency and provide consumer education on the rate review process.

The rate review regulation establishes the criteria for determining whether or not a State has an effective rate review program. HHS worked closely with State regulators to determine if a State has an effective program based on the criteria set forth in the regulation and has notified the States of the Department's initial determinations. I am pleased that 40 States and the District of Columbia will be reviewing rates in all markets. This result serves to preserve the historic role of the States in regulating health insurance markets.

Experience shows that rate review helps to lower the cost of coverage for people and employers. Recent examples include:

• Rhode Island's Insurance Commissioner was able to use its rate review authority to reduce a proposed increase by a major insurer in that State by 6 percentage points—lowering a proposed increase of 7.9 percent to 1.9 percent.[2]

• Californians were saved from a third rate increase in less than a year when a California carrier withdrew its proposed increase after it drew scrutiny from the State Insurance Commissioner. The three rate increases would have totaled as much as 87 percent for some policyholders.[3]

• Nearly 30,000 North Dakotans saw a proposed increase of 23.7 percent cut to 14 percent after public outcry drew attention to it.[4]

• In Connecticut, one insurer requested an increase of 20 percent. The Insurance Department rejected this increase as excessive, and because of the law in Connecticut, it cannot go into effect.[5]

• About 59,000 individual insurance customers were protected from significantly higher premiums when the Oregon Insurance Division rejected a 22.1 percent premium increase in favor of a lower, 12.8 percent increase.[6]

These examples demonstrate the impact that transparency and scrutiny can have to make health insurance premiums affordable for all Americans.

TRANSPARENCY AND ACCOUNTABILITY

As we have implemented these new programs and processes, we have pursued them in an open and transparent manner. CMS has published extensive information on our rulemaking and other decisions on the Web site *www.CCIIO.CMS.gov* and on the consumer-oriented *www.HealthCare.gov* to ensure that information is widely available for public input and understanding.

For example, the Affordable Care Act requires the Secretary, in conjunction with the States, to develop a process for the review and disclosure of unreasonable rates. The implementation process began with a Request for Comment published on April 14, 2010, and continued with a proposed rule, published on December 23, 2010. HHS reviewed all public comments and issued a final rule on May 19, 2011, with a 60-day comment period related to association coverage.

The process for seeking public input continues after the issuance of regulations. Based on comments and questions HHS, Labor, and the Treasury have received on regulations issued to date, we have provided additional interpretive guidance to affected parties on regulations relating to grandfathering, medical loss ratio, PCIP, ERRP, internal and external appeals, and provisions relating to annual limits on health plan coverage. We continue to work with stakeholders to implement the Affordable Care Act and to provide additional clarity.

CONCLUSION

The Affordable Care Act includes a wide variety of provisions designed to promote accountability, affordability, quality and accessibility in the health care system for all Americans, and to make the health insurance market more consumer-friendly and transparent. The law is working to make coverage more affordable by holding insurers accountable for the premiums they charge consumers.

The CHAIRMAN. Mr. Larsen, thank you very much for summing that up. And as I said, your statement will be made a part of the record in its entirety.

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[2] *http://wrnihealthcareblog.wordpress.com/2011/03/09/koller-slashes-bcbs-proposed-rate-increase/*.

[3] *http://www.insurance.ca.gov/0400-news/0100-press-releases/2011/release040-11.cfm*.

[4] *http://www.inforum.com/event/article/id/314397/*.

[5] *http://www.hartfordbusiness.com/news15875.html*.

[6] *http://www.oregonhealthrates.org/?pg=public_hearing.html*.

We'll start a round of 5-minute questions.

Mr. Larsen, I mentioned in my opening statement that several insurance companies have reported their second-quarter earnings over the past week. All indications are that the industry is doing very well. After their first-quarter earnings report this spring, when the medical loss ratio requirement was first in effect, United Health Group's share price shot up 10 percent to a 3-year high; Humana's share similarly jumped 7 percent after the first quarter.

The chart I have up there basically illustrates the growth trend across the insurance industry. Humana made almost $1.8 billion in profits last year, up about $700 million from the year before; so from about $1.1, $1.2 to $1.8 billion in 1 year. Aetna continued to grow steadily, up to almost $1.8 billion also in profits. As I mentioned, United Health Care is growing at a gargantuan rate. Their net profits last year were $4.6 billion. Just last week, United Health Care announced quarterly profits of $1.27 billion for one quarter, up 13 percent from the same period last year. Its shares have risen 44 percent this year, 44 percent. And the Standard & Poor's index for large health insurance overall has climbed at a 40 percent rate in 1 year.

So it's no mystery, I think, what's feeding this. If you look at the growth and the profits, that's on the left side, on the right side is the premiums, family premiums. Those two lines just about parallel each other. As the premiums go up, profits go up.

So given these numbers, Mr. Larsen, what is your perspective on the ability of insurance companies to remain viable in the health reform area?

Now, we've heard that a lot of these numbers have gone up. Certainly premiums have gone up. Some people may say, well, if we hadn't passed the Affordable Care Act, that wouldn't be going up. I don't know whether or not that is because, as Senator Feinstein has alluded to, are they trying to get in before the exchanges go into effect in 2014, get their prices up as high as possible, or is this just simply market forces saying, "hey, if we can make more profit, make more profit," without anybody regulating or guiding it?

How does the Affordable Care Act, through provisions like the medical loss ratio and the review of insurance rates, begin to change the insurance market so that more premium dollars are returned to consumers rather than just to company profits? Can you elaborate on that, please?

Mr. LARSEN. Thank you. I think both provisions will help between now and 2014, certainly. I know with respect to some of the major companies that have reported in some cases record profits, in some cases their stock is trading at an all-time high, I know some of the Wall Street analysts have indicated that medical trends have been moderating somewhat, but the premiums haven't lowered at the same rate of the trends. So essentially some of the companies are benefitting from the spread between their premiums and moderating medical trends.

The MLR standard particularly helps that because it forces the companies to look down the road, and if they don't want to pay rebates to consumers, they're going to have to moderate their rate increases. In fact, we've seen and heard, both from the States and I think from public reports, that companies are now going to be pric-

ing to 80 percent, and that means they're going to have to moderate the rate at which their premiums are increasing and track more closely to what actual medical cost trends are.

The CHAIRMAN. I think, if I'm not mistaken, is your office preparing for a second round of rate review grants? And if so, how do you see these building on the first ones? Can you just tell us maybe what some of the criteria for that would be?

Mr. LARSEN. We are. There was a first round of grants that we issued that was about $1 million per State that really just laid the foundation for the States. I think, as was mentioned earlier in Senator Feinstein's testimony, I think it's in the GAO report, a huge variation among the States, and particularly on the resources that the States have to perform this review.

So the second round of grants will enhance the work that's been done so far. Again, the first round is the building blocks. It helped get a lot of States to a basic level, but I think the next round is really going to improve the capability of the States between now and 2014.

The CHAIRMAN. I have one more question I'd like to ask, but I see my time is basically up. So I'll ask it maybe in the next round, Mr. Larsen.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

Some folks in the Administration are still having a problem understanding the CBO scoring that the new health care law would increase insurance premiums. CBO said the average premium would be 27 to 30 percent higher because Americans would be forced to obtain a greater amount of coverage mainly because of more mandated benefits. But they also said that the average premiums would be 7 to 10 percent lower because of greater administrative efficiencies, and the average premiums would be 7 to 10 percent lower because of healthier people getting coverage.

If I subtract 27 minus 7 minus 7, I come up with 13 percent increase. So would you agree that CBO said the new health care law will increase premiums by about 13 percent?

Mr. LARSEN. As you point out, there were a number of moving parts in the CBO analysis, and they did analysis for both the individual small group and large group markets. So with respect to the small group market, there were factors that could lead to increases and factors that they thought would lead to decreases. So, for example, in the small group market I think it was a wash or to the good for the small group market, particularly because of the efficiencies that small businesses are going to get. And again, I think it was similar for the large group market as well.

And I think with respect to the individual market, I don't recall exactly. Again, as you point out, there were moving parts. Certain aspects of it, by improving the risk pool and getting more healthy people into the risk pool, that was going to improve the overall experience of the individual market, and then there were some additional benefits that would move in the other direction.

So I don't recall the exact pluses and minuses that were in the CBO report, but I think we certainly took the view when we put out some of our regulations that the impact was going to be in potentially small numbers, but when you add in the preventive care

and other benefits that you get, that it was going to be a benefit for health care consumers.

Senator ENZI. The Congressional Research Service confirms that all new plans will be forced to have essential health benefit packages that are dictated by the Secretary. It's also interesting to me that Secretary Sebelius used to be an insurance commissioner, and she didn't use her authority to change the rates. She kept a merger from happening once but never changed the rates.

Now, on a different question, apparently HHS prohibited the Institute of Medicine from considering cost implications when they drafted the recommendations that will mandate women's clinical preventive services that insurers must provide for free. To the extent that the Federal Government will now be subsidizing many insurance plans, if these mandates increase costs, won't that increase the Federal deficit? And why did HHS prohibit the Institute of Medicine from considering the cost of these new mandates?

Mr. LARSEN. The IOM recommendations with respect to women's preventive services, those apply only in the private insurance market. So I'm not sure what you mean by the Federal Government subsidizing it.

But with respect to your second question, the statute with respect to all of the preventive services that non-grandfathered plans are required to provide are not applied with respect to cost/benefit analysis. So we didn't, I don't think, prohibit IOM. It wasn't part of the legislative charge or the charge. They had a panel of medical experts that looked at the efficacy of these various preventive services and found that they were effective, and that's why IOM presumably recommended them to HRSA and the Secretary.

Senator ENZI. I have several questions, too, about the way that children-only policies are, but I have somebody that's really worked on this. Senator Murkowski has done a lot of work on that, and I'll let her handle those questions and any others she's interested in.

The Department of Health and Human Services will write a $250 million check for the grants for these rate reviews that you were mentioning. Forty-six States have already gotten funding. How many of these State recipients claimed more stringent rate review policies would lead to decreased overall health care spending in their State? Does merely reviewing a rate increase result in lower health care costs?

Mr. LARSEN. We absolutely think that there is huge value in reviewing rates, in bringing transparency and sunshine to the rate review process, and I think some of these examples that we've cited earlier—you know, not every State, as was pointed out, has prior approval authority. But simply reviewing and bringing to light the underlying issues associated with a rate increase can have the effect of having insurance companies go back and sharpen their pencils and revisit the proposed rate increases.

So we think review alone is a very powerful tool. Obviously, many States have a prior approval authority, which provides even more protection to consumers. But we think the baseline of review is a good place to start.

Senator ENZI. Thank you. My time has expired.

The CHAIRMAN. Thank you, Senator Enzi.

I have in order of arrival Senator Franken, Senator Murkowski, and Senator Blumenthal.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman.

Thank you, Mr. Larsen, for your testimony. Mr. Larsen, experts agree that rising health care costs in our country are unsustainable for the Federal Government, for States, and for consumers. During the health reform debate, I looked to Minnesota for ideas to bend the health care cost curve, and it struck me that our insurers were offering high-value products in Minnesota, where most of the dollars they took in premiums were going directly to health care services, but it wasn't that way everywhere.

In some States, the so-called medical loss ratio for individual and small group policies was as low as 60 percent, 50 percent, or even 40 percent, meaning that insurers were spending only 40 percent of their dollars from premiums on health care services.

Based on Minnesota's experience, I introduced a bill that was ultimately included in the health reform requiring insurers to spend at least 80 in the small group and individual markets and 85 percent of insurance premiums on actual health care services in the large group market.

During a hearing before this committee in March, you testified that you had already seen premiums go down due to MLR. Can you walk us through some of the examples of how you've seen the MLR provision help to moderate premium increases?

Mr. LARSEN. The couple of ones that I can cite off the top of my head. First, in the process of reviewing requests from the States to adjust the MLR standard between now and 2014, there's a process. You know, if some States are starting at 50 and it's a heavy lift to get there, to 80 percent in a year, so States can submit a request to adjust those. And we have quite a bit of back and forth with the States in that process, and what we've learned is that many States who were at much lower than 80 percent are now pricing to 80.

What that means is, when I say pricing to 80 percent, is that they have to make sure that they are not charging so much to their consumers that they're continuing to generate that lower loss ratio. So what that results in practically speaking is a moderation of the rate increases that they otherwise would have gotten. So that's one thing we've seen.

And then also a number of the publicly traded companies have announced that rather than paying rebates, they will moderate their pricing, and then I think Coventry indicated they would do that. I think we heard Wellpoint was going to be looking at shaving some of their administrative expenses and trying to be more efficient. So across the markets, we are seeing that happen.

Senator FRANKEN. Aetna in Connecticut, I understand, is——

Mr. LARSEN. Yes. That was a perfect example.

Senator Franken [continuing]. Lowering their premium, on average, 10 percent.

Mr. LARSEN. Right.

Senator FRANKEN. OK. Mr. Larsen, CCIIO——

Mr. LARSEN. CCIIO?

Senator FRANKEN. Yes. CCIIO has already granted MLR waivers to five States to phase in the requirements on insurers in the individual market. I'm extremely concerned that these waivers are being granted without sufficient evidence that these States would truly see a disruption of their insurance market without such a waiver. In a recent waiver that CCIIO granted in Nevada, it was clear that the State did not make its case. In fact, it appeared that CCIIO relied on information that wasn't even included in the application to make its decision, and out of the six waiver applications that have been decided, only one has been rejected.

I wrote a letter to Secretary Sebelius 2 months ago expressing my concern about the number of waivers being approved. Since then I have not received a response, and two more waivers have been approved.

First of all, can I expect a response to that letter, and when? And second, can you address the concern that CCIIO is willing to give waivers to nearly any State that applies, even if they do not provide necessary data? Approximately how much money will consumers lose in the States where insurers are granted waivers that don't have to spend even just 80 percent of insurance premiums on actual health care services?

Mr. LARSEN. Thank you. And first, let me personally apologize to you for not getting a prompt response back. I will make sure that you get that as soon as I get back to the office.

Senator FRANKEN. Thank you.

Mr. LARSEN. With respect to the six requests for adjustments that we've gotten, we take that review process very seriously, and it's a very in-depth process. If you've had or your staff had the opportunity to look at the letters that we send back and forth, there's a record that's developed. It's an extensive record. We have denied one, and of the others that we have approved, I can tell you that we modified every request that has come in. We have not granted the request as it came in the door.

Ultimately it's a balancing act, right? We want the consumers to make sure they get the benefit of the 80 percent provision. Some States have a number of smaller companies that in some cases are kind of on the edge of making money or not making money, and these are the ones that we're most concerned about leaving the market. And if there aren't other options available to individuals in the market, we don't want them—if the company were to leave, and some of them have said they would leave—they don't always explicitly threaten they're going to leave, but sometimes they tell the commissioner, "look, if we have to hit that 80 percent in 1 year, we may have to leave the market."

So we try and reach a balance in doing that, and I think the decisions that we've rendered where we've not granted what the insurance commissioner requested, tried to get as close as we can to 80 percent as quickly as we can, I think that's reflected in our decisions, and we support the MLR provision. We think it's incredibly important, and we'll continue to look at these very closely.

Senator FRANKEN. Thank you, and I look forward to a response to my letter.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Senator Murkowski.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

Senator Enzi, you mentioned the child-only policies and that as an issue. I thank you for your leadership on this aspect of health care and the study that you have conducted, along with your staff.

Alaska is one of these 17 States now that has been impacted in really a very, very harsh way. We currently have no child-only policies since the Affordable Care Act went into effect. It's not only been harmful to my State, but as I look around the dais here, Minnesota now does not have one, Connecticut does not have one, and Wyoming does not have these child-only policies. And I think it's fair to say this is harmful to these States where we don't have any coverage. We've got to deal with this.

I've been working on legislation that would allow parents and grandparents in my State and any other State to purchase child-only policies across State lines to ensure that we're not leaving any of these children behind. The legislation would also require the Department of Health and Human Services to issue a uniform annual enrollment period of at least 45 days.

Mr. Larsen, I appreciate your testimony here today. A couple of questions for you, and these relate to the news stories that describe the burden that this provision has on these 17 States. The main concerns are that the child-only policies do not have uniform open enrollment policies so parents can sign their kids up for insurance on the way to the emergency room, and then this adverse selection prompts carriers to exit the child-only market. I think it goes without saying that as a direct result of this policy, what we're seeing is our Nation's children are put in a very difficult position.

Now, we can talk about who is at fault here, whether it's the insurers or whatnot. I'm not here to defend the insurers. But the question to you this morning would be what other options are out there to these children in the 17 States currently? Maybe there will be more. What other options exist when there's only one insurer that's writing child-only policies left in the market, and what is the Administration doing to help get children access to insurance?

Mr. LARSEN. Thank you. And we certainly share your concern about what has happened, and it's been disappointing, frankly, to see the reaction of the insurers who—we've given them a number of tools that they can use to manage the risk. They can charge higher rates. They can have their own open enrollment periods. We've given them almost every option to insure both the sick and the healthy kids, and I think it's clear that they ultimately didn't want to insure the sick kids. So they've decided to not participate in some of the markets.

I want to make clear that this doesn't affect kids that are currently covered. They've stopped issuing new policies.

And I think there are a number of options available in the States. First of all, as you point out, States have employed different tools. Some have passed legislation requiring that if you're in the individual market, you also have to cover child-only policies. We know under the ACA, and this is new, that kids now have coverage through their parents' policies up to age 26. So to the extent that

there's parental coverage, you have access to that under the new provision under the ACA.

We've also made some changes to the PECIP program, the Preexisting Condition Insurance Program that operates across the States to, No. 1, lower premiums so that they're more affordable; and No. 2, to make it easier for kids to get into the PECIP program. We've allowed insurers to screen kids for availability in other programs like PECIP, like the CHIP program. So when you put all of these provisions together, we think there are many avenues for access for kids, and then there are tools available for the States and the issuers like open enrollment periods, and we encourage that.

Senator MURKOWSKI. Is the Administration planning on issuing guidance that defines a uniform open enrollment period?

Mr. LARSEN. We haven't yet, in part because we have seen——

Senator MURKOWSKI. Do you think, though, that it makes sense to do so?

Mr. LARSEN. We can. I mean, our preference, frankly, is for the States to design a State-based solution, and that's why many States have enacted open enrollment periods.

Senator MURKOWSKI. Right. But in a State like Alaska, where we don't have anybody there, 16 others don't have anybody there, we're really caught in a bind. And, of course, Alaska's population is low enough that we're not very attractive to too many insurers coming into the market in the first place. So when we lose those that will write the child-only policies, we're stuck.

So my proposal to allow for purchasing across State lines is one avenue. But I think we recognize that even with the expansion of Medicaid and the SCHIP, the fact of the matter is you're going to have a lot of children whose parents won't qualify for either of those programs, so we've got a real gap here. And I appreciate the fact that the Administration recognizes that, but you've got to be working with us so that we can find these solutions so we don't leave these kids hanging, as I believe that we are.

Mr. LARSEN. We can certainly look harder at that as an option. Again, I think our initial preference is, because States were taking action, not to override what the States were doing. But if we're at the point where States have done as much as we can, then we can certainly look at kind of a backstop open enrollment provision for States that, for whatever reason, still have an issue for these kids.

Senator MURKOWSKI. Mr. Chairman, my time is expired. I do have another question on the flexibility that's granted to States, but maybe we'll do that in a second round. Thank you.

The CHAIRMAN. Thank you very much.

Senator Blumenthal.

STATEMENT OF SENATOR BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. I want to thank the Chairman for having this hearing on a very important topic.

And thank you, Mr. Larsen, for your continuing work on this very complex and profoundly important issue.

I know a little bit about it from the standpoint of a State official, having served as attorney general in Connecticut, having actually

participated in a number of hearings on rate review issues, hearings that were not required under Connecticut law. One of the weaknesses of Connecticut law is that hearings are not required. Rates can go into effect without prior approval, and despite your citing an example in Connecticut and, I agree, a very encouraging example of one insurance proposal being cut as a result of, in effect, public notice and attention being focused on that proposed increase of 20 percent, there are still more examples of rates going up than rate proposals being cut. And I venture to say that's true across the country.

So let me begin with a question based on my experience. Would you agree that prior approval or disapproval is a very important feature of effective rate review?

Mr. LARSEN. If I can answer it this way, we define effective rate review in the context of the provisions that were in the ACA, which is truly a review process. If the question is in the spectrum of activities that kind of fully protect consumers, at one end you've got States that had file and use, use and file, where rates could go into effect really without any review, and then you've got a review process and public disclosure and public input, and then kind of at the other end of the spectrum is prior approval, certainly the prior approval provisions and the protections that Senator Feinstein indicated provide the maximum level of protection to consumers that the commissioner can modify or deny a rate increase.

Senator BLUMENTHAL. In my personal view, without being excessively critical of my own State, I believe that our rate review system should absolutely be strengthened by providing more transparency and accountability, including the opportunity for citizens to participate and for prior approval by the insurance commissioner after that kind of process, and a right of appeal, which many States lack as well. Would you agree that that right is also an important feature of accountability?

Mr. LARSEN. I think those are all important features of a full and fair rate process, public input and the right to appeal.

Senator BLUMENTHAL. Aside from the grants that you can provide, and thank you for benefitting Connecticut with a grant among the other States that you've done, what more can the Administration do, do you think, to encourage more accountable and effective review systems across the country given its present authority?

Mr. LARSEN. We're certainly in the process of granting, making and administering the grants. I mean, we have a lot of back and forth with the staffs of the insurance departments, and hopefully we can play a role in kind of cross-pollinating ideas from different States. We get asked that question a lot, and so we can certainly provide more technical expertise, let States know what the activities are in other States. We're working with the NEIC in that regard as well.

In terms of as we evaluate the progress that States are making in executing on their grant plan, we certainly want to hold them to standards and make sure they're doing what they said they were going to do to get the grant. I think that's an important part of maintaining an effective rate review process.

Senator BLUMENTHAL. Would you say that the industry could do more in perhaps encouraging that kind of review, especially compa-

nies in the industry, and unquestionably there are some, who want a responsible and accountable system?

Mr. LARSEN. It's been my experience the industry is usually kind of wary of the rate review process.

Senator BLUMENTHAL. Wary is a euphemism.

Mr. LARSEN. Not weary, but wary, yes, or maybe both.

Senator BLUMENTHAL. Or maybe both. But certainly they can be encouraged to play a more——

Mr. LARSEN. I think if they felt that it was a fair process, which I think it should be, can be, and is, but I think they have to feel that it's a fair process to engage in it as well.

Senator BLUMENTHAL. Would they feel, do you think, and would you feel—two separate questions, I suppose—that a fairer process would be one administered at the Federal level that might be applied more uniformly nationwide?

Mr. LARSEN. You know, I don't know how to answer that. I think that most—my experience was most companies want, and we want, for the reviews to be conducted at the local level by the local State insurance commissioner who is more familiar with the market, and where people are situated that are covered by the policies. So it's not our objective to have a large Federal involvement in the rate review process. It's our objective to have that performed at the State level, and we're only performing what I described as a backstop function. Only where States can't get to an effective rate review point will we be doing the reviews.

Senator BLUMENTHAL. Thank you. My time has expired, but I would welcome a continuing dialogue or conversation on this issue. Thank you very much.

Mr. LARSEN. Thank you.

The CHAIRMAN. Thank you, Senator Blumenthal.

Senator Hatch.

STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Mr. Chairman. Thank you for having this hearing to discuss the rising cost of health care in this country and how the health law has so far failed to deliver its promise to reduce premiums for individuals, families, and businesses.

CMS just recently published their annual National Health Expenditures report that shows that as a result of the health law, premiums will increase by 9.4 percent in 2014, and I would like to ask for unanimous consent that my opening statement be included in the hearing record, along with the health affairs article written by the CMS Office of the Actuary on National Health Care Spending.

[The article referred to may be found in Additional Material.]

The CHAIRMAN. So ordered.

Senator HATCH. Thank you, sir.

Welcome, Mr. Larsen. Appreciate the work you're doing and trying to do there at CMS.

CMS recently published its annual National Health Expenditures report for 2010. The report found that the health insurance pre-

miums will increase by 9.4 percent in 2014 as a result of the President's health law.

In your testimony you discuss two tools, as I view it, that the Administration is using to decrease the rate of premium increases. However, the central premise or promise of the law was that it would reduce premiums, not reduce the rate of growth in premiums.

Now, in the light of the new report issued by your agency, how can the law keep its central promise of reducing premiums by $2,500?

Mr. LARSEN. First, my understanding of the NHE report was it showed that the rate of health care spending for last year was at the lowest that it had been in many, many years. In fact, the rate was moderating, and I think that's a significant point.

I apologize. I'm not able to speak, I guess, to the estimates by the CMS actuary. I know that—I guess it's the difference between what rates would have been with or without the ACA. But, I mean, we continue to believe that the Affordable Care Act is going to moderate, significantly, premiums. Now, how it's going to do that in the different markets depends. Certainly with respect to health insurance exchanges, I know that for the small businesses, they're going to have opportunities that they don't have today, and they're going to get efficiencies through the exchanges that they don't have today.

So we continue to believe that the tools that are available in the ACA are going to help moderate—

Senator HATCH. The CMS National Health Expenditures report also found that prescription drug spending will increase by 10.7 percent in 2014, which is 5.1 percent higher than without the health law; physician and clinical services will increase by 8.9 percent in 2014, which is 3.1 percent higher than without the health law; and hospital spending will increase by 7.2 percent in 2014, which is 1 percent higher than without the health law.

Now, this report shows that the President's health law did not reduce the cost of health care in the long run and instead will bend the cost curve in the wrong direction. Do you agree with your own chief actuary that the cost of health care continues to rise and that the tools under the President's health law will not bend the cost curve downward in the long run?

Mr. LARSEN. I don't agree, but I have to admit that I haven't reviewed the CMS actuary's estimates. But I do know that the—

Senator HATCH. All right, that's fair. In your written testimony you said that, "States are the principal regulators of the private insurance market." Now, how does the rate review program established under the President's health law respect the States' role as principal regulator of the law if the law requires the Federal Government to conduct rate review in States without a Federally approved process for reviewing rates?

Mr. LARSEN. That's an important question, and I think we touched on it a little bit in the prior exchange. Our objective, and I think we've largely reached that, is for the States to be the primary reviewer. So we just completed an evaluation of all the States and the level of effectiveness that they have, and I think we found that only seven States so far were not effective, meaning that the

vast majority of States are effective. And even those ones that aren't, at any point they can come back to us and say, "look, we've got some kind of authority to review rates," because that's usually the biggest barrier. Some States don't have an existing State law, and a lot of States passed legislation this year.

But the vast majority are effective reviewers, and we will do everything we can to support the small number of States that are left to get them there.

Senator HATCH. OK. Now, you have an entire section in your testimony focusing on transparency and accountability. However, there are a number of areas where the Administration, in my opinion, has fallen short on both. For example, the preventive benefits that were mandated for coverage by August 1 of next year will not receive a public comment period. I sent a letter to the Secretary asking that she fully consider the impact of these benefit mandates and urged her to provide a comment period. However, none was provided.

Now, can you please tell me why the Administration is seemingly transparent in their implementation process for some programs but not all?

Mr. LARSEN. When we issued the initial interim final rule on preventive services last year, we did get comments on various aspects of preventive services and what should be included and the cost and things like that. So we took those comments into account when we just issued the latest decision with regard to women's preventive services.

So we do feel like we took comment. We responded to the comment. Nonetheless, I think in the amended interim final rule that we just put out, we have an initial comment period, and if we get comments that indicate that we should revisit the policies that we just announced, then we will do that.

Senator HATCH. Mr. Chairman, I have to leave, but can I ask just one other question? I think if it hasn't been asked, it should be asked. And that is, do you believe that a majority of the employers will be incentivized to stop providing health insurance as a result of the employer mandate and penalties under the law?

Mr. LARSEN. We think that employers will continue to offer. And, in fact, the rate of offers by particularly small businesses will increase between now and certainly when the exchanges are online in 2014.

Senator HATCH. You actually believe that?

Mr. LARSEN. Yes.

Senator HATCH. OK.

Mr. LARSEN. And I think that there are a number of studies from Rand and the Urban Institute that also make that projection.

Senator HATCH. OK. If you could submit those to the committee, I'd like to read them.

Mr. LARSEN. OK.

Senator HATCH. Thank you so much.

Thanks, Mr. Chairman.

[The prepared statement of Senator Hatch follows:]

PREPARED STATEMENT OF SENATOR HATCH

Mr. Chairman, I want to thank you for the opportunity to comment on the well-documented increases in health insurance premiums in the last year and their relationship to the President's health care law. Although the President promised to reduce premiums for all Americans by $2,500, a report published last week by the Centers for Medicare and Medicaid Services shows that premiums will increase by 9.4 percent in 2014. The impact of these increases will be catastrophic for American families forced to purchase insurance by the individual mandate, and for taxpayers who will have to foot the bill for the health law's subsidies for these inflated premiums.

In fact, the annual report by CMS on national health expenditures for 2010 found that by 2020, once the President's health law is fully implemented, $1 in $5 of the American economy will be spent on health care. The health share of the gross domestic product (GDP) will increase from 17.6 percent in 2009 to 19.8 percent in 2020. The report also found that the President's health law doubles the size of entitlements to $2.3 trillion by 2020; increases prescription drug spending by 10.7 percent in 2014; increases physician and clinical services by 8.9 percent in 2014; and increases hospital spending by 7.2 percent in 2014.

It is safe to say that in the history of ill-conceived Federal lawmaking, no law has failed as magnificently and predictably as the President's misguided and misleading effort at health care reform. The central promise of the White House's partisan health law was that it would reduce health care costs, but unfortunately, as the report by CMS shows, this law is only making things worse. By implementing further price controls, Federal mandates, and tax increases on health products, the Administration is only exacerbating the high cost of health care for individuals, families and businesses.

Estimates from the Congressional Budget Office show that premium increases, as a result of the new law, could be as high as 27 percent to 30 percent in the individual market. I will continue to work to repeal the President's health law to ensure that these premium increases are not fully realized. The Administration should take heed of the recent report by CMS which demonstrates the true impact of the President's health law on insurance premiums. Only by first coming to grips with the fact that the health care law is bending the cost curve upward, will we be able to prevent the law's costly mandates from being implemented and further hindering access to health insurance for all Americans.

The CHAIRMAN. Thank you, Senator Hatch.

Senator Hagan.

STATEMENT OF SENATOR HAGAN

Senator HAGAN. Thank you, Mr. Chairman.

Mr. Larsen, thank you for your testimony. I appreciate the work that your office is doing, and I do hear from my constituents on a regular basis about how frustrated and concerned they are that their insurance premiums obviously continue to rise.

In your experience, can you tell me what are the top three reasons that health insurance insurers continue to have such large increases in rates?

Mr. LARSEN. There are a number of different reasons. I mean, the insurance companies would indicate that they are simply passing along health care costs that they see. Health care costs are driven by kind of a unit cost, how much they're paying for a doctor visit or a hospital stay, and then how many of these services they're delivering. So there are a number of different reasons why costs increase, and I think one of the things that this provision, this rate review provision is going to get at is bringing transparency to exactly why rates are going up.

I think there's not always a good answer to your question, and I think there's a lot of confusion, and that's I think—I may not be answering your question, but I think that's the real benefit of this provision, is for the first time we're going to have a uniform disclosure form about what it is that's driving these rate increases, and then we can have a discussion about why they're going up.

Senator HAGAN. As a follow-up, the 10 percent threshold that you mentioned in your testimony, is that a good benchmark for the percentage increases we should expect to see in the future? Or should we perhaps expect further reductions in premium increases? In other words, when States set their own specific thresholds starting in 2012, do you expect that the threshold will be greater or less than 10 percent?

Mr. LARSEN. That's going to vary by State, and I think that raises a good point. The 10 percent was a starting point. We looked at a number of medical trend indices and landed on 10 percent. We thought that was the best one to start with. It is a national number, but we all know that markets, insurance markets are very local, and the rate of increase in one State can be a lot different in another. Cost factors are different. So the 10 percent may turn into a 12 percent in one State and a 9 percent in another State depending on local factors.

Senator HAGAN. I hear from constituents all the time, particularly small businesses in North Carolina, and they too are frustrated because their premiums obviously continue to increase. Under these new regulations, will there be an opportunity for consumers to file requests for reviews of premium increases either with you in your office or their State insurance commissioner?

Mr. LARSEN. The way it's structured now, the consumers don't have the ability, I guess, to ask for a review formally. We did add into the final rule that we issued an explicit provision that requires States to have public input in some way, because many States had no public input into the process.

The reviews are actually triggered by simply a rate being filed that's over the 10 percent. So the reviews don't depend on whether someone asks for them. They're kind of automatic based on that trigger. But we did, as I say, add in that provision for explicit public input into the process.

Senator HAGAN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hagan.

I thought about your question about why are these increases going up, and before you arrived I talked about letters I had re-

ceived from my own constituents on this. And I don't know what it's like in North Carolina, but in Iowa, when you have two carriers that have over 80 percent of the market, and in some areas of my State only one carrier, this is a monopoly practice—why are the rates going up? Because they can. I used that chart there to show the increase in the profits that these companies are making, and then you look at the increase in the premiums and they just about match.

So that's why rate review is so important. Both rate review and medical loss ratio that we put into this are so important to try to get on top of this. And as Mr. Larsen said, the transparency, at least getting the information out there of what's happening, because a lot of times we just don't know. There's kind of like a cloud out there. We can't really know what's driving those costs.

We do know that from 1999 to about the middle of this last decade, insurance costs went up about 131 percent, but the medical inflation was only 31 percent, so 100 percent more than the medical rate of inflation. So some of these companies are doing quite well.

Mr. Merkley, did you have any questions for Mr. Larsen?

Senator MERKLEY. Thank you, Mr. Chairman. I'm going to pass so we can go on to the next panel.

The CHAIRMAN. OK. Mr. Larsen, thank you very much for being here again for the second time.

Oh, I'm sorry. Senator Murkowski.

Senator MURKOWSKI. May I just ask a very, very quick question? This follows on the discussion earlier about the flexibility to the States.

Ten States were told at the end of June that they have insufficient rate review authority—you mentioned that as well—and that they might be taking them over. HHS is taking them over in September if they don't get it fixed.

You also mentioned the fact that several of these States lack that authority to fix it, and unfortunately, it's my understanding many of these States don't have legislators that are currently in session. In Alaska, we passed a law this year to address this, the rate review structure. It goes into effect January 2012. But what is going to happen is that HHS is still going to step in for this period between September and the date that it goes into enactment, and I really have to question how this promotes States' flexibility.

You've got a State that lacked the authority. We passed the law to gain it. It doesn't quite mesh with the requirements under the law, and so we've got a 3-month period where you all step in. Does this really promote the flexibility that we're hoping for? It just doesn't seem like it works to me.

Mr. LARSEN. I think you put it well when you said it doesn't quite mesh. We're kind of caught in the switches between the September 1 date in the regulation and the date that your law takes effect. I can certainly go back and talk to our staff. I mean, the one thing we wanted to make sure is that somehow or another the consumers in the State of Alaska were going to get the benefit of the law, and my understanding was that until the law took effect for the markets that are involved in Alaska, that the insurance department there didn't have the authority to actually get all the information to do the reviews.

So the challenge for us is, like I said, we would prefer for the States to do it.

Senator MURKOWSKI. And we would as well.

Mr. LARSEN. Right.

Senator MURKOWSKI. We'd like to work with you on this to see if there's some way. It just seems highly inefficient and goes against the goals here for you to have a 3-month——

Mr. LARSEN. Yes. I mean, our challenge would be if there were—if you couldn't do it and we didn't step in, and then you're going to have companies who are going to be raising rates typically for January. So this is the period of the year when they're looking for increases, and the rates aren't getting reviewed, and then probably you and HHS and others are going to get asked, well, how come these rates aren't getting reviewed? We thought we were supposed to get that.

So I think we have the same goal, and if there's a way to get there——

Senator MURKOWSKI. Alaska's situation is probably unique, but it does also bring up the issue for these other States that, again, lack the authority. Their legislatures are not in session to do anything about it, and you're just kind of hung in there. I'd like to know that perhaps we can be working with you so that we provide for the information that we're all hoping for without some really serious inefficiencies within the system.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Thank you, Mr. Larsen, for being here again.

Mr. LARSEN. Thank you.

The CHAIRMAN. We'll call our next panel. Our next panel will have three witnesses.

Mr. John Dicken, Director for Health Care Issues at the U.S. Government Accountability Office, where he directs GAO's evaluations of private health insurance, long-term care insurance, and prescription drug pricing issues.

We have Daniel Withrow. Mr. Withrow is president of the CSS Distribution Group, an international packaging company headquartered in Kentucky, and his testimony covers the U.S. Chamber of Commerce.

I will yield to Senator Merkley for purposes of the third introduction.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you, Mr. Chairman. It's my pleasure to introduce Teresa Miller, Oregon's Insurance Division administrator. I commend her for her stellar work leading Oregon's Department of Consumer and Business Services Insurance Division.

She joined the Division in 2008, bringing a background in legislative and policy issues, previously having worked as legislative director for former Oregon governor Ted Kulongoski. As insurance administrator, she oversees a staff of 100 and an annual budget of $10 million. In addition to regulating health insurance rates in the small group and individual markets, the Division protects consumers by licensing insurance companies and agents, making sure

insurers are financially sound, reviewing policies for consumer protections, and investigating potential violations of insurance law.

She has done a superb job of bringing diverse parties to the table and of taking Oregon forward based on a strong rate review statute which preceded Congress' passage of the Affordable Care Act.

Delighted you're here to share your insights. Welcome.

The CHAIRMAN. Thank you, Senator Merkley.

And welcome, Ms. Miller.

We'll start with Mr. Dicken and then go across. Your statements will all be made a part of the record in their entirety. If you could sum up in 5 to 7 minutes, we would appreciate that.

Mr. Dicken, welcome and please proceed.

STATEMENT OF JOHN DICKEN, DIRECTOR OF HEALTH CARE, GOVERNMENT ACCOUNTABILITY OFFICE, WASHINGTON, DC

Mr. DICKEN. Thank you. Mr. Chairman, Ranking Member Enzi, and members of the committee, I am pleased to be here today to discuss the State oversight of health insurance premiums. As the cost of health insurance coverage continues to rise, policymakers have raised questions about the extent to which these increases in health insurance premiums are justified and could adversely affect consumers.

While oversight of private health insurance, including premium rates, is primarily a State responsibility, the 2010 Patient Protection and Affordable Care Act established a role for HHS. The Act requires the Secretary of HHS to work with States to establish a process for the annual review of unreasonable premium increases. In addition, the Act requires the Secretary to award grants to assist States in their review practices.

My statement highlights key findings from a report requested by Chairman Harkin and Senator Feinstein that GAO is releasing today. This report describes State oversight of health insurance premium rates in 2010 and changes that States that received HHS rate review grants have begun making to enhance their oversight. For this report, we surveyed officials from the insurance departments of all 50 States and the District of Columbia. We also conducted interviews with insurance department officials and other experts, and reviewed the States' rate review grant applications submitted to HHS.

In brief, we found that oversight of health insurance premium rates varied among States in 2010. While 48 of the 50 State officials who responded to our survey reported that they reviewed rate filings in 2010, the practices reported by State insurance officials varied in three key areas.

First, there was variation in terms of the timing of rate filing reviews. Specifically, respondents from 38 States reported that all reviewed rate filings were reviewed before the rates took effect, while other respondents reported reviewing at least some rate filings after they went into effect.

Second, there is variation in the types of information respondents reported reviewing. While nearly all survey respondents reported reviewing information such as trends in medical costs and services, fewer than half of respondents reported reviewing carriers' capital levels. Some survey respondents also reported conducting com-

prehensive reviews of rate filings, while others reported reviewing little information or conducting cursory reviews.

A third area of variation was in opportunities for consumer involvement in rate reviews. Fourteen survey respondents reported providing consumers with opportunities to be involved in premium rate oversight such as participation in rate review hearings or public comment periods. However, most respondents reported that their State did not provide opportunities for consumer involvement.

Not only States' practices but also the outcomes of States' reviews of rate filings varied among States in 2010. Specifically, survey respondents from five States reported that over half of the rate filings they reviewed in 2010 were disapproved, withdrawn, or resulted in rates lower than originally proposed. In contrast, State survey respondents from 19 States reported these outcomes occurred from their rate reviews in less than 10 percent of the time.

Let me close by discussing how States have begun using rate review grants provided by HHS. Our survey found that 41 respondents reported their States have begun making changes to enhance their State's abilities to oversee health insurance premium rates. For example, about half of these respondents reported taking steps to either review their existing rate review processes or develop new processes. Some States also reported that they were changing information that carriers are required to submit with rate filings, incorporating additional data or analyses in rate filings, or taking steps to involve consumers in the rate review process.

In addition, over two-thirds reportedly have begun to increase their capacity to oversee premium rates. These capacity enhancements included hiring staff or outside actuaries, and improving the information technology systems used to collect and analyze rate filing data.

Finally, more than a third reported that their States have taken steps such as introducing or passing legislation in order to obtain additional legislative authority for overseeing health insurance premium rates.

Mr. Chairman, this concludes my statement. I will look forward to answering any questions you or other members of the committee may have.

[The prepared statement of Mr. Dicken follows:]

PREPARED STATEMENT OF JOHN DICKEN

SUMMARY

My statement will highlight key findings from a report requested by Chairman Harkin and Senator Feinstein that describes State oversight of health insurance premium rates in 2010 and changes that States that received HHS rate review grants have begun making to enhance their oversight of health insurance premium rates. For that report, we surveyed officials from the insurance departments of all 50 States and the District of Columbia, and received responses from all but one State. We also interviewed other State and Federal officials and experts and reviewed applications for HHS rate review grants.

We found that oversight of health insurance premium rates—primarily reviewing and approving or disapproving rate filings submitted by carriers—varied across States in 2010. While nearly all—48 out of 50—of the State officials who responded to our survey reported that they reviewed rate filings in 2010, the practices reported by State insurance officials varied in terms of the timing of rate filing reviews, the information considered in reviews, and opportunities for consumer involvement in rate reviews. Specifically, respondents from 38 States reported that all rate filings reviewed were reviewed before the rates took effect, while other respondents re-

ported reviewing at least some rate filings after they went into effect. Survey respondents also varied in the types of information they reported reviewing. While nearly all survey respondents reported reviewing information such as trends in medical costs and services, fewer than half of respondents reported reviewing carrier capital levels compared with State minimums. Some survey respondents also reported conducting comprehensive reviews of rate filings, while others reported reviewing little information or conducting cursory reviews. In addition, while 14 survey respondents reported providing consumers with opportunities to be involved in premium rate oversight, such as participation in rate review hearings or public comment periods, most did not. Finally, the outcomes of States' reviews of rate filings varied across States in 2010. Specifically, survey respondents from 5 States reported that over 50 percent of the rate filings they reviewed in 2010 were disapproved, withdrawn, or resulted in rates lower than originally proposed, while survey respondents from 19 States reported that these outcomes occurred from their rate reviews less than 10 percent of the time.

Our survey of State insurance department officials found that 41 respondents from States that were awarded HHS rate review grants reported that they have begun making changes in order to enhance their States' abilities to oversee health insurance premium rates. For example, about half of these respondents reported taking steps to either review their existing rate review processes or develop new processes. Other States reported that they were changing information that carriers are required to submit with rate filings, incorporating additional data or analyses in rate filings, or taking steps to involve consumers in the rate review process. In addition, over two-thirds reported that they have begun to make changes to increase their capacity to oversee premium rates, including hiring staff or outside actuaries, and improving the information technology systems used to collect and analyze rate filing data. Finally, more than a third reported that their States have taken steps—such as introducing or passing legislation—in order to obtain additional legislative authority for overseeing health insurance premium rates.

Chairman Harkin, Ranking Member Enzi, and members of the committee, I am pleased to be here today to discuss State oversight of health insurance premium rates in 2010 and changes that States that received Department of Health and Human Services (HHS) rate review grants have begun making to enhance their oversight of premium rates. In 2009, about 173 million nonelderly Americans, about 65 percent of the U.S. population under the age of 65, had private health insurance coverage, either through individually purchased or employer-based private health plans. The cost of this health insurance coverage continues to rise. In a 2010 survey, over three-quarters of U.S. consumers with individually purchased private health plans reported health insurance premium increases. Of those reporting increases, the average premium increase was 20 percent.[1] A separate survey found that premiums for employer-based coverage more than doubled from 2000 to 2010.[2] Policymakers have raised questions about the extent to which these increases in health insurance premiums are justified and could adversely affect consumers.

Oversight of the private health insurance industry is primarily the responsibility of individual States.[3] This includes oversight of health insurance premium rates, which are actuarial estimates of the cost of providing coverage over a period of time to policyholders and enrollees in a health plan.[4] While oversight of private health

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[1] The Kaiser Family Foundation, "Survey of People Who Purchase Their Own Insurance," (Menlo Park, CA, June 2010).

[2] The Kaiser Family Foundation and Health Research & Education Trust, "Employer Health Benefits 2010 Annual Survey," (Menlo Park, CA, September 2010).

[3] See Law of Mar. 9, 1945, ch. 20, 59 Stat. 33 (codified, as amended, at 15 U.S.C. ch. 20) (popularly known as the McCarran-Ferguson Act). The McCarran-Ferguson Act provides States with the authority to regulate the business of insurance, without interference from Federal regulation, unless Federal law specifically provides otherwise. Therefore, States are primarily responsible for overseeing private health insurance premium rates in the individual and group markets in their States. Through laws and regulations, States establish standards governing health insurance premium rates and define State insurance departments' authority to enforce these standards. In general, the standards are used to help ensure that premium rates are adequate, not excessive, reasonable in relation to the benefits provided, and not unfairly discriminatory.

[4] To determine rates for a specific insurance product, carriers estimate future claims costs in connection with the product and then the revenue needed to pay anticipated claims and nonclaims expenses, such as administrative expenses. Premium rates are usually filed as a formula that describes how to calculate a premium for each person or family covered, based on information such as geographic location, underwriting class, coverage and copayments, age, gender, and number of dependents.

insurance, including premium rates, is primarily a State responsibility, the 2010 Patient Protection and Affordable Care Act (PPACA) established a role for HHS by requiring the Secretary to work with States to establish a process for the annual review of unreasonable premium increases.[5] In addition, PPACA required the Secretary to carry out a program to award grants to assist States in their review practices.[6] Since the enactment of PPACA, Members of Congress and others have continued to raise questions about rising health insurance premium rates and States' practices for overseeing them.

My statement will highlight key findings from a report we are publicly releasing today that describes State oversight of health insurance premium rates in 2010 and changes that States that received HHS rate review grants have begun making to enhance their oversight of health insurance premium rates.[7] For that report, we surveyed officials from the insurance departments[8] of all 50 States and the District of Columbia (collectively referred to as "states"). We received responses from all but one State.[9] In order to obtain more detailed information about State oversight of health insurance premium rates in 2010, we also conducted interviews with insurance department officials from five selected States.[10] Additionally, we interviewed other experts and officials from relevant organizations, including the Center for Consumer Information and Insurance Oversight within the Centers for Medicare & Medicaid Services, the National Association of Insurance Commissioners (NAIC), the American Academy of Actuaries, America's Health Insurance Plans, two large carriers based on their number of covered lives,[11] NAIC consumer representatives (individuals who represent consumer interests at meetings with NAIC), and various advocacy groups such as Families USA and Consumers Union. We also reviewed portions of the States' Cycle I rate review grant applications submitted to HHS and other relevant HHS documents. Our work was performed from September 2010 through July 2011 in accordance with generally accepted government auditing standards.

In brief, we found that oversight of health insurance premium rates— primarily reviewing and approving or disapproving rate filings submitted by carriers—varied across States in 2010. While nearly all—48 out of 50—of the State officials who responded to our survey reported that they reviewed rate filings in 2010, the practices reported by State insurance officials varied in terms of the timing of rate filing reviews, the information considered in reviews, and opportunities for consumer involvement in rate reviews. Specifically, respondents from 38 States reported that all rate filings reviewed were reviewed before the rates took effect, while other respondents reported reviewing at least some rate filings after they went into effect. Survey respondents also varied in the types of information they reported reviewing. While nearly all survey respondents reported reviewing information such as trends in medical costs and services, fewer than half of respondents reported reviewing carrier capital levels compared with State minimums. Some survey respondents also reported conducting comprehensive reviews of rate filings, while others reported reviewing little information or conducting cursory reviews. In addition, while 14 survey respondents reported providing consumers with opportunities to be involved in premium rate oversight, such as participation in rate review hearings or public comment periods, most did not. Finally, the outcomes of States' reviews of rate filings varied across States in 2010. Specifically, survey respondents from 5 States reported that over 50 percent of the rate filings they reviewed in 2010 were disapproved,

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[5] Pub. L. 111–148 §§1003, 10101(i), 124 Stat. 119, 139, 891 (adding and amending §2794 to the Public Health Service Act (PHSA)).

[6] Pub. L. 111–148 §1003, 124 Stat. 139, 140, 891 (adding and amending PHSA §2794 (a)(1) and (c).

[7] GAO, *Private Health Insurance: State Oversight of Premium Rates*, GAO–11–701 (Washington, DC: July 29, 2011).

[8] For the purposes of this report, we refer to the entities responsible for the oversight of premium rates as insurance departments, even though the entity responsible for oversight of premium rates in each State was not always called the Department of Insurance. For example, in Minnesota, the Department of Commerce is responsible for the oversight of health insurance premium rates.

[9] Officials from the Indiana Department of Insurance declined to complete our survey. In addition, not all States responded to each question in the survey. We conducted the survey from February 25, 2011 through April 4, 2011, collecting information primarily on State practices for overseeing premium rates in calendar year 2010.

[10] We selected these States—California, Illinois, Maine, Michigan, and Texas—based on differences among the five States in terms of their (1) State insurance departments' authority to oversee premium rates, (2) proposed changes to their existing practices for overseeing premium rates, (3) size, and (4) geographic location.

[11] A carrier is generally an entity—either an insurer or managed health care plan—that bears the risk for and administers a range of health benefit offerings.

withdrawn, or resulted in rates lower than originally proposed, while survey respondents from 19 States reported that these outcomes occurred from their rate reviews less than 10 percent of the time.

Our survey of State insurance department officials found that 41 respondents from States that were awarded HHS rate review grants reported that they have begun making changes in order to enhance their States' abilities to oversee health insurance premium rates. For example, about half of these respondents reported taking steps to either review their existing rate review processes or develop new processes. Other States reported that they were changing information that carriers are required to submit with rate filings, incorporating additional data or analyses in rate filings, or taking steps to involve consumers in the rate review process. In addition, over two-thirds reported that they have begun to make changes to increase their capacity to oversee premium rates, including hiring staff or outside actuaries, and improving the information technology systems used to collect and analyze rate filing data. Finally, more than a third reported that their States have taken steps—such as introducing or passing legislation—in order to obtain additional legislative authority for overseeing health insurance premium rates.

Chairman Harkin, Ranking Member Enzi, this concludes my prepared remarks. I would be pleased to respond to any questions you or other members of the committee may have at this time.

The CHAIRMAN. Thank you very much, Mr. Dicken, and thanks for getting the report out in a timely manner.

Now, Ms. Miller, please proceed.

STATEMENT OF TERESA MILLER, ADMINISTRATOR, OREGON INSURANCE DIVISION, SALEM, OR

Ms. MILLER. Good morning. Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee. For the record, my name is Teresa Miller, and I'm the administrator of the Oregon Insurance Division of the Department of Consumer and Business Services, and I'm honored to be here today and appreciate the opportunity to talk to you about how Federal grants available through the Affordable Care Act are improving our health insurance rate review process in Oregon.

Oregon has worked very hard over the last 4 years to strengthen our State rate review law and open our process. Because of these efforts, Oregon's rate review process is one of the most transparent in the country and is supported by a strong rate review statute.

As we've continued to improve our process, the Federal rate review grants have allowed us to hire the staff necessary to conduct more in-depth reviews of rate filings and have provided the funds necessary to solicit meaningful public comments.

In my written testimony I've included more detail about the key features of our rate review process. But just briefly, those include: posting all documents contained in a rate filing in their entirety upon submission on our Web site; emailing policyholders who signed up to be notified of rate filings; opening a 30-day public comment period; and issuing a plain-language summary of our decision, and then emailing policyholders with a link to that decision.

I want to focus my remarks this morning on the improvements that we've made to our process with Federal grant dollars. First, the funding that we've received as part of the Cycle 1 rate review grant allowed us to solicit more detailed and meaningful public comments. I mentioned that we have a 30-day public comment period. Initially, that public comment period attracted few comments, and those who did comment generally simply said that they couldn't afford their rising premiums, but they didn't address the statutory factors that we review as we review rate filings.

So this is why we used $100,000 of our Cycle 1 grant to contract with a consumer advocacy group to weigh in on behalf of consumers. This group used the funding we provided to hire an actuary and has been providing very detailed analyses focused on the factors contained in our statute.

Unlike many States, Oregon has a competitive health insurance market. We have seven Oregon-based insurers who actively compete in the small group and individual markets that we regulate. Because of our competitive process, we review approximately 40 rate requests a year in these markets.

The first round of Federal grants enabled us to add an actuary to our staff, and we're proposing to add another actuary in our next grant cycle. This will allow us to dig even deeper in rate filings to address issues brought up by the consumer advocacy group and to hold public hearings so that those who want to watch or participate in our process can see the scrutiny firsthand that we provide with regard to these rate requests.

Federal grant dollars have also allowed us to communicate better with consumers about rate filings. We created a new Web page devoted to health insurance rates, with a search engine that allows consumers to more easily find a rate filing, as well as information about how we review health insurance rate filings. We used grant dollars to create a 7-minute animated story about health insurance costs that breaks down the premium dollar and describes how we review health insurance rates. We also used Federal dollars to conduct a public hearing on a recent filing.

So how have consumers benefitted from the improvements that we've made? Aside from the transparency efforts that help educate consumers about what's driving health insurance costs and give them opportunities to weigh in on requests, the changes that we've made have saved consumers money. In the year that followed the strengthening of our State's rate review law, we lowered insurance company requests 50 percent of the time, saving consumers more than $25 million, or just under $10 per person on a monthly insurance premium. Of course, that doesn't solve the affordability of health insurance, but every percentage point of a rate request matters to us because it matters to consumers.

At the same time, we understand that we must control health care costs to stabilize insurance rates. That brings me to the study that we're conducting with first-year grant funds. Ultimately, the key to stabilizing health insurance costs is controlling medical costs. In Oregon, considering all insurance markets, an average of 89 cents of every premium dollar goes to pay health care costs. To try to tackle health care costs, we used $150,000 to contract with an actuarial firm for a study. The study, which will wrap up in the fall, is exploring whether there are opportunities within our current rate review process to control the growth of health care costs or improve the health care delivery system.

As I mentioned earlier, we're applying for a second round of grant money to hire another health actuary and to allow us to conduct public hearings for most of our rate requests. In conducting a public hearing on a recent rate filing, it became clear that even with one of the most open processes in the country, consumers are unaware of the scrutiny we apply to rate filings. I am proud of the

work that we do, and I want Oregonians to see the rigor of our reviews.

The Federal grant funding available through the Affordable Care Act is helping States improve the review of health insurance rates. It is giving States like Oregon the resources needed to solicit detailed and meaningful consumer input, conduct more in-depth reviews of rate filings to prevent excessive increases, and improve rate filing information available to consumers.

In Oregon, the next frontier in rate review is finding ways to help lower medical costs so that we can make insurance more affordable for consumers. Thank you for the opportunity to share Oregon's experience and for the funding that enables us to strive for continued improvement.

I'd be happy to answer any questions.

[The prepared statement of Ms. Miller follows:]

PREPARED STATEMENT OF TERESA MILLER

SUMMARY

Over the past 4 years, Oregon has strengthened its rate review law and opened up its process. Today, we have one of the most transparent reviews in the country, supported by a strong rate review statute. As we have improved our process, Federal rate review grants provided staff to conduct more in-depth reviews of rate increases and funds to solicit meaningful public comment.

Key features of our rate review process

- Post to Web site all rate filing documents.
- Email policyholders who sign up to be notified of rate filings.
- Open 30-day public comment period.
- Consumer advocacy group begins its review of the rate request.
- Division review looks at actual and projected claims costs, a company's past history of rate changes and its financial strength, enrollment trends, premiums, administrative costs by line of business, and a company's overall profitability as opposed to just its performance in one line of business. Division can consider factors such as investment income, surplus and cost containment/quality improvement efforts.
- Issue a plain language summary of our decision.
- Email policyholders with a link to our decision.

Improvements we have made with Federal grant dollars

- **Advocacy group:** We used $100,000 of our cycle 1 grant to contract with a consumer advocacy group to weigh in on behalf of consumers. This group used the funds to hire an actuary and offer detailed analyses.
- **In-depth reviews:** We hired an actuary and market analyst, among others, so that we can conduct more in-depth reviews of the approximately 50 rate requests we evaluate annually. We propose to add a second actuary in the next grant cycle, doubling the number of our health actuaries from two to four. This will allow us to pursue any issues raised by the consumer group and to hold more public hearings.
- **Enhance communications:** We created a new web page (*www.oregonhealthrates.org*) devoted to health insurance rates with search engines that allow consumers to more easily find a rate filing along with other information about how we review health insurance rates.
- **Study:** Ultimately, the key to stabilizing health insurance costs is controlling medical costs. We used $150,000 to contract with an actuarial firm to find ways to use rate review to control the growth of health care costs or improve the health care delivery system. The results of the study are due this fall.

Improvements we propose to make with future grant dollars

- Continue existing staff and consumer group funding from cycle 1.
- Incorporate public hearings into most rate requests.
- In addition to another health actuary, establish a health insurance rate liaison to explain our process and to provide rate information to consumers.
- Hire a health reform/exchange coordinator to assist with Federal and State reform efforts that impact our rate review process.

INTRODUCTION

Good morning Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee. My name is Teresa Miller, and I am the administrator of the Oregon Insurance Division of the Department of Consumer and Business Services. I am honored to be here today and appreciate the opportunity to explain how Federal grants are improving our health insurance rate review process in Oregon.

Over the past 4 years, Oregon has transformed its review of rate requests, making it more transparent, rigorous, and inclusive. Our process is as open as any in the country and it is backed by a strong rate review statute. As we strengthened our State law and opened our process, Federal grants available through the Affordable Care Act provided additional staff to conduct more in-depth reviews of rate increases and funds to solicit meaningful public comment. In addition to giving the Oregon Insurance Division the ability to prevent excessive rate increases, Oregon's rate review allows us to engage consumers and educate them about the factors that lead to rising health insurance costs.

I would like to give you some background on rate review in Oregon and the improvements we have made—and plan to make—with grants available under the Affordable Care Act.

RATE REVIEW IN OREGON

Oregon, unlike many States, has a competitive health insurance market. Seven Oregon-based insurers actively compete in the small group and individual markets that we regulate. Insurers in these markets must submit rates and have them approved by the State before they take effect.

The Oregon Insurance Division reviews rates to ensure they are reasonable in relation to the benefits provided. During our review, we look at the cost of medical care and prescription drugs, the company's past history of rate changes, the financial strength of the company, actual and projected claims costs, enrollment trends, premiums, administrative costs, and profit. Oregon's own health reform law passed in 2009 expanded the factors we can consider in evaluating a rate request. It gives us, for example, explicit authority to consider factors such as an insurer's investment income, surplus, and efforts to control costs and improve quality.

Perhaps most significantly, we may also consider an insurer's overall profitability rather than just the profitability of a particular line of insurance. Finally, insurers must separately report and justify changes in administrative expenses by line of business and must provide more detail about what they spend on salaries, commissions, marketing, advertising, and other administrative expenses.

In addition to strengthening our authority, we also have taken many steps in recent years to make our process more transparent. For example, we have added the following elements:

- We post rate filings for individual, portability, and small-employer plans on the Insurance Division Web site once they are deemed complete. All information is public.
- A required feature of the filing by the insurer is a plain-language summary highlighting the insurer's request along with a 5-year history of rate increases for that line of insurance.
- The posting of the filing triggers a 30-day public comment period. We send an email to policyholders who sign up for email notification when their company files a rate request. Any comments consumers make are posted to the Web site.
- We contract with a consumer group, using Federal grant money, to comment on key rate requests on behalf of consumers.
- We must issue a decision within 10 days of the close of the public comment period—meaning we have 40 days to complete most of the work.
- Because every rate change is based on a unique set of facts, we file a plain-language summary on the Web site listing key factors underlying each rate filing decision.
- Finally, we send policyholders an email with a link to the decision.

Let me explain how this process works in the context of a rate filing. This past spring, Regence BlueCross BlueShield of Oregon, the largest carrier in the markets we regulate, requested a 22.1 percent rate increase. This affected about 59,000 people with individual health plans, the State's single-largest group of individual health plan policyholders.

Once our intake coordinator (hired with new Federal grant funding) verified the filing was complete, we posted all the company's documents on our Web site, notified consumers that Regence had filed for a rate increase, and launched the 30-day public comment period.

At the same time, a consumer watchdog group that we contract with using Federal grant funds began its analysis of the request. In addition to reviewing the filing with its own actuary, this group generated an additional 800 public comments as part of its outreach.

Finally, because of the size of the proposed increase and number of policyholders affected, I scheduled the division's first public hearing in at least 20 years. We used Federal grant funds to help pay the hearing costs. At the hearing, which was attended by more than 150 people, the company outlined its request, the division posed questions to the insurer, and the consumer group outlined its concerns.

In this case, our actuaries questioned the company's assumptions about future medical costs and the costs of new benefits required by Federal reform. Our authority to take into account an insurer's surplus and overall profitability were also key factors.

Of course, we analyzed the company's medical loss ratio—that is how much of the premium dollar goes to health care costs as opposed to administration and profit. In Oregon's competitive market, most or all of our large health insurers already meet the new Federal requirement to spend at least 80 percent of premium dollars on medical costs.

The division ultimately approved a 12.8 percent rate increase instead of the 22.1 percent requested. The division's decision to significantly reduce the rate increase was based on a desire to stem a recent history of enrollment losses in these particular plans and to spur greater stability in rates going forward. And, it was done with the knowledge that Regence is financially sound with substantial surplus, which could help offset any losses incurred from these plans.

Once the decision was made, our grant-funded project coordinator drafted a brief, plain-language explanation of our decision as well as a detailed response to the consumer group's comments. We posted these online and sent an email link to consumers.

ACA GRANTS TO IMPROVE RATE REVIEW

Federal grants have proved essential for us to conduct these detailed reviews and to solicit meaningful public comments. Here are some examples of how we have spent Federal grant dollars to date.

Public input: When we instituted a 30-day public comment period, we initially attracted few public comments. After all, the bulk of rate filing materials remain highly technical. Those who did comment generally said they could not afford rising premiums but did not address the factors we must consider by law in weighing rate requests. That is why we used $100,000 of our cycle 1 grant to contract with a consumer advocacy group to weigh in on behalf of consumers. This group's detailed analyses have been extremely helpful. Oregon State Public Interest Research Group (OSPIRG) keeps us on our toes and reminds us of the questions consumers want answered.

In-depth review: Because Oregon has a competitive health insurance market, we review approximately 50 rate requests a year. The first round of Federal grants enabled us to add an actuary to our staff, and we propose to add another one in the next grant cycle. This would double the number of our health actuaries, from two to four. This enables us to do a more in-depth analysis, to pursue any issues raised by the consumer group, and to hold more public hearings so that those who want to watch or participate can see the scrutiny we give these requests.

Additionally, the grant funds pay for a market analyst who tracks insurers' administrative costs by line of business and for staff to process filings, manage the grants and write the explanations of our rate decisions.

These additional staff members are key to making decisions within the required 40 days from the time a filing is deemed complete. Meeting this deadline became increasingly difficult as we added steps to open up our process and as we required more information from insurers through our strengthened rate review law.

Our strengthened law and additional staff have resulted in cost savings for consumers. In the year that followed the strengthening of our State's rate review law, we lowered insurance company rate requests 50 percent of the time. The size of the reduction averaged 4 percentage points—for example a company would request a 16 percent rate increase and we would grant a 12 percent increase. That saves consumers just under $10 a month. Of course, that does not solve the problem of affordability, but every percentage point of a rate request matters to us. At the same time, we understand we must control health care costs to stabilize insurance rates.

Communications: Although insurance company rate request documents have been public for several years, they have been difficult for consumers to find on our Web site. With the Federal grant, we were able to create a new web page devoted

to health insurance rates featuring a search engine that allows consumers to more easily find a rate filing, a 7-minute animated video explaining why health insurance costs so much, and other information about how we review health insurance rates. I have attached a screenshot of this page. On the day we issued the Regence decision, we had 500 hits on this page. We also used some money to conduct the Regence public hearing, which was instructive for a variety of reasons. The Oregonians who attended appreciated the opportunity to have their voice heard as well as watching us question the company about the request.

Study on how rate review could help lower medical costs: Ultimately, the key to stabilizing health insurance costs is controlling medical costs. In Oregon, considering all insurance markets, an average of 89 cents of every premium dollar goes to pay for health care. To explore how we might be able to affect health care costs in rate review, we used $150,000 of our first-year Federal grant to contract with an actuarial firm to conduct a study. The study results are due this fall, and may result in legislation. One idea we are exploring is to deny rate requests if the insurer reimburses providers for specified medical errors that should never happen. With Oregon's competitive insurance market, providers in more rural parts of the State often have an upper hand in contract negotiations. One of the goals of this study is to identify ways of leveling the playing field between insurers and providers by, for example, requiring all insurers to include certain provisions aimed at controlling costs in their contracts with providers.

FUTURE GRANT PROPOSALS

In conducting the recent public hearing in Oregon, it became clear that even with one of the most open processes in the country, consumers are unaware of the scrutiny we apply to rate requests. I'm proud of our work and want Oregonians to see the rigor of our reviews, so we plan to apply for additional Federal grant money to incorporate public hearings into most individual and small group rate requests.

We anticipate approximately 20 public hearings a year and would expand funding to the consumer group so it could provide comments and participate. During the proposed hearings, our actuaries and a contracted consumer advocacy group would pose questions to insurance company actuaries—covering issues that we might oth-

erwise call or email about. At the conclusion, we would open the meeting to public comment. We are including money in the grant for technology that would allow people to watch the hearings from their computers—live or later at their convenience. By fall, we also hope to begin posting all the actuarial correspondence between the division and insurers. While this correspondence is public record, it currently is not readily accessible to the public.

In addition to the public hearings, we will propose using grant money to hire another health actuary to scrutinize rate requests and participate in public hearings and a health insurance rate liaison to explain our process and to provide rate information to consumers. We also will propose a health reform/exchange coordinator to assist with Federal and State reform efforts that impact our rate review process. In Oregon, the Health Insurance Exchange is governed by a public corporation, and much of the planning rests with this corporation and a separate State agency charged with coordinating and implementing State health care reform. We work closely with the Exchange and this agency and will continue to do so as the Exchange in Oregon becomes operational. For example, we will review health plans offered through the Exchange to ensure that they meet the standards established by the State Exchange and the Affordable Care Act.

Finally, we will continue improvements to our web and print publications designed to better educate consumers about rate review, including the key factors that drive health insurance rates.

CONCLUSION

Federal grants to improve States' review of health insurance rates are essential to educating the public and preventing excessive rates. In Oregon, the next step in rate review is finding ways to help lower medical costs so that we can truly make health insurance affordable to consumers. Thank you for this opportunity to share Oregon's experience and for the funding that enables us to strive for continued improvement. I'm happy to answer your questions.

REFERENCES

- Oregon's rate review web page: *www.oregonhealthrates.org*.
- Example of a decision summary: *http://www.oregonhealthrates.org/files/decision.pdf*.
- Insurance Division response to OSPIRG analysis: *http://www.oregonhealthrates.org/files/dcbs__response__ospirg.pdf*.
- Grant page: *http://insurance.oregon.gov/consumer/federal-health-reform/rate-review-grant.html*.
- Oregon's administrative rules on rate review (836–053–0471): *http://arcweb.sos.state.or.us/rules/OARS__800/OAR__836/836__053*.html.

The CHAIRMAN. Thank you very much, Ms. Miller.

Mr. Withrow, please proceed.

STATEMENT OF DANIEL C. WITHROW, PRESIDENT, CSS DISTRIBUTION GROUP, INC., LOUISVILLE, KY

Mr. WITHROW. Chairman Harkin, Ranking Member Enzi, and Senator Franken, Senator Merkley, thank you for inviting me today to testify on health care, the efforts to empower the States.

My name is Dan Withrow. I'm president of CSS Distribution Group, headquartered in Louisville, KY. Behind me sits my beautiful daughter, Hallie Grace Withrow. And I apologize. I might be a bit nervous because I'm testifying in front of my biggest fan.

I'm honored to be here, and thank you for your service to the United States.

In 2006, after working in the packaging and distribution industry for decades, my wife and I borrowed nearly $1 million from friends, banks, credit card companies, to open CSS Distribution Group. At our company, we approach everything with a challenge of building trust and partnerships by doing the right things right. We've worked hard to grow our company, but to date, CSS has not made a net profit. Although we projected this year would be a

breakout year, it's now hard to see how new regulations will impact our business. We did reduce our workforce from 16 to 10 full-time employees in order to retain as much flexibility as possible, and we're paying our full-time employees overtime instead of hiring new employees. We're trying to hedge our bets.

One element of our business that continues to be unpredictable is the cost of health care coverage, and we've offered our employees health care coverage ever since we opened our doors. As a small business, our employees are like family to us. So for the past 5 years, we have offered all employees a choice between PPOs and HSA health savings accounts. At this time, half of our employees take up the offering, three participate in our HDHP, two are enrolled in the PPO. Of the employees that do not participate, three are covered under their spouse's plan, one has elected to purchase a less expensive, more basic plan, and that leaves one more, and that's my wife.

While I'm committed to offering coverage to all my employees, the premium increases that we have seen and those that we continue to see are beyond what we can afford, and even more worrisome, it's beyond what my employees can afford. Each year we have seen at least 30 percent premium increases, except the summer after the health reform law was passed. Last summer, after the enactment of the Patient Protection and Affordable Care Act, we were quoted an increase of over 42 percent.

I've tried everything that I know to do to mitigate the increases, and the only way I've been able to moderately curtail these increases is by restructuring the plans, increasing deductibles, revising co-payments and drug tiering formulary. These changes have helped reduce the premiums, but they really do nothing to impact the out-of-pocket costs that we all have to pay for.

These year-over-year increases, in my opinion, cannot be blamed on my plan or the insurance industry at large. I believe health care costs are what's driving this, not the insurance companies. Each year I spend between 30 and 45 days researching other plans and insurance options. I'm in the middle of that research right now. Despite my repeated efforts, I have not been able to find any other options that I can offer to my employees at lower premiums and, unfortunately, I'm an optimist at heart, I don't think this will change.

The reason premiums are increasing is because the cost of coverage is increasing. It's pretty simple economics. Additionally, plans are now required to cover a laundry list of services, many at no cost to the enrollee or the participant. The thing is, merely requiring a review of premium increases, in my opinion, will not stop that from happening. Restructuring the insurance market while also mandating plans cover an exhaustive list of benefits will also not reduce the cost of coverage.

It's really simple. If you want more, it's going to cost more. A product cannot be sold for less than it costs to create or offer. This business principle applies to the pallets that I sell or the coverage for health care services that my plan provides.

In conclusion, I know this may not be what you want to hear, but the new health care law has made it more difficult for small business to compete than you may realize. I hope what I've shared

today is helpful and urge you to repeal the costly parts of the law. On behalf of thousands and thousands of business men and women in America, please listen to our concerns.

Thank you for allowing me to testify, and I look forward to taking your questions.

[The prepared statement of Mr. Withrow follows:]

PREPARED STATEMENT OF DANIEL C. WITHROW, ON BEHALF OF THE U.S. CHAMBER OF COMMERCE*

SUMMARY

My name is Dan Withrow. I am the president of CSS Distribution Group, Inc. headquartered in Louisville, KY and I am honored to speak with you on behalf of the U.S. Chamber of Commerce. I hope that my testimony and remarks will help further explain the burdens that the new health care law places on the ability of businesses, including small ones like mine, to compete, grow and create jobs. Despite efforts to expand coverage options and curtail dramatic health insurance premium increases, the law in fact is having a negative impact on our ability to continue to offer our employees health care benefits.

While our customers are large, oftentimes multinational, businesses, CSS is a small, privately owned business. While our business has grown in terms of sales and customers and we've been able to give back in our community, we unfortunately recently had to reduce our number of employees. Because of the overall uncertainty brought on by the economic downturn and the rising costs of health insurance, we went from 16 to 10 employees in 2010. For the first 4 years of operation, CSS did not make a net profit. This year is supposed to be our breakout year; we had hoped that it would be the first time we will realize a net profit. Despite a positive projection, we cannot really be sure what all the new regulations will actually bring. In fact, in order to retain as much flexibility as possible, we are paying our full-time employees overtime instead of hiring any new employees.

Skyrocketing premiums continue to harm our ability to offer coverage, even now—16 months after the passage of the health reform law. Even when we first began our company and had to borrow nearly $1 million from friends, banks and credit card companies to open our doors, we offered health care coverage to our employees. The premium increases that we have seen, and those we continue to see, are beyond what I can afford and even more worrisome, it is beyond what my employees can afford too. These increases cannot be blamed on my plan or the insurance industry at large. Each year, I have researched other plans and insurance options. Despite my repeated efforts, I have not been able to find *any* other options that can offer coverage to my employees at lower premiums.

While I understand that in 2014 there may be new marketplaces called exchanges where my employees may be able to purchase coverage, I am not sure how they will work or what coverage in the exchanges will look like and cost. I do not want to leave my employees in the lurch; they are all valued team members and I want to have some security that they are going to get affordable and appropriate coverage.

*The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than 3 million businesses of all sizes, sectors, and regions, as well as State and local chambers and industry associations.

More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the Nation's largest companies are also active members. We are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large.

Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business—manufacturing, retailing, services, construction, wholesaling, and finance—is represented. Also, the Chamber has substantial membership in all 50 States.

The Chamber's international reach is substantial as well. It believes that global interdependence provides an opportunity, not a threat. In addition to the U.S. Chamber of Commerce's 115 American Chambers of Commerce abroad, an increasing number of members are engaged in the export and import of both goods and services and have ongoing investment activities. The Chamber favors strengthened international competitiveness and opposes artificial United States and foreign barriers to international business.

Positions on national issues are developed by a cross-section of Chamber members serving on committees, subcommittees, and task forces. More than 1,000 business people participate in this process.

I'm here today to share with you the real effect the law is having on me and other small businesses. I hope what I've shared today is helpful and urge you to repeal the most costly parts of the law, such as the employer mandate. This employer mandate truly prevents us from expanding our businesses and hiring more people—in other words creating new real jobs.

Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee, thank you for inviting me to testify before you today on health reform and efforts to empower States to serve consumers. I hope that my testimony and remarks will help further explain the burdens that the new health care law places on the ability of businesses, including small ones like mine, to compete, grow and create jobs. Despite efforts to expand coverage options and curtail dramatic health insurance premium increases, the law, in fact, is having a negative impact on our ability to continue to offer our employees health care benefits.

My name is Dan Withrow. I am president of CSS Distribution Group, Inc., headquartered in Louisville, KY and I am here today with my oldest daughter, Hallie Grace Withrow. I am honored to speak with you today on behalf of the U.S. Chamber of Commerce. The U.S. Chamber of Commerce is the world's largest business federation, representing the interests of more than 3 million businesses and organizations of every size, sector, and region. As you might know, more than 96 percent of the Chamber's members are small businesses with 100 or fewer employees and 70 percent of which have 10 or fewer employees, just like mine.

COMPANY BACKGROUND

A Certified Woman-Owned Enterprise by the Women's Business Enterprise National Council (WBENC), CSS Distribution Group aims to maximize our customers' packaging and shipping efficiency throughout a nationwide network of locations. Our national network helps our clients leverage their buying power by essentially creating one national supply chain. By allowing our clients to purchase collectively for all of their locations across the country, we can save our clients millions of dollars and positively impact their bottom line. For example, one of our customers has 43 warehouse locations across the country. In the past, each of the 43 facilities individually bought pallets and shipping materials from a different supplier, making it virtually impossible for the customer to track company-wide costs, payments, etc. CSS has helped this customer save significantly by serving as one supplier for all of their facilities. This has streamlined the system and saved on average 7–10 percent per facility for our customer.

Helping companies reduce their costs is one of our top priorities and we approach every challenge with the goal of "Building Trust and Partnerships by Doing the Right Things Right." Our distribution super center is located in Louisville; and, by utilizing strategic partners across the country, we are able to ensure timely, superior customer service without incurring a large overhead. Whether it's sourcing shipping pallets or providing custom automated packaging, we strive to fulfill our customers' needs and help to move their goods economically and proficiently through the global supply chain.

While our customers are large, oftentimes multinational, businesses, CSS is a small, privately owned business. While we have grown to serving 20 customers and anticipate doing $18.5 million in sales this year, we started with just one customer, a strong desire to succeed and a willingness to work hard and take risks. I've spent 25 years in the packaging industry and my wife, Mindy, has 15 years of equal experience in the packaging industry. In 2006, we partnered with a friend and investor to borrow $500,000 and set up a $250,000 line of credit from a bank to pursue our dream of starting and owning our own company. In June of that year, we launched our company and we have never looked back.

The success we have had in growing our business has not gone unnoticed. Last year, CSS Distribution Group ranked #55 on *Inc. Magazine's* "Inc. 500" which celebrates the fastest growing privately held companies in the United States, and my wife Mindy was ranked #5 on the "Inc. 5000," as one of the top women entrepreneurs. While we appreciate the accolades, we have not forgotten the community we call home. I am proud to serve on Mayor Jerry Abramson's High Impact Program, a public-private partnership designed to help Louisville's fast-growth and innovative companies overcome obstacles that might impede their progress. I am also active in Greater Louisville Inc., the Metro Chamber of Commerce and the region's leading business organization. I have also just recently been assigned to Kentucky Governor Beshear's "Business One Stop Portal Focus Group" and we are leaving

Washington after my testimony so that I can attend our first meeting in Frankfort, KY tomorrow.

CSS is a supporter of our local swim team, the Hillcrest Hurricanes. My wife serves on the team's board and is an active member of the local PTA and a volunteer at our children's school, Goshen Elementary. CSS also supports the Girl Scouts, annually buying Girl Scout cookies and sending them to members of our Armed Forces serving our Nation overseas. Additionally, CSS is a good steward of the environment through our green practices. We have four beautiful children and certainly care about the health of the planet we leave for them. CSS sells more than 2 million pallets a year and by reducing the amount of wood a pallet has in it and recycling old pallets we are able to save trees and reduce our carbon footprint.

While our business has grown in terms of sales and customers and we've been able to give back in our community, we unfortunately recently had to reduce our number of employees. Because of the overall uncertainty brought on by the economic downturn and the rising costs of health insurance, we went from 16 to 10 employees in 2010. This was not an easy decision. Our employees are like family; but for the health and future stability of our business, it was necessary.

For the first 4 years of operation, CSS did not make a net profit. This year is supposed to be our breakout year; we had hoped that it would be the first time we will realize a net profit. Despite a positive projection, we cannot really be sure what all the new regulations will actually bring. In fact in order to retain as much flexibility as possible, we are paying our full-time employees overtime instead of hiring any new employees. We are trying to hedge our bets as best we can because it seems every time we take a step forward, we get hit in the face and are forced to take two steps back. One of the things already pushing us backwards despite our projections is the health care law. At a time when we may finally become profitable, we are still struggling to offer health care coverage to our employees. Skyrocketing premiums continue to harm our ability to offer coverage, even now—16 months after the passage of the health reform law.

HEALTH CARE: MY EXPERIENCE WITH PREMIUM INCREASES

Even when we first began our company and had to borrow nearly $1 million from friends, banks and credit card companies to open our doors, we offered health care coverage to our employees. We are a small business and our employees are like family to us—so for the past 5 years, we have offered our employees a choice between coverage through a Preferred Provider Organization (PPO) or a High Deductible Health Plan (HDHP) with a Health Savings Account. At this time, half of our employees take up this offering—with three participating in the HDHP, and two enrolled in the PPO. Of our employees that do not participate, three of them are covered under their spouse's plan and one has elected to purchase a less expensive more basic plan on her own.

While I am committed to offering coverage to my employees, it is becoming more and more challenging to continue to provide our employees coverage. The premium increases that we have seen, and those we continue to see, are beyond what I can afford and even more worrisome, it is beyond what my employees can afford too.

Each year, when it comes time to renew our coverage we have seen at least 30 percent premium increases—with the exception of the summer after the health reform law was passed. Last summer, after the enactment of the Patient Protection and Affordable Care Act, we had increases of 42.2 percent and 42.4 percent in our PPO and HDHP plans respectively. Unfortunately, for me, the law is *not* making health care affordable. As with every other year when we have been quoted insurance with increases, I spent between 30 to 45 days researching other options. I have tried everything I know to do to try to mitigate these increases.

Last year, when facing the highest premium increase for our company ever, we had to agree to an increase in the PPO's deductible by $1,500 (from $1,500 to $3,000). Additionally, all of our co-payments were raised across the board. For office visits, the copayments increased from $25 to $50 for in-network providers, and from $30 to $60 for out-of-network providers. For urgent-care visits, copayments increased from $50 to $75. We revised the pharmacy drug tier formula from 3 levels to 4 levels, which meant that some drugs would cost $150, even after the deductible had been met. So instead of our PPO premiums jumping up $1,080/month, we were able to reduce the premium jump to $743/month. These changes amounted to an annual savings of $4,044. While these changes brought the overall monthly increase to 26.7 percent, down from 42.2 percent, it still raised our out-of-pocket expenses—which are nearly impossible to measure year over year.

Similarly, we had to restructure our HDHP plan in 2010. While previously our HDHP had covered prescription drugs at 100 percent once the deductible is met, we

changed to a tiered drug formulary where prescriptions cost either $10, $30, $50, or $150, even after the deductible is met. We increased the maximum out-of-pocket expenses from $2,500 to $3,500 for individual coverage and from $5,000 to $7,000 for family coverage. These changes to the HDHP allowed us to reduce the premium increase from 42.4 percent to 26.5 percent. So instead of our premiums jumping up $768.75/month, we were able to cut the premium jump to $483.45/month. These changes amount to an annual savings of $3,423.60.

HEALTH CARE—WHY?

One thing that I want to make perfectly clear in talking about these year-over-year increases which have continued despite the passage of health reform, these increases cannot be blamed on my plan or the insurance industry at large. Each year, I have researched other plans and insurance options. Despite my repeated efforts, I have not been able to find *any* other options that can offer coverage to my employees at lower premiums. While we continue to uphold our motto when it comes to our employees and "build trust and partnerships by doing the right things right," we are struggling with how to continue to offer our team health insurance.

So is there someone or something to blame? Really, the only thing to "blame" is the increasing health care costs which the law regrettably does very little to curtail. Merely requiring a review of premium increases will not stop them from increasing. In fact, the law in many ways will increase costs and drive premiums up. By requiring all plans to cover a laundry list of services, many of which have to be covered 100 percent with no copayment or cost born by the enrollee/participant, the law eliminates the ability to mitigate premium increases. It is really simple economics and simple business, if you want more, it will cost more. This applies to pallets that I sell, or coverage for health care services that my plan covers.

HEALTH CARE—SO, WHAT NOW?

So where does this leave me, as an employer committed to offering health coverage and "doing the right things right?" Honestly, I don't know. Because of the plan design changes that I have made over the years, the plans that I offer my employees are not grandfathered plans. As a result, my plan will have to comply with the full list of new mandates and requirements including the new internal claims and appeals and external review process, among other things. Many of these new requirements add an additional layer of administrative and procedural requirements, which will increase the cost of coverage just as mandating coverage of additional services will. Because of the size of my payroll, I am not eligible for the small business tax credit and will therefore not receive any help in paying for my employees' coverage. Since I am not deemed a "large employer" under the law, I will not be penalized if I stop offering coverage to my employees. The law has put me, a practical businessman, in a very strange place. Despite the law's premium rate review, the cost of coverage is continuing to increase—and most likely will continue to do so—by amounts neither I, nor my employees can absorb. While I understand that in 2014 there may be new marketplaces called exchanges where my employees may be able to purchase coverage, I am not sure how they will work or what coverage in the exchanges will look like and cost. I do not want to leave my employees in the lurch; they are all valued team members and I want to have some security that they are going to get affordable and appropriate coverage. How do I continue "Doing the Right Things Right"—now?

CONCLUSION

By nature I'm an optimist. I always have been, but given the fragile state of our economy and a lot of uncertainty coming from Washington, I'm more worried about our future than ever before. Right now, our company cannot afford to expand or hire more people. I want to, but I'm just not certain what the Federal Government's going to do next week, next month, or next year—let alone by 2014. This may not be what you want to hear, but this new health care law has made it much more difficult for small businesses to compete than you may realize.

I'm here today to share with you the real effect the law is having on me and other small businesses. I hope what I've shared today is helpful and urge you to repeal the most costly parts of the law, such as the employer mandate. This employer mandate truly prevents us from expanding our businesses and hiring more people—in other words creating new real jobs.

On behalf of the thousands and thousands of small business men and women in America, please listen to our concerns. The bottom line is that the decisions you make will either hurt us or help us. I'm very concerned that our new health care law may end up significantly hurting business and our country.

Thank you for this opportunity to testify, and I look forward to your questions.

The CHAIRMAN. Thank you very much, Mr. Withrow.

We'll start a series of 5-minute questions.

Ms. Miller, I'll start with you. I was reading your testimony last night, and you're talking about what you did. You used $100,000 to make a contract with a consumer advocacy group to weigh in on behalf of consumers. The Oregon State Public Interest Research Group, as you said, keeps us on our toes and reminds us of the questions consumers want answered.

You also made a contract with an actuarial firm. Quite frankly, I don't know of any other insurance commissioner in the entire country that would do something like that. I applaud you for that. Not many insurance commissioners want to contract with a consumer advocacy group like the PIRGs, who usually are a thorn in your side. But I compliment you for that because I think, as you mentioned, that gives you input from consumers and what they want. So I think you have shown some great leadership there.

One of the other things you mentioned is you were looking at different ideas on how you can affect health care costs, and you mentioned in your testimony, you said one idea we are exploring is to deny rate requests if the insurer reimburses providers for specified medical errors that should never happen. I find that very intriguing. Can you flush that out a little bit more for me?

Ms. MILLER. Mr. Chairman, thank you for the question. It really gets down to the contracts that insurers enter into with providers. And when I reach out and talk to the insurers in Oregon, one of the things I heard for years was that they have a difficult time negotiating with providers, particularly the hospitals, and getting all the provisions in the contract that they would like to see in the contract, and they raised this as a specific issue and said we would really like to include a provision in our contract with hospitals that essentially says if a never event happens, if you amputate the wrong arm, if something happens that we can all agree should never happen, who should bear the brunt of that expense? Should policyholders pay it? Should it come out of the provider?

And what I heard from our carriers is that they had a very difficult time getting providers to agree to those sorts of provisions. I understand that today it's more common for those provisions to be included in contracts, but that's one of the ways—again, we're studying this because I don't know exactly how we get at these underlying costs. But I think as State regulators, we may have an interesting opportunity to get at these costs.

And so trying to look at, can we influence that insurer-provider contracting process, that might be an interesting place to look. So I hope that's helpful.

The CHAIRMAN. That's very helpful. Are you looking at things like re-admission rates, for example, in hospitals? Now, we know there are some hospitals in this country that are doing a great job in keeping the re-admission rates extremely low. Other hospitals don't. But then when you have all these re-admission rates time and time again, who bears it? Should policyholders bear that, or not? So I hope you're also looking at re-admission rates, too, since you're looking at never-should-happen events.

Ms. MILLER. Mr. Chairman, part of what we asked the actuary who is looking into this and performing this study is let's look at everything. I don't want anything to be off the table, because if there's a way for us to address health care costs and make a dent in those costs, I think we want to do it. So I think everything is on the table for that study.

The CHAIRMAN. I compliment you for what you've done. I think you set a very high standard for insurance commissioners around the country.

Ms. MILLER. Thank you.

The CHAIRMAN. Mr. Withrow, welcome again. Is that Haley or Hallie?

Mr. WITHROW. It's Hallie Grace.

The CHAIRMAN. Hallie.

Mr. WITHROW. Hallie Grace.

The CHAIRMAN. All right, Hallie Grace. Welcome. Are you enjoying Washington?

You know one thing I can tell, you're having a great summer. You look like you've been swimming, right? Thanks for coming.

Mr. Withrow, you said something in your testimony about the health insurance exchanges, which will be up in 2014. Since I come from a State that has a lot of small businesses and I met with them on this issue many, many times, in 2014 when the insurance exchanges come up, because of the number of employees you have, you'll be then able to go to an exchange, and you'll have more competition, more people competing for covering you, and it will be open, it will be transparent. Won't that help you in terms of both your premiums and the quality and coverage?

Mr. WITHROW. I really don't know. Senator Harkin, thank you for the question. Because there's no definitive information about exchanges at this point that I can read about, I can't really comment on what the exchanges will do for me. I've done my best to try to research that, and even working through the Chamber of Commerce it's difficult to find that information.

The CHAIRMAN. States are setting up the exchanges now. I don't know where Kentucky is right now on that, but States are in the process of setting up those exchanges right now. But I think the law basically sets out how those exchanges are to operate. Again, I don't know Kentucky. I can only tell you that in our State, where we have two insurance carriers that have 80 percent of the market, there's not much competition, and there's not much transparency. So that when the exchanges come up, a lot of small businesses that have a few employees will be able to go on them.

Let me also ask you, right now small businesses can get a tax credit for the purchases of their—for what they put in for their employees, right? Up to 50 employees, and you don't have 50 employees.

Mr. WITHROW. No, sir.

The CHAIRMAN. Are you taking advantage of the tax credit?

Mr. WITHROW. No, sir. We pay our employees too well, so we don't qualify for the tax credit.

The CHAIRMAN. Oh, you're over the $50,000——

Mr. WITHROW. Yes, correct.

The CHAIRMAN [continuing]. Cutoff on that. So you don't get the tax credit. But you will be able to shop on the exchange.

Mr. WITHROW. According to the law, yes. I just—we try to plan business in 1- and 2-year increments, and not having information on it, it's very difficult to plan for it.

The CHAIRMAN. I think my time has run out. Thank you very much, Mr. Withrow.

Mr. WITHROW. Thank you.

The CHAIRMAN. Senator Enzi.

Senator ENZI. I think we're still short about five rules yet on the exchanges for the States to even begin working on it. So I don't think there's much out there that any of us can comment on exchanges yet.

But, Mr. Dicken, I want to thank you for the work that GAO does. It's a tremendous help, and I appreciate the reports that have come out.

In looking at the States' authority to review rates, did any of the States provide evidence that because of the rate review process burden or the review results, that any of the companies have pulled out of the market in that State? Is there any evidence to suggest that the rate review policies for States will decrease the number of policies available to consumers, or at least decrease the types of policies available for consumers?

Mr. DICKEN. Thank you, Senator Enzi. We did not specifically ask as part of our survey as to whether there were any changes in the market share or carriers in the market. Certainly your point is very fair. We have looked in the past at the market shares of carriers in the small group market, and many States only have one carrier that may represent half of the market or more. Many States, I think 23 States had five or fewer carriers that were representing 90 percent of the market. So we did not examine to what extent carriers may have either increased or decreased their role in the market as part of these rate reviews.

Senator ENZI. Thank you. I still think the small business health plans would have increased the number of companies that were out there participating, and I'm hoping that this health care reform does, too.

Ms. Miller, congratulations on hiring an actuarial firm. The only thing better is an accounting firm.

[Laughter.]

So I assume that the actuary was used to determine the rate that you allow Regents to pursue, Regents company.

Ms. MILLER. Senator Enzi, just to be clear, we have actuaries on staff that do the review of our rate filings. The study that I mentioned, we hired an actuarial firm to conduct that study, which is really a separate study from our rate review process, just to clarify. So we have actuaries on staff. We added an additional actuary to deal with workload issues with the Federal grant funds in addition to hiring an actuarial firm, if that makes sense.

Senator ENZI. OK. Concentrating a little bit here on the Regents company, if they're selling a product for less than what the people pay, that wouldn't be a sustainable business model. So if their costs are higher than the actuarial charts apparently say, how long do you think Regents will be able to take in less premiums than they

pay providers in the medical claims? Do you have an adjustment for that?

Ms. MILLER. Senator Enzi, when we consider surplus and an insurer's overall profitability as part of the rate filing process, we do so very carefully, and we understand that long-term, products need to be priced appropriately.

So, with that said, in the Regents case, we reduced the initial request, which was a 22.1 percent request, to a 12.8 percent increase, and there were additional concerns that caused us to have them dip or potentially dip into their surplus. The company's enrollment in their individual plans has been a concern for us and was actually a concern pointed to by the consumer advocacy group.

Their plans have dropped from enrollment of about 100,000 members in 2007 to less than 60,000 members today. So the key concern here was that if we had approved a 22.1 percent increase, that would result in further enrollment losses. Typically your healthiest people are leaving, and that would drive up claims, resulting in the future in even higher increases down the road. So part of what we were trying to do in the Regents case, by potentially having them dip into surplus, was to try to stem those enrollment losses.

Senator ENZI. Thank you.

Mr. Withrow, I thank you for bringing your daughter on this experience to Washington. I did that when my kids were young, and they have a lot of memories from it.

But getting back to the insurance, though, did you know that in 2014 the small businesses will not be able to buy health insurance plans that have deductibles that are more than $2,000 for individual plans or $4,000 for family plans? So do you think this new requirement will increase your premiums?

Mr. WITHROW. Senator, thanks for the question. No, I did not know, but I can tell you from the work that I've done in the last 30 days that the only way that we can stem the increasing cost is by raising deductibles. So if we have a cap of $2,000 and $4,000, then our monthly premiums should rise.

Senator ENZI. My time has expired.

The CHAIRMAN. Thank you, Senator Enzi.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

First of all, I can assure the Ranking Member that Minnesota is hard at work in setting up its exchange even though the final rule isn't out, and I know that many States are as well. My former legislative assistant, Lauren Gilchrist, is now deputy commissioner of health in Minnesota, and I keep in touch with her, and she's very, very hard at work setting up that exchange. So the fact that the final rules aren't in really hasn't slowed that down.

Senator ENZI. Is the information out to the businesses, though, on that exchange?

Senator FRANKEN. I think it's available. Certainly that is available, but I can't speak to that. But what you said was that you don't know if they are working on it, and I just want to assure you that they are.

Mr. Withrow, in your testimony—first of all, you have a beautiful daughter.

Hallie, you don't have to stand up again.

[Laughter.]

You can stay there.

You at one point in your testimony said there was a laundry list, and then I can't remember what you said, of new medical procedures or care that are required.

Mr. WITHROW. Right, the lifetime maximum that children who are 26 years old, the insurance companies having to cover for anyone that does not get insurance because of a pre-existing condition. Those benefits are what I was referring to as were adding cost to the system. As we add cost to the system, premiums are going to rise, in my opinion.

Senator FRANKEN. OK. And that's anyone that has a pre-existing condition, any adult?

Mr. WITHROW. What I know of the law——

Senator FRANKEN. I mean, I don't think that's part of the law now. I think that kicks in in 2014.

Mr. WITHROW. Right, right. I'm not sure I understand the question that you're asking.

Senator FRANKEN. You enumerated what you said were the requirements that increased the cost, and you stated one that I don't think exists now.

Mr. WITHROW. Then I stand corrected.

Senator FRANKEN. OK. And you're representing the Chamber of Commerce here.

Mr. WITHROW. Yes.

Senator FRANKEN. OK. I just think it's very important that we just——

Mr. WITHROW. Absolutely.

Senator FRANKEN [continuing.] When you testify in front of the Senate, that you be accurate. I think that's very important.

Are you aware of what the medical loss ratio is?

Mr. WITHROW. No, I'm not. I sell pallets. I'm not an insurance person.

Senator FRANKEN. OK. The medical loss ratio is part of the law. In Oregon, for example, Ms. Miller, the medical loss ratio is about 89 percent. Is that it? OK. And the medical loss ratio is the percentage of premiums that are paid into a health insurance company that must be actual health care. So it's 85 percent for the large group market because of this law. There was no law before. And it's 80 percent for individual and small groups, and small groups have typically been much, much smaller.

And when you're on the exchange, you'll be in a much larger group, and the medical loss ratio will be 85 and above, which means that 85 percent of all premiums will have to be spent on actual health care, not on administrative costs and not on advertising or marketing, and not on CEO salaries, et cetera. And that's why in certain markets already we're seeing—in Connecticut, Aetna, we're seeing them cut premiums by 10 percent on an average.

Is that right, Ms. Miller? Do you think that medical loss ratio is going to bring down health care costs or the cost of premiums?

Ms. MILLER. Senator Franken, in just speaking for Oregon, since we have such high medical loss ratios, I don't think that medical loss ratio will make a big difference in Oregon, but I'm not as fa-

miliar with other States and what's happening in other States in terms of medical loss ratios. It certainly could have an impact in other States.

Senator FRANKEN. Minnesota has an over 90 percent medical loss ratio. That's because Oregon and Minnesota are high-value States. And part of actually one thing that I believe is going to bring down the bend in the cost curve is that we're going to increase the value of health care, that we're going to reward, incentivize States that have high-value care.

My time is up, but I did want to point out that earlier Senator Hatch said that the purpose of health care reform was not to reduce the rate of growth of premiums but to reduce premiums, and I don't think that's the case.

And sometimes I hear that from opponents of health reform who say, like, "well, premiums went up, and we were told they'd go down." Well, no. We didn't say that premiums would go down. We said that the rate of growth of premiums would go down. That at least was the goal, and whether that's been achieved everywhere, we will have to see if that's the case. But I just wanted to clarify the goal.

And I also wanted to clarify because Senator Murkowski from Alaska was talking about children-only plans, because children now do have pre-existing conditions covered. If you have pre-existing, you're allowed to get care. And in Minnesota, while we don't have a children-only plan, that's being taken care of by State plans, and that is the reason for an individual mandate, that everyone will have to get care. That's the whole purpose of the individual mandate, is so that we cover people with pre-existing conditions.

So I just wanted to clarify a couple of things, and I apologize for going over my time, Mr. Chairman.

The CHAIRMAN. Excuse me. Senator Merkley.

Senator MERKLEY. Thank you very much, Mr. Chair.

It's a pleasure to have you all testifying today.

It was in 2007 that the Oregon legislature passed a bill that made the health insurance rate filing process public, and then in 2009 they expanded on that by creating more protocols for interaction with the public. And it was in June, Ms. Miller, that you hosted this public testimony on the rate increase, and I believe that was the first public testimony on a rate increase in 20 years.

Were you required to do that by the law, or you just said this would be an interesting experiment?

Ms. MILLER. Senator Merkley, this was the first time in about 20 years that we conducted a public hearing on a rate filing. We, of course, have had the public comment period so people could comment for a couple of years, but this was the first public hearing, and we were not required by law to do that.

Senator MERKLEY. So if I recall, you were a little skeptical about how that would unfold. And how did it unfold? Was it valuable?

Ms. MILLER. Senator Merkley, I have to say, it was—I didn't know what to expect going into the hearing. I didn't know if consumers would find the experience helpful or valuable, and I didn't know how the company would react to it. And I have to say, I found it to be—and I think everyone who attended found it to be a very valuable experience. I heard from consumers that they so

appreciated the opportunity to be heard and to come and testify and make their views known and have somebody listen to them.

We also had a lot of comments about—the way we structured the hearing, we had the company present the rate filing. I asked the company about 10 questions, and then we had the consumer advocacy group that we contract with present their thoughts on the filing, and then we took comments from the public. And we got comments from people as they were leaving—they left comment cards and whatnot—that said things like I have a lot more confidence in the work that the Oregon Insurance Division does having witnessed this hearing. That meant a lot to me because I know behind closed doors that we are doing an excellent job of scrutinizing rate filings, but if people don't have an opportunity to see that, they don't necessarily know that and they don't have the confidence in our process. But I certainly do, and have for years.

I think it was a very valuable experience, and the company I think also found it to be a valuable experience.

Senator MERKLEY. I think it's just absolutely terrific. Part of this process was to create a plain-language strategy so the public could actually understand the documents before them. Could you just share a little bit about that?

Ms. MILLER. Senator Merkley, I will tell you that over the last 3 years that I have been at the department, I think our single greatest challenge has been to try to find a way to take what otherwise is a very technical process that historically has been actuaries speaking to actuaries, our department actuaries speaking to the company actuary, to try to take that process and turn it into something that you and I can understand and the public can understand has been one of our biggest challenges, and it's why we did take some of our grant funding, as I mentioned, and created the animated story of the health insurance premium.

We've tried to do everything we can to make this more easily understandable. We spend a lot of time and staff time developing our plain-language decision summaries because we want people—that's our way of holding ourselves accountable. But we want people to understand why their rates are going up and why we approve the rate we approve.

Senator MERKLEY. Could you bring that expertise to bear on our legislative language?

[Laughter.]

I want to switch to the health insurance exchange. You've set up a public corporation, the Health Insurance Exchange Corporation, and are hard at work designing the elements of that. How is that going?

Ms. MILLER. In terms of developing the exchange, I will tell you Rocky King is the—I think his title is administrator or interim executive director, whatever it is, and I will tell you they are just starting to do things like try to find office locations. Some of the things they're doing right now are very basic in terms of setting up a corporation.

So I would say it's a little bit slow only because there are things that we don't necessarily think of that they've had to focus on, like finding buildings, figuring out where their office is going to be located, getting workers comp coverage for their employees.

Senator MERKLEY. So in general, the vision of the exchange, which is to have all the policies in one computer site where a consumer can compare them to see what features would best fit their family and so forth, is that resonating? Is there a lot of interest in that, a lot of support for it, or do people see that as unnecessary?

Ms. MILLER. Senator Merkley, I think especially in a market like Oregon, if you go to healthcare.gov now and you look at all of your options, the last time I did it for an individual like myself, I think there were 77 options that came up, and sometimes I think too many options is difficult for consumers in terms of figuring out which is the best plan for them.

So I think the exchange, I think particularly in Oregon there's a lot of excitement because it will make it easier for people to compare plans. We have so many options today, but they're not necessarily plans that are easy to compare.

Senator MERKLEY. Good. So I just have one last request. My colleague from Minnesota likes to point out that Oregon has a medical loss ratio of only 89 percent, while Minnesota is at 90 percent. Can you do something about that so that I don't have to continue to hear this?

[Laughter.]

Ms. MILLER. Senator Merkley, we will work on that.

Senator MERKLEY. Thank you very much. Thank you, Mr. Chair.

Senator FRANKEN. It's 91 percent in Minnesota.

[Laughter.]

The CHAIRMAN [Inaudible]. I'll submit those to you in writing.

Senator FRANKEN. May I just thank Mr. Withrow for coming here and bringing your family, and for having a small business. I love pallets. I do.

[Laughter.]

Palletizing things, that's a great thing. I've been on a USO tour where they palletize everything on the back of that plane, and I love pallets. So it's a good business.

The CHAIRMAN. In fact, a friend of mine and a former colleague of mine who is in Minnesota by the name of Richard Nolan, a former congressman, went into the pallet business.

Senator FRANKEN. You've got to put stuff on pallets. I mean, if you go to any factory, they're putting stuff on pallets. Food, all food, goes on pallets.

Mr. WITHROW. Senator Franken, would you mind if I clarified something I said earlier?

Senator FRANKEN. Yes.

Mr. WITHROW. And I'll never forget it again.

Senator FRANKEN. OK.

Mr. WITHROW. The areas that I mentioned, the additional cost, is what's concerning me, but also the preventive costs, and also the addition that's added by the Health and Human Services Secretary Sebelius that added additional cost on women's lactose, lactician—excuse me—breastfeeding, and also birth control. Those additional costs is what I was referencing when I said there's additional cost here that I think is really going to hurt us from a small business perspective on the exchanges. So I appreciate correcting what I had said before.

Senator FRANKEN. I think that when you attribute the—and I don't know what's going on in Kentucky, but when you attribute the cost going up because of provisions that are in the Affordable Care Act that have not kicked in, I just think that, you know, as you say, you're a small businessman who pays attention to his business, and you obviously care about your employees, and you're obviously doing what we need Americans to be doing, which is working to build businesses and working to create economic opportunity for people. You pay your employees too much to qualify for the tax credit, so I credit you on that.

But so you're not, I think, you're not expected to know every detail of the law, which is over 2,000 pages long.

Mr. WITHROW. It just speaks to the confusion of it.

Senator FRANKEN. Thank you.

The CHAIRMAN. Senator Enzi.

Senator ENZI. Some of those provisions have already gone into effect, including the prevention provisions.

Senator FRANKEN. Some have. But I'm saying that some that were mentioned as having gone into effect haven't, and I just wanted to make that clear.

The CHAIRMAN. Thank you all very much. The record will stay open for 10 days for further submissions or questions.

Senator Merkley.

Senator MERKLEY. Can I insert one last question? I wanted to follow up on your lactation point, Mr. Withrow, because that was something I was very much involved in in Oregon. I championed companies providing this basic work and the flexibility for women to express milk. And here in the Senate, Dr. Coburn from Oklahoma partnered with me on the Senate side because it was basically no cost. In fact, actually, it turned out from the experiment in Oregon that they had much less absenteeism and a much higher esprit de corps among women who were returning to work after childbearing because it helped relieve that stress over whether they're doing the right thing by their child or not.

So you mentioned the cost associated with lactation, and I'm not sure what costs you were referring to.

Mr. WITHROW. I'm talking specifically about the coaches, the breast pump rentals. I mean, having had four kids, I certainly know the costs that we had to pay in order to either buy or rent breast pumps, and also birth control. Those costs are what concern me because we just seem to be adding more and more to the ticket of benefits, and as we add benefits, typically in business, you add benefits, the more you add, the more it's going to cost. So it concerns me from a small business perspective that we seem to keep adding more and more to the party.

Senator MERKLEY. Yes. My understanding, and I could be wrong, but my belief is that those features that you referred to actually are not a mandate in the law. Those are not required. Many companies are putting them in because they have a very strong appeal to the customer. But that's a market decision, not a mandate decision.

I'll check on that and close the loop with you.

Mr. WITHROW. Would it be to everyone? Is it something that has to be part of the entire mandate that everyone has to have that available, or could it——

Senator MERKLEY. No, no. That's my point. It's my understanding that those services are not mandated, that that is an insurance company decision. But let me check on that and close the loop for you.

Mr. WITHROW. OK, OK.

Senator ENZI. Actually, everyone has to pay for all of those for free, and they are mandated benefits.

The CHAIRMAN. As long as everyone is weighing in, I guess the Chairman will weigh in on this.

[Laughter.]

Being the basic author of the prevention section of the health care bill, I would just say it again, that we keep paying and paying and paying and paying to fix, to mend, to cure, to patch. We spend precious little on prevention. That's the one failure, the one big failure of our health care system in America, that we've not put enough into prevention, about 4 cents, less than 4 cents of every dollar goes into prevention. And your mother was right, an ounce of prevention is worth a pound of cure.

And so as we're making this shift, we are putting more out there for preventive services, and in some cases they do cost a little bit more. They're added on. But every single study I have ever seen indicates that the amount that you have put into proven preventive services, approved by the U.S. Preventive Services Task Force, pay off huge amounts in the future in terms of cutting health care expenditures to patch and mend and fix later on.

So we want to do more in preventive health care, a lot more. A lot of companies, are stepping up to the bar. Some have preceded this with prevention. We were just talking about Safeway that did a great job on this in the past, and it was one of those companies that we looked at in how you devise preventive health services and interventions.

Also, as the former chair at one time of the national breast feeding coalition, it's been a lifelong goal of mine to change society's attitudes in this country on breast feeding. It should be available easily. We all know from pediatricians that the first months of a child's life is enhanced immeasurably by mother's milk. There's no substitute for it anywhere.

Now, again, some people can. I understand that there have to be replacements in infant formula and stuff, but we should make it as easy as possible for every mother to be able to nurse her child, as easily as possible, in the workplace, in traveling, no matter where. It ought to be the norm, not the exception that we do this.

I don't know your business from anything, Mr. Withrow, or any other businesses here. But I have seen small businesses that really go out of their way to provide time, to provide whatever modicum of support they can give to women and young women who are in their childbearing years to be able to nurse their children. To those I say God bless you, keep doing more, and I hope all businesses will do that, and I hope we do that on the government level, both Federal, State, and local governments. This is one of the best things we can do for the health of this country.

Mr. Merkley.

Senator MERKLEY. Thank you, Mr. Chair. It was very interesting in Oregon that we had an exemption for any company that applied and said it's just not feasible to provide privacy and flexibility in break time in our setting. So we assumed that a number of companies would take advantage of that situation, and what actually transpired was that not a single Oregon company has asked for that exemption. Some have explored it and basically tried to understand what's required of them and how can they make it fit, and they've gotten advice on how other companies have tackled it, and I think it really is a testimony to the fact that when people pause, they realize what profound value it is for women to be able to express milk. There is no substitute for it for the child, and it's not only good for the child's health, it's tremendous for the mother's health.

We had testimony in this very committee from Dr. Coburn, who said, when I first introduced that amendment, "Senator Merkley hasn't begun to say all the advantages to it." So I think it was a tremendous step.

The CHAIRMAN. I think we'd better close now before we're accused of practicing pediatric medicine without a license here.

[Laughter.]

Thank you all very much. The committee will stand adjourned.

Mr. WITHROW. Thank you.

[Additional material follows.]

ADDITIONAL MATERIAL

HEALTH AFFAIRS—AT THE INTERSECTION OF HEALTH, HEALTH CARE AND POLICY

(By Sean P. Keehan, Andrea M. Sisko, Christopher J. Truffer, John A. Poisal, Gigi A. Cuckler, Andrew J. Madison, Joseph M. Lizonitz and Sheila D. Smith)*

NATIONAL HEALTH SPENDING PROJECTIONS THROUGH 2020: ECONOMIC RECOVERY AND REFORM DRIVE FASTER SPENDING GROWTH†

ABSTRACT: In 2010, U.S. health spending is estimated to have grown at a historic low of 3.9 percent, due in part to the effects of the recently ended recession. In 2014, national health spending growth is expected to reach 8.3 percent when major coverage expansions from the Affordable Care Act of 2010 begin. The expanded Medicaid and private insurance coverage are expected to increase demand for health care significantly, particularly for prescription drugs and physician and clinical services. Robust growth in Medicare enrollment, expanded Medicaid coverage, and premium and cost-sharing subsidies for exchange plans are projected to increase the Federal Government share of health spending from 27 percent in 2009 to 31 percent by 2020. This article provides perspective on how the Nation's health care dollar will be spent over the coming decade as the health sector moves quickly toward its new paradigm of expanded insurance coverage.

National health spending is expected to grow 5.8 percent per year for the period 2010 through 2020, 1.1 percentage points faster than the expected average annual rise in gross domestic product. As a result, the health share of the gross domestic product is projected to increase from 17.6 percent in 2009 to 19.8 percent by 2020.[1] During this period, we expect that the Affordable Care Act of 2010 will reduce the number of uninsured people by nearly 30 million, lead to prescription drugs and physician services accounting for a greater share of health spending than would have been the case otherwise, and contribute to an increase in the government-sponsored (Federal, State, and local) share of health spending to just under 50 percent by 2020.

In this article we review some highlights of overall projected spending trends in several time periods; summarize our methods and assumptions; then provide an outlook for major health industry sectors, payers, and sponsors. In so doing, we provide perspective on how the Nation's health care dollar will be spent over the coming decade as the health sector moves quickly toward its new paradigm of expanded insurance coverage.

2010

National health spending is estimated to have reached $2.6 trillion in 2010, reflecting a growth rate of 3.9 percent over the previous year, which is slightly slower than the previous historic low growth rate of 4.0 percent in 2009 (Exhibits 1 and 2).[2] Growth in nominal gross domestic product (that is, not adjusted for inflation) accelerated to 3.8 percent in 2010 from—1.7 percent in 2009.[3] Because the rate of economic growth has accelerated and the projected rate of growth of health spending is similar, the health share of gross domestic product is projected to remain unchanged in 2010 at 17.6 percent. This is in contrast to the period from 2008 to 2009, when the health share of gross domestic product rose by 1 percentage point.

The continued low rate of estimated growth in national health spending in 2010 reflects two major factors. First, Medicare spending growth is estimated to have been lower as the rate of growth in payments to private plans under the Medicare Advantage program slowed in 2010. Second, the continuing impact of losses in employment and health insurance coverage associated with the recession helped to limit growth in private spending. Private health insurance spending growth is estimated to have been just 2.6 percent in 2010 as the number of people enrolled in private plans fell by roughly 5 million. Moreover, out-of-pocket spending climbed just 1.8 percent (after 0.4 percent growth in 2009) as many people continued to restrain their use of health care goods and services.

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*The opinions expressed here are the authors' and not necessarily those of the Centers for Medicare and Medicaid Services. The authors thank Richard Foster, Stephen Heffler, John Shatto, Kent Clemens, Liming Cai, Tristan Cope, and Cathy Curtis. [*Published online July 28, 2011*].

†The online version of this article, along with updated information and services, is available at: *http://content.healthaffairs.org/content/early/2011/07/27/hlthaff.2011.0662.full.html*.

Exhibit 1.—National Health Expenditures (NHE), Aggregate and Per Capita Amounts, and Share of Gross Domestic Product (GDP), Selected Calendar Years 2008–20

Spending category	2008	2009	2010	2011	2012	2013	2014	2020
NHE, billions	$2,391.4	$2,486.3	$2,584.2	$2,708.4	$2,823.9	$2,980.4	$3,227.4	$4,638.4
Health Consumption Expenditures	2,234.2	2,330.1	2,424.3	2,540.8	2,646.9	2,792.6	3,027.6	4,337.7
Personal health care	1,997.2	2,089.9	2,166.6	2,266.9	2,354.8	2,481.6	2,680.0	3,840.7
Hospital care	722.1	759.1	794.3	831.4	873.1	919.1	985.2	1,410.4
Professional services	652.2	674.9	690.4	718.0	728.3	768.0	834.2	1,164.2
Physician and clinical services	486.5	505.9	517.8	538.4	542.9	573.5	624.3	867.7
Other professional services	63.4	66.8	70.2	74.0	75.8	79.7	88.2	128.7
Dental services	102.3	102.2	102.4	105.7	109.6	114.7	121.7	167.9
Other health, residential, and personal care [1]	113.3	122.6	130.7	137.6	147.4	158.4	170.8	271.5
Home health care [2]	62.1	68.3	71.9	75.7	80.2	85.7	92.0	136.1
Nursing care facilities and continuing care retirement communities [2 3]	132.8	137.0	140.6	145.6	150.7	157.3	164.5	218.4
Retail outlet sales of medical products	314.7	328.0	338.7	358.7	375.1	393.1	433.4	640.1
Prescription drugs	237.2	249.9	258.6	275.7	290.2	305.3	337.9	512.6
Durable medical equipment	35.1	34.9	35.7	37.0	37.5	38.7	41.2	55.0
Other nondurable medical products	42.3	43.3	44.4	46.0	47.3	49.1	54.2	72.4
Government administration [4]	29.2	29.8	32.8	35.6	38.6	42.1	48.3	71.5
Net cost of health insurance [5]	134.8	133.2	144.0	152.1	162.2	171.9	195.8	271.0
Government public health activities	72.9	77.2	81.0	86.2	91.3	97.1	103.5	154.4
Investment	157.2	156.2	159.9	167.6	176.9	187.8	199.9	300.7
Research [6]	43.2	45.3	49.9	53.3	56.7	60.3	64.1	93.0
Structures and equipment	114.0	110.9	110.0	114.3	120.3	127.4	135.8	207.7
Population (millions)	304.8	307.5	310.3	313.2	316.0	318.8	321.6	338.4
NHE per capita	$7,845.0	$8,086.5	$8,327.3	$8,648.5	$8,936.8	$9,348.8	$10,035.2	$13,708.8
GDP, billions of dollars	$14,369.1	$14,119.0	$14,659.6	$15,334.4	$16,071.0	$16,891.1	$17,803.8	$23,388.4
NHE as percent of GDP	16.6	17.6	17.6	17.7	17.6	17.6	18.1	19.8

Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Notes: Numbers may not add to totals due to rounding. Data from 2010 to 2020 are projections.

[1] Includes spending for residential care facilities (North American Industry Classification Codes (NAICSI 623210 and 623220), ambulance providers (NAICS 621910), medical care delivered in nontraditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.

[2] Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care.

[3] Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (623314 State and local government nursing facilities, and nursing facilities operated by the Department of Veterans Affairs.

[4] Includes all administrative costs (Federal, State, and local employees' salaries; contracted employees including fiscal intermediaries; rent and building costs; computer systems and programs; other materials and supplies; and other miscellaneous expenses) associated with insuring individuals enrolled in the following public health insurance programs: Medicare, Medicaid, Children's Health Insurance Program, Department of Defense, Department of Veterans Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services Administration, and other Federal programs.

[5] Net cost of health insurance is calculated as the difference between calendar year premiums earned and benefits paid for private health insurance. This includes administrative costs, and in some cases, additions to reserves; rate credits and dividends; premium taxes; and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following public programs: Medicare, Medicaid, Children's Health Insurance Program, and workers' compensation (health portion only).

[6] Research and development spending of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product fails.

Exhibit 2.—National Health Expenditures (NHE), Average Annual Growth From Prior Year Shown, Selected Calendar Years 2008–20

Spending category	2008 [In percent]	2009 [In percent]	2010 [In percent]	2011 [In percent]	2012 [In percent]	2013 [In percent]	2014 [In percent]	2020 [In percent]
NHE, billions	7.1	4.0	3.9	4.8	4.3	5.5	8.3	6.2
Health Consumption Expenditures	7.1	4.3	4.0	4.8	4.2	5.5	8.4	6.2
Personal health care (PHC)	7.0	4.6	3.7	4.6	3.9	5.4	8.0	6.2
Hospital care	7.2	5.1	4.6	4.7	5.0	5.3	7.2	6.2
Professional services	6.7	3.5	2.3	4.0	1.4	5.4	8.6	5.7
Physician and clinical services	6.7	4.0	2.4	4.0	0.8	5.6	8.9	5.6
Other professional services	7.0	5.3	5.0	5.5	2.4	5.2	10.7	6.5
Dental services	6.5	-0.1	0.2	3.2	3.7	4.7	6.1	5.5
Other health, residential, and personal care [1]	7.2	8.3	6.6	5.3	7.1	7.5	7.8	8.0
Home health care [2]	8.5	10.0	5.3	5.3	6.1	6.8	7.3	6.8
Nursing care facilities and continuing care retirement communities [2 3]	5.7	3.1	2.6	3.5	3.5	4.4	4.6	4.8
Retail outlet sales of medical products	7.4	4.2	3.3	5.9	4.6	4.8	10.2	6.7
Prescription drugs	8.8	5.3	3.5	6.6	5.3	5.2	10.7	7.2
Durable medical equipment	4.3	-0.8	2.3	3.8	1.4	3.0	6.5	5.0
Other nondurable medical products	3.7	2.2	2.7	3.6	2.9	3.7	10.4	4.9
Government administration [4]	7.0	2.0	9.9	8.7	8.4	9.0	14.6	6.8
Net cost of health insurance [5]	9.8	−1.2	8.1	5.6	6.6	6.0	13.9	5.6
Government public health activities	6.8	5.9	4.8	6.5	6.0	6.3	6.6	6.9
Investment	7.3	−0.6	2.4	4.8	5.6	6.1	6.5	7.0
Research [6]	6.8	4.8	10.1	6.8	6.3	6.5	6.3	6.4
Structures and equipment	7.5	−2.7	−0.8	3.9	5.2	6.0	6.5	7.3
Population (millions)	1.0	0.9	0.9	0.9	0.9	0.9	0.9	0.8
NHE per capita	6.1	3.1	3.0	3.9	3.3	4.6	7.3	5.3
GDP, billions of dollars	4.7	−1.7	3.8	4.6	4.8	5.1	5.4	4.7

Sources: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; U.S. Department of Commerce, Bureau of Economic Analysis; and U.S. Bureau of the Census.

Notes: 2008 shows average annual growth, 2000-08; data from 2010 to 2020 are projections; percent changes are calculated from unrounded data.

[1] Includes expenditures for residential care facilities (North American Industry Classification Codes (NAICS) 623210 and 623220), ambulance providers [NAICS 621910, medical care delivered in nontraditional settings (such as community centers, senior citizens centers, schools, and military field stations), and expenditures for Home and Community Waiver programs under Medicaid.

[2] Includes freestanding facilities only. Additional services of this type provided in hospital-based facilities are counted as hospital care.

[3] Includes care provided in nursing care facilities (NAICS 6231), continuing care retirement communities (623311), State and local government nursing facilities, and nursing facilities operated by the Department of Veterans' Affairs.

[4] Includes all administrative costs (Federal, State, and local employees' salaries; contracted employees including fiscal intermediaries; rent and building costs; computer systems and programs; other materials and supplies; and other miscellaneous expenses) associated with insuring individuals enrolled in the following public health insurance programs: Medicare, Medicaid, Children's Health Insurance Program, Department of Defense, Department of Veterans' Affairs, Indian Health Service, workers' compensation, maternal and child health, vocational rehabilitation, Substance Abuse and Mental Health Services administration, and other Federal programs.

[5] Net cost of health insurance is calculated as the difference between calendar year premiums earned and benefits paid for private health insurance. This includes administrative costs, and in some cases, additions to reserves; rate credits and dividends; premium taxes; and plan profits or losses. Also included in this category is the difference between premiums earned and benefits paid for the private health insurance companies that insure the enrollees of the following public programs: Medicare, Medicaid, Children's Health Insurance Program, and workers' compensation (health portion only).

[6] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research expenditures" but are included in the expenditure class in which the product falls.

2011–13

For the period 2011–13, national health spending is projected to increase more rapidly than the preceding 2 years, averaging 4.9 percent. Underlying this projection is expected faster growth in private health insurance spending (reaching 4.8 percent in 2013), related to anticipated gains in employer-sponsored health insurance enrollment. Out-of-pocket spending is also projected to grow faster through 2013, averaging 3.2 percent growth in this period. The accelerated growth in out-of-pocket spending is driven by increases in disposable personal incomes during economic recovery and expansion, which in turn leads to greater use of more medical services. The projection is also based on an expectation that many employers will continue the recent trend of offering health insurance plans that require higher cost sharing, also leading to higher out-of-pocket spending.[4]

During the period 2011–13, the immediate reforms prescribed by the Affordable Care Act will continue to be implemented, including two programs that expand access to insurance coverage to specific populations. The Pre-Existing Condition Insurance Plan program (for those who have had difficulty acquiring individual coverage because of their medical conditions) and the expansion of dependent coverage to eligible people under age 26 are projected to provide coverage to 1.6 million people in 2013. The impact of these reforms on overall health spending levels, however, is projected to be minor during this period (averaging 0.1 percent higher).

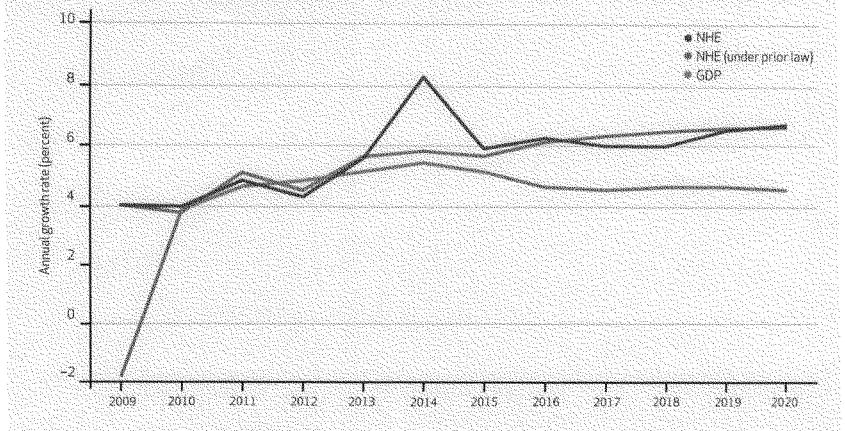
Medicare spending growth through 2013 most notably reflects the effect of a 29.4 percent scheduled physician payment rate reduction, effective January 1, 2012. This rate reduction is mandated by Medicare's sustainable growth rate formula, which determines the rates that Medicare pays for services under the physician fee schedule. Accordingly, Medicare spending growth is projected to decelerate sharply in 2012 to 1.7 percent, down from 5.9 percent in 2011. Under the alternative Medicare projection scenario in which physician payment rate increases are based on growth in the Medicare Economic Index,[5] Medicare spending growth is projected to accelerate to 6.6 percent in 2012.

2014

In 2014, the Affordable Care Act will greatly expand access to insurance coverage, mainly through Medicaid and new State health insurance exchanges which will facilitate the purchase of insurance. The result will be an estimated 22.9 million newly insured people, some of whom will be covered through employer-sponsored insurance. The associated increases in Medicaid spending (20.3 percent) and private health insurance spending (9.4 percent) for this newly insured population are anticipated to contribute to a significant acceleration in the national health spending growth rate in 2014 (8.3 percent, compared to 5.5 percent in 2013) (Exhibit 3). Correspondingly, out-of-pocket spending is projected to decline by 1.3 percent as the number of people with insurance coverage increases and many services formerly paid for out-of-pocket are now covered by insurance.[6]

EXHIBIT 3

Annual Growth Rates, Gross Domestic Product (GDP) And National Health Expenditures (NHE) Calendar Years 2009–20



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group; US Department of Commerce, Bureau of Economic Analysis. **NOTES** 2009 is a historical estimate; 2010 through 2020 are projections. 2010–13 is based on recovery from recession, includes impact of some Affordable Care Act provisions, and a 2012 Medicare physician payment cut. 2014 reflects the beginning of the major Affordable Care Act coverage expansions. 2015–20 reflects that Affordable Care Act coverage expansions continue through 2017, and other provisions of the act impact payment and coverage. Elevated Medicare enrollment growth is due to baby boomers.

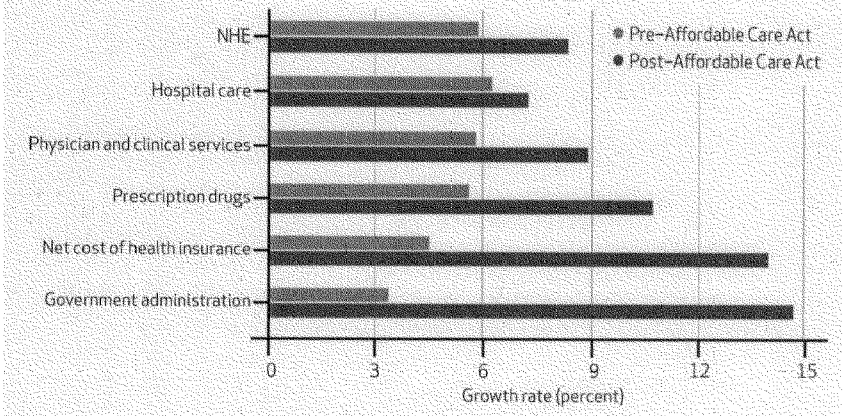
Spending growth for major health care services and goods in 2014 is expected to be higher than in previous years as the effects of expanded coverage more than offset the Medicare savings provisions found in the Affordable Care Act. (These Medicare savings include a slowing in the rate of growth of payments to hospitals, for example.) Notably, because many of the newly insured will be younger and healthier, on average, compared to the existing Medicaid and private insurance pop-

ulations, they are expected to use physician services and prescription drugs to a greater extent than hospital or other more intensive services.

Prescription drug spending growth is projected to be 10.7 percent in 2014, or 5.1 percentage points higher than in the absence of the Affordable Care Act. The higher growth rate stems from the fact that the newly insured are expected to consume more prescriptions because of substantially lower out-of-pocket requirements for prescription drugs (Exhibit 4). Spending growth for physician and clinical services is projected to be 8.9 percent (3.1 percentage points higher than in the absence of the Affordable Care Act) in 2014, driven by an expected increase in office visits. Hospital spending is projected to grow 7.2 percent or 1.0 percentage point higher than it would have without the passage of the Affordable Care Act.

EXHIBIT 4

2014 Growth Rates By Selected Sector, Before And After The Impact Of The Affordable Care Act



SOURCE Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

2015–20

For 2015–20, national health spending growth is projected to average 6.2 percent per year. During this period, some large employers with low-wage employees are expected to discontinue offering health insurance to their workers and instead pay the penalty mandated in the Affordable Care Act. Of the workers losing employer-based coverage, many are expected to obtain insurance coverage through the State exchanges, while others would enroll in Medicaid (and some would become uninsured). Also, the Affordable Care Act mandates an excise tax on high-cost insurance plans starting in 2018; costs of employer-sponsored health insurance plans that exceed $10,200 for an individual employee or $27,500 for dependent coverage will be subject to a 40 percent tax. Consequently, many plans that exceed the taxable threshold are expected to provide enrollees incentives to enroll in plans with lower premiums and higher cost-sharing requirements. The effect is likely to be a slowdown in the growth of health services, health insurance premiums, and health spending overall. As a result, in our projection both premiums and the use of health services are expected to grow more slowly in 2018 than in the absence of this provision.

MODEL AND ASSUMPTIONS

These projections are generated within a "current-law" framework that incorporates actuarial and econometric modeling techniques, as well as judgments about future events and trends that influence health spending. The projections use the economic and demographic assumptions from the 2011 *Medicare Trustees Report*, which are updated to reflect the latest macroeconomic data.[7]

Consistent with the trustees report methodology, the Medicare projections are estimated under two scenarios: current law (where growth in physician payment rates is based on the sustainable growth rate formula) and an alternative scenario (where growth in physician payment rates is based on growth in the Medicare Economic Index).[5 7 8] The Centers for Medicare and Medicaid Services' Office of the Actuary health reform model and other actuarial cost estimates were used to determine the full effect of reform on national health spending and to assign the impact of reform among categories for goods and services.[9]

The projections presented in this article differ somewhat from past projections. Specifically, they incorporate data and classification changes made in a recent National Health Expenditure Accounts comprehensive revision, in addition to incorporating new and revised source data and refinements to our models.[10 11] In addition, this article features health spending projections by sponsor or source of financing, as well as the typical projections by payer and service.

These projections remain subject to substantial uncertainty given the variable nature of future economic trends and a lack of historical experience for many Affordable Care Act health system reforms. Moreover, "supply-side" impacts of the Affordable Care Act, such as changes in provider behavior in reaction to an influx of newly insured patients, remain highly uncertain and are not estimated at this time.[12]

OUTLOOK FOR MEDICAL SERVICES AND GOODS

The Affordable Care Act is expected to exert varying effects on spending trends for medical services and goods. For the three largest sectors (hospital services, physician and clinical services, and prescription drugs), total spending is projected to be higher when the major expansions of this law are implemented in 2014. However, the magnitude of the impact on their respective growth rates is expected to be different. The increased demand in response to expanded insurance coverage for physician services and pharmaceuticals is anticipated to be higher than that of hospital services. One reason is that insurance expansions can typically lead to more efficient use of health care services (that is, more preventive care), which would increase office visits and prescription drugs, and could lead to less reliance on hospital care.[3] As a result, the projected share of national health spending in 2020 accounted for by physicians (19 percent) and prescription drugs (11 percent) is higher than it would have been in the absence of the Affordable Care Act, and the hospital share (30 percent) is lower.

Hospital Care. Hospital spending growth is estimated to have slowed by half a percentage point to 4.6 percent in 2010 and to have reached $794.3 billion (Exhibits 1 and 2). Growth in private health insurance spending on hospital care is estimated to have remained relatively low at 2.1 percent in 2010 (compared to 2.7 percent in 2009), reflecting the impact of the recent recession and a continued decline in service use.[14] Largely as a result of a 3.4-percent reduction to Medicare's private health plan payments, growth in Medicare spending on hospital care is estimated to have slowed in 2010 to 4.0 percent, from 5.9 percent in 2009.[7]

For 2011 through 2013, growth in hospital spending is projected to accelerate, reaching 5.3 percent by 2013. With expected gains in employment, a rebound in projected private health insurance enrollment is also expected. As a result, private health insurance hospital spending is projected to be 4.2 percent in 2013. Medicare hospital spending growth is projected to grow faster in each year, reaching 6.4 percent in 2013. This trend mainly reflects faster growth in Medicare enrollment as the baby boom generation reaches age 65, offsetting much slower growth in per person spending due to the savings provisions in the Affordable Care Act. These provisions include reduced fee-for-service provider payment updates and lower payments to private plans.

In 2014, overall hospital spending growth is projected to accelerate to 7.2 percent, which is 1.0 percentage point and $8.6 billion higher than projected in the absence of health reform (Exhibit 4). This growth rate reflects the net impact of increased service use associated with the coverage expansions under Medicaid and private insurance. These impacts are partially offset by lower Medicare payment rate increases for hospitals mandated by the Affordable Care Act, which result in Medicare hospital spending growth of 6.7 percent in 2014, 1.8 percentage points slower than projected had the Affordable Care Act not become law.

Hospital spending is projected to grow 6.2 percent per year during the period 2015–20. By 2020, Medicare hospital spending growth is projected to reach 7.3 percent (up from 5.1 percent in 2015), while private health insurance spending is projected to slow to 5.8 percent. This trend largely reflects the net result of the baby boom enrollment shift from private health insurance coverage to Medicare and is not related to coverage expansions in the Affordable Care Act.

Physician and Clinical Services. Spending growth for physician and clinical services is estimated to have slowed from 4.0 percent in 2009 to a historically low rate of 2.4 percent in 2010, and to have reached $517.8 billion (Exhibits 1 and 2). This trend is driven by recession-related declines in physician visits, as many consumers delayed health care to reduce expenses, and in part, by a less severe flu season than in the previous year, 2009.[15] [16] Private health insurance spending growth is estimated to have slowed to only 0.9 percent in 2010 (from 1.9 percent in 2009) in response to elevated unemployment and increased cost sharing in employer-based plans.[14] After rebounding temporarily in 2011 to 4.0 percent, spending growth for physician and clinical services is projected to slow to 0.8 percent in 2012 largely due to the 29.4-percent Medicare physician payment rate reduction that is mandated by Medicare's sustainable growth rate formula. Under the alternative Medicare projection scenario, total physician and clinical spending growth would be 4.5 percent in 2012. This scenario is more fully described in the "Model and Assumptions" section.

By 2014, spending growth for physician and clinical services is projected to accelerate 3.3 percentage points to 8.9 percent, which is 3.1 percentage points and $17.8 billion higher than projected in the absence of reform (Exhibit 4). Given the demographic and health profile of the populations expected to gain insurance through Medicaid or the exchanges—generally expected to be younger, healthier, and requiring less acute care than those currently insured—the newly insured are anticipated to devote a higher proportion of their total health spending to physician and clinical services.[13]

Overall, spending growth for physician and clinical services is projected to average 5.6 percent for the period 2015–20. Medicaid spending growth for these services (averaging 7.4 percent) is driven by enrollment growth and, in part, by the projected higher proportion of new enrollees' benefits going toward these services. Medicare spending growth for physician and clinical services, averaging 5.7 percent, is driven by higher enrollment in tandem with somewhat suppressed growth in payment levels. This growth rate is expected to slightly outpace that of private health insurance (averaging 5.1 percent) as more people shift into Medicare from private insurance.

Prescription Drugs. Prescription drug spending is estimated to have grown 3.5 percent in 2010, down from 5.3 percent in 2009, and totaled $258.6 billion (Exhibits 1 and 2). This deceleration resulted from continued slow growth in the use of drugs and the ongoing change in the mix of drugs purchased. Through tiered copays and other mechanisms, health plans have continued to shift medication use toward less-costly generic drugs. Thus, the generic dispensing rate is projected to have increased to 69 percent in 2010, up from 66 percent in 2009.[2]

For the period 2011–13, prescription drug spending growth is projected to be faster than in 2010, averaging 5.7 percent as economic conditions improve. Offsetting this faster growth somewhat, 6 of the top 50 brand-name drugs (based on 2010 retail sales) are scheduled to lose patent protection in 2011, which is projected to affect growth the most in 2012 as lower-priced generic versions of these drugs become available for a full 12 months.[17] [18]

In 2014, growth in prescription drug spending is expected to increase sharply to 10.7 percent, which is 5.1 percentage points and $15.8 billion higher than projected in the absence of the Affordable Care Act (Exhibit 4). This acceleration is driven mainly by the expectation of a substantial increase in the use of drugs by the newly insured portion of the population.[19]

From 2015 through 2020, prescription drug spending growth is expected to average 7.2 percent. This reflects, in part, a projected leveling off of the dispensing rate for generic drugs, resulting in slightly higher drug price growth, and higher spending for new drugs due to an expected increase in the Food and Drug Administration's approvals for new molecular entities and therapeutic biologics during this period.[20]

OUTLOOK FOR PAYERS

Medicare. Growth in Medicare spending (including spending for fee-for-service providers, private health plans, and administrative costs) is estimated to have slowed from 7.9 percent in 2009 to 4.5 percent in 2010, and to have reached $525.0 billion (Exhibit 5). This deceleration reflects slower growth across most of Medicare's service categories due in part to an across-the-board reduction of 3.4 percent in Medicare's payments to private health plans.[7] In 2011, Medicare spending growth is projected to increase 5.9 percent before slowing to 1.7 percent in 2012, as a result of the 29.4-percent reduction in physician payment rates scheduled in current law.[21] Under the alternative Medicare projection scenario, projected 2012 Medicare spending growth will accelerate to 6.6 percent.

Average annual Medicare spending growth is anticipated to be 6.3 percent for 2013 through 2020. This rate is the net result of, on the one hand, increasing enrollment that will drive up spending, and on the other hand, provisions of the Affordable Care Act that call for reduced fee-for-service provider payment updates and lower payments to private plans.[7] By 2020, Medicare's share of national health spending is expected to remain at 20 percent (unchanged from 2009). This, too, is the net result of different forces: on the one hand, increases in enrollment from the baby boom generation; on the other, the non-Medicare coverage expansions that will cause spending to rise for other payers, lower Medicare payment updates, and other Medicare savings provisions in the Affordable Care Act.

Medicaid. Medicaid spending (Federal and State combined) is estimated to have grown 7.2 percent in 2010, down from 9.0 percent in 2009, and to have accounted for $400.7 billion (Exhibit 5). The slowdown in Medicaid spending growth was primarily driven by slower enrollment growth (6.0 percent in 2010 compared to 7.4 percent in 2009) following the end of the recession.[22] Medicaid spending per enrollee is estimated to have grown slowly in 2010 (1.1 percent). This slow rate of growth was due to projected faster enrollment growth of beneficiaries with relatively lower health care costs (mainly children and adults under age 65) than other Medicaid beneficiaries. Further projected improvements in the economy are expected to result in slower enrollment growth in Medicaid during 2011–13, leading to a slight deceleration in spending growth (averaging 6.8 percent).[4]

Exhibit 5.—National Health Expenditures (NHE), Amounts And Average Annual Growth From Previous Year Shown, By Source of Funds, Selected Calendar Years 2008–20

Source of funds	2008[1]	2009	2010	2011	2012	2013	2014	2020
NHE ($ in billions)	$2,391.4	$2,486.3	$2,584.2	$2,708.4	$2,823.9	$2,980.4	$3,227.4	$4,638.4
Health consumption expenditures	2,234.2	2,330.1	2,424.3	2,540.8	2,646.9	2,792.6	3,027.6	4,337.7
Out-of-pocket	298.2	299.3	304.9	312.1	322.0	334.6	330.3	443.8
Health insurance	1,681.8	1,767.4	1,847.5	1,942.8	2,023.9	2,139.9	2,371.3	3,411.4
Private health insurance	790.6	801.2	822.3	850.3	884.4	926.9	1,013.7	1,402.0
Medicare	465.7	502.3	525.0	556.1	565.6	599.5	636.8	922.0
Medicaid	343.1	373.9	400.7	428.1	456.8	487.8	586.8	908.1
Federal	202.4	247.0	270.9	261.5	264.5	284.5	366.0	561.1
State and Local	140.7	127.0	129.9	166.6	192.3	203.3	220.8	347.0
Other health insurance programs[2]	82.4	90.0	99.5	108.3	117.1	125.7	134.0	179.4
Other third-party payers and programs and public health activity[3]	254.1	263.3	271.9	285.8	300.9	318.1	326.0	482.4
Investment	157.2	156.2	159.9	167.6	176.9	187.8	199.9	300.7
Average Annual Growth From Prior Year Shown:								
NHE (In percent)	7.1%	4.0%	3.9%	4.8%	4.3%	5.5%	8.3%	6.2%
Health consumption expenditures	7.1	4.3	4.0	4.8	4.2	5.5	8.4	6.2
Out-of-pocket	5.0	0.4	1.8	2.4	3.2	3.9	(1.3)	5.0
Health insurance	7.8	5.1	4.5	5.2	4.2	5.7	10.8	6.2
Private health insurance	7.1	1.3	2.6	3.4	4.0	4.8	9.4	5.6
Medicare	9.6	7.9	4.5	5.9	1.7	6.0	6.2	6.4
Medicaid	6.9	9.0	7.2	6.8	6.7	6.8	20.3	7.5
Federal	7.1	22.0	9.7	(3.5)	1.2	7.6	28.7	7.4
State and local	6.7	(9.8)	2.3	28.3	15.4	5.7	8.6	7.8
Other health insurance programs[2]	11.0	9.2	10.6	8.9	8.1	7.3	6.6	5.0
Other third-party payers and programs and public health activity[3]	5.3	3.6	3.3	5.1	5.3	5.7	2.5	6.8
Investment	7.3	(0.6)	2.4	4.8	5.6	6.1	6.5	7.0

Source. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
Notes. Numbers may not add to totals due to rounding. Percentage change is calculated from unrounded data. Data from 2010 to 2020 are projections.
[1] Average annual growth, 2000–08.
[2] Includes Children's Health Insurance Program (Titles XIX and XXI), Department of Defense, and Department of Veterans Affairs.
[3] Includes worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other Federal programs, Substance Abuse and Mental Health Services Administration, other State and local programs, and school health.

In 2014, Medicaid spending is projected to increase substantially (20.3 percent) as a result of the expansion in Medicaid eligibility under the Affordable Care Act. Enrollment (75.6 million) is projected to be about one-third higher than in 2013 as eligibility is extended to all persons under age 65 in families with incomes at or below 138 percent of the Federal poverty level. The transition into the program for those newly eligible is expected to take about 3 years, contributing to projected Medicaid spending growth of 7.5 percent in 2015 and 8.5 percent in 2016. By 2020, Medicaid is projected to account for nearly 20 percent of national health spending (from 15 percent in 2009).

Private Health Insurance. Growth in private health insurance premiums is estimated to have accelerated, but remained low, reaching 2.6 percent in 2010 (up from 1.3 percent in 2009) and accounted for $822.3 billion (Exhibit 5). A drop of 5.1 million in the number of people enrolled in private health insurance was the major reason for this slow growth. Additionally, because growth in the use of services was slower than was anticipated when premiums were originally set, the net cost of insurance, or the difference between premiums collected and benefits paid, grew significantly in 2010 at 8.7 percent.[23]

Also in 2010, private health insurance benefit payments totaled an estimated $725.5 billion, representing an increase of just 1.9 percent (down from 2.8 percent in 2009). This historically low rate of growth was influenced by the same factors that contributed to the relatively low premium growth, namely the drop in the number of private health insurance enrollees, as well as slowing growth in the use of some services (such as elective hospital procedures and physician visits).[14 16]

For 2011–13, private health insurance enrollment is projected to increase by 4.0 million as employment levels increase and more individuals are covered by employer-sponsored insurance due, in part, to the Affordable Care Act. Notably, growth in benefits per enrollee is expected to fall from 4.7 percent in 2010 to below 3 percent in 2011 due, in part, to the Affordable Care Act's expansion of coverage to relatively less-expensive benefits for children under age 26 who can join their parents' policies.

In 2014, growth in private health insurance premiums is expected to accelerate to 9.4 percent, 4.4 percentage points higher than in the absence of health reform, as an estimated 13.9 million people obtain coverage through exchange plans. At that time, private health insurance is anticipated to account for roughly 31 percent of national health spending, or about the same share as was expected without enactment of the Affordable Care Act.

For 2015–20, growth in private health insurance premiums is expected to slow somewhat and average 5.6 percent annually. Underlying this expectation is that some employers of low-wage workers will stop offering health coverage (and many of their employees will move to the exchange plans, while others move into Medicaid or become uninsured). Also, as discussed earlier, in 2018, the excise tax on high-cost employer-based insurance plans will take effect, placing further downward pressure on health insurance premiums.

Out-of-Pocket Spending. Out-of-pocket spending is estimated to have grown 1.8 percent in 2010, up from 0.4 percent in 2009, and to have reached $304.9 billion (Exhibit 5).[24] The low growth in out-of-pocket health spending was influenced by job losses and the corresponding loss of employer-sponsored insurance, as well as employers' willingness to increase deductibles and/or copayments.[4] For 2011–13, growth in out-of-pocket spending is projected to accelerate, reaching 3.9 percent in 2013, partly due to faster growth in disposable personal income that leads to more consumption of medical care.

In 2014, out-of-pocket spending is projected to decline 1.3 percent, largely as a result of the uninsured attaining health coverage through Medicaid or health insurance exchange plans. In addition, cost sharing for exchange plan enrollees in families with incomes at or below 250 percent of the Federal poverty level is subsidized, thereby reducing their out-of-pocket spending at the point-of-service.[25] Out-of-pocket spending growth is anticipated to reach a projection-period high of 6.6 percent in 2018. This outcome is expected as enrollment shifts to higher cost-sharing employer-sponsored insurance due to the existence of the new excise tax on high-cost insurance plans.

Although cost sharing is expected to increase throughout the projection period, the out-of-pocket share of national health expenditures is projected to fall from 12 percent in 2009 to 9.6 percent in 2020 (the projected out-of-pocket share in 2020 would be 10.5 percent had the Affordable Care Act not been enacted).

In contrast to the preceding analysis of national health expenditures by payer, our sponsor analysis focuses on the financing of health care. In 2010, health spending financed by governments (Federal and State) is estimated to have grown 7.2 percent (reaching $1.2 trillion) while spending by businesses, households, and other private sources is expected to have risen 1.4 percent (reaching $1.4 trillion) (Exhibit 6). The effects of the recession, as well as increased Federal matching rates to States for Medicaid, are estimated to have influenced the shift of health care financing toward the Federal Government. For 2010, the Federal Government's share of national health spending is estimated to have increased by just over 1 percentage point, to 29 percent, with State and local governments maintaining their 16-percent share (see online Appendix).[26]

For 2011–13, government outlays (averaging 5.2 percent growth) are projected to roughly maintain a 45-percent share of total health spending. The Federal Government share of health spending is projected to decline to 27 percent by 2013, partly due to the expiration of temporary increases in the Federal share of Medicaid and the slowdown in Medicare expenditure growth related to the sustainable growth rate formula-based reduction in physician payment rates. Reflecting faster projected economic growth, spending growth financed through private businesses and households is expected to increase during this period (averaging 4.6 percent).

Exhibit 6.—National Health Expenditures (NHE), Amounts and Average Annual Growth From Previous Year Shown, By Type of Sponsor, Selected Calendar Years 2010–20

Type of sponsor	Expenditures (billions)				Percent change		
	2010	2013	2014	2020	2011–13	2014	2015–20
NHE	$2,584.2	$2,980.4	$3,227.4	$4,638.4	4.9	8.3	6.2
Business, households and other private	1,423.4	1,628.9	1,707.2	2,356.5	4.6	4.8	5.5
Private business	518.8	595.3	635.6	820.5	4.7	6.8	4.3
Employer contributions to private health insurance premiums [1]	394.9	452.5	485.6	622.8	4.6	7.3	4.2
Other [2]	123.8	142.8	150.1	197.8	4.9	5.1	4.7
Household	727.7	828.0	854.2	1,205.3	4.4	3.2	5.9
Household private health insurance premiums [3]	257.5	291.7	306.3	439.1	4.2	5.0	6.2
Medicare payroll taxes and premiums [4]	165.3	201.6	217.6	322.4	6.8	7.9	6.8
Out-of-pocket health spending	304.9	334.6	330.3	443.8	3.2	-1.3	5,0
Other private revenues [5]	176.9	205.6	217.3	330.7	5.1	5.7	7.2
Government	1,160.8	1,351.5	1,520.2	2,281.9	5.2	12.5	7.0
Federal Government	741.6	816.1	950.8	1,445.2	3.2	16.5	7.2
Employer contributions to private health insurance premiums	28.8	32.6	34.0	43.4	4.3	4.3	4.1
Employer payroll taxes paid to Medicare hospital insurance trust fund	4.0	4.1	4.2	5.3	0.3	3.9	3.8
Medicare [6]	249.6	266.5	283.5	425.7	2.2	6.4	7.0
Medicaid [7]	280.1	292.3	374.2	574.1	1.4	28.0	7.4
Other programs [8]	179.1	220.7	254.9	396.7	7.2	15.5	7.7
State and local government	419.2	535.4	569.4	836.8	8.5	6.4	6.6
Employer contributions to private health insurance premiums [1]	131.2	143.2	150.8	214.5	3.0	5.3	6.1
Employer payroll taxes paid to Medicare hospital insurance trust fund	11.4	13.0	13.8	18.4	4.6	5.8	4.9
Medicaid	133.9	209.4	227.3	357.3	16.1	8.5	7.8
Other programs [9]	142.7	169.8	177.5	246.5	6.0	4.6	5.6

Source. Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.
Note: Numbers may not add to totals due to rounding. Percentage change is calculated from unrounded data.
[1] Includes premiums paid on behalf of employees.

[2] Includes employer Medicare hospital insurance payroll taxes, one-half self-employment payroll taxes, temporary disability insurance, workers' compensation, and worksite health care.
[3] Includes household contributions to employer-sponsored health insurance, health insurance purchased through Exchanges, and other private health insurance.
[4] Includes employee and self-employment payroll taxes and premiums paid to Medicare hospital insurance and supplementary medical insurance trust funds.
[5] Includes health-related philanthropic support, nonoperating revenue, investment income, and privately funded structures and equipment.
[6] Includes trust fund interest income, Federal general revenue contributions to Medicare less the net change in the trust fund balance, and payments for the Retiree Drug Subsidy. Excludes Medicare hospital insurance trust fund payroll taxes and premiums, Medicare supplementary medical insurance premiums, State phase-down payments, Medicaid buy-ins, and taxation of benefits.
[7] Includes Medicaid buy-ins for the dually eligible Medicare premiums.
[8] Includes maternal and child health, Children's Health Insurance Program (Titles XIX and XXI), vocational rehabilitation, Substance Abuse and Mental Health Services Administration, Indian Health Service, Federal workers' compensation, other Federal programs, public health activities, Department of Defense, Department of Veterans Affairs, research, structures and equipment, and exchange premium and cost-sharing subsidies.
[9] Includes State phase-down payments, maternal and child health, public and general assistance, Children's Health Insurance Program (Titles XIX and XXI), vocational rehabilitation, other State and local programs, public health activities, research, and structures and equipment.

As the major coverage expansions of the Affordable Care Act are implemented in 2014, health care financing is anticipated to further shift toward governments. In 2014, the Federal share of national health spending is projected to rise 2 percentage points to 29 percent, primarily a result of premium and cost-sharing subsidies for exchange coverage and a 100-percent Federal match rate for Medicaid coverage expansion costs. In contrast, households' share of expenditures is projected to decrease to 26 percent, from 28 percent in 2013, due mostly to net lower out-of-pocket spending for those who gain coverage.

By 2020, government health care spending is projected to be 49 percent of national health spending, up from 47 percent in 2014, reaching a total of $2.3 trillion; it is expected that the Federal Government will pay almost two-thirds of this amount. During this period, projected increases in the government's share of health care financing is largely associated with the robust projected Medicare enrollment growth, the Medicaid expansion, and Federal costs associated with the exchange premium and cost-sharing subsidies (but offset somewhat by the lower Medicare expenditures resulting from Affordable Care Act provisions). As the government share of spending rises, the projected share for private businesses declines (from 20 percent in 2014 to 18 percent by 2020), and the share for households remains at 26 percent.

CONCLUSION

This article provides an analysis of projected health care spending by sector, payer, and sponsor inclusive of the effects of the Affordable Care Act. Average annual growth in national health spending is expected to be 0.1 percentage point higher (5.8 percent) under current law compared to projected average growth prior to the passage of the Affordable Care Act (5.7 percent) for 2010 through 2020. Simultaneously, by 2020, nearly 30 million Americans are expected to gain health insurance coverage as a result of the Affordable Care Act.

The largest impact on the growth of health spending is expected to occur in 2014, when the major coverage expansions begin. There is projected to be a proportionately larger impact on physician and clinical services and on prescription drug spending growth relative to other services and goods, as those who gain coverage are likely to be relatively young and healthy and to use less intensive care than the populations currently enrolled in Medicaid and private health insurance.

Combined with the entry of the baby boomers into Medicare and Medicaid, the impact of the Affordable Care Act—stemming from the expansion of Medicaid, subsidies associated with exchanges, and administrative costs associated with implementing and operating the various provisions—is projected to increase Federal, State, and local governments' estimated share of total health spending to near 50 percent in 2020. At the same time, households and private businesses are anticipated to pay for a smaller portion of the Nation's health bill than they would have without the Affordable Care Act, but still will face a growing burden on their respective limited resources.

NOTES

1. Under the alternative Medicare projection scenario in which physician payment increases are based on growth in the Medicare Economic Index, national health spending would grow 6.0 percent per year over the projection period, resulting in a health share of gross domestic product of 20.1 percent. For more information on the Medicare projection scenarios, see the "Model And Assumptions" section of this article.

2. Martin A, Lassman D, Whittle L, Catlin A. Recession contributes to slowest annual rate of increase in health spending in five decades. Health Aff (Millwood). 2011;30(1): 11–22.

3. For comparing national health spending and gross domestic product, nominal levels and growth rates are used. Gross domestic product is often measured in real, inflation-adjusted terms; real gross domestic product growth was −2.6 percent in 2009 and 2.9 percent in 2010.

4. Claxton G, DiJulio B, Whitmore H, Pickreign J. Health benefits in 2010: premiums rise modestly, workers pay more toward coverage. Health Aff (Millwood). 2010;29(10): 1942–50.

5. The Medicare Economic Index is a price index that measures the price changes of the inputs physicians require in order to provide services.

6. Other things being equal, the availability of coverage would cause a sizable decrease in out-of-pocket costs for affected individuals. The new coverage, however, typically induces greater use of health care services, thereby increasing out-of- pocket costs in many instances.

7. Boards of Trustees. 2011 annual report of the boards of trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds [Internet]. Baltimore (MD):CMS; 2011 May [cited 2011 May 13]. Available from: *http://www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2011.pdf*.

8. The full effects that a 29.4-percent reduction in physician reimbursement would have are difficult to predict. No secondary effects of the reduction in physician payment rates are modeled in these projections. For more information, see Clemens MK, Shatto JD. Projected Medicare expenditures under an illustrative scenario with alternative payment updates to Medicare providers [Internet]. Baltimore (MD): Centers for Medicare and Medicaid Services; 2011 May [cited 2011 May 13]. Available from: *http://www.cms.gov/ReportsTrustFunds/downloads/2011TRAlternative Scenario.pdf*.

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14. Boorady C, Giacobbe R, Santangelo G, Carter C. Making sense of the utilization downtrend. New York (NY): Credit Suisse; 2010.

15. Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report (MMWR): Update: influenza activity—United States, 2010–11 season, and composition of the 2011–12 influenza vaccine [Internet]. Atlanta (GA): CDC; [cited 2011 Jun 8]. Available from: *http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6021a5.htm*.

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17. Carollo K. Lipitor among top drugs coming off patent. ABC News, 9. March 2011 [cited 2011 Jul 11]. Available from *http://abcnews.go.com/Health/top-selling-drugs-coming-off-patent-paving-cheaper/story?id=13048629*.

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20. Medco. 2011 drug trend report: healthcare 2020. Franklin Lakes (NJ); Medco;2011.

21. As Medicare's private health plan payment rates and spending are affected by changes in Medicare's fee-for-service payment rates, the decrease in physician payment rates in 2012 under current law would also result in slower growth in Medicare private health plan payments across most service categories.

22. Kaiser Commission on Medicaid and the Uninsured. Medicaid matters: understanding Medicaid's role in our health care system. Menlo Park (CA): Kaiser Family Foundation; [cited 4 Mar 2011]. Available from: *http://www.kff.org/medicaid/upload/8165.pdf*.
23. Abelson R. Health insurers making record profits as many postpone care. *New York Times*. 13 May 2011.
24. Out-of-pocket spending consists of direct spending by consumers for health care goods and services including coinsurance and deductibles; enrollee premiums for private health insurance and Medicare are not within this funding category.
25. Kaiser Family Foundation. Focus on health reform. Explaining health care reform: questions about health insurance subsidies. Menlo Park (CA): KFF; 2010 Apr [cited 2011 Jul 6]. Available from: *http://www.kff.org/healthreform/upload/7962-02.pdf*.
26. To access the Appendix, click on the Appendix link in the box to the right of the article online.

Response to Questions of Senator Harkin by Steve Larsen

Question 1. A recent report released by the CMS Office of the Actuary found a 3.9 percent growth in national health spending in 2010—an historic low. Further, overall Medicare cost growth dropped from 7.9 to 4.5 percent between 2009 and 2010. The report projects that average annual growth in national health spending is expected to be 0.1 percentage point higher under the Affordable Care Act for 2010 to 2020, but that, by 2020, 30 million Americans will gain health insurance as a result of this law.

Many critics of the ACA highlight the report's finding that "in 2014, growth in private health insurance premiums is expected to accelerate to 9.4 percent" to argue that the ACA will cause insurance premiums to rise. However, the report draws no such conclusion—the projected increase in 2014 is in total expenditures for private insurance premiums, not in premium rates. Indeed, the report explicitly links this expenditure increase to the significant expansion of coverage in 2014.

In addition, the nonpartisan Congressional Budget Office estimated that under the new law, health insurance premiums in the individual and group markets will decrease. CBO found that by 2016, premiums per person for those receiving subsidies in the individual market could decrease by up to 56 percent; by 2 percent in the small group market; and by 3 percent in the large group market.

Can you please clarify the CMS Actuary's projections about expenditures for health insurance premiums in its July report?

Answer 1. In a report issued in July 2011, the CMS Office of the Actuary estimated that the coverage expansions included in the Affordable Care Act will result in an estimated 22.9 million newly insured Americans by 2014 and about 30 million over the next decade. Covered primarily through Affordable Insurance Exchanges and Medicaid, the newly insured population is, as expected, projected to contribute to increased national health spending in 2014, including the estimated 9.4 percent increase in private health insurance spending. This is not an estimate for the projected increase in the cost of private health insurance premiums.

The CMS actuary also estimates that in 2014, out-of-pocket spending will decline by 1.3 percent as the number of people with insurance coverage increases and many services formerly paid for out-of-pocket are now covered by insurance.

Most importantly, however, the CMS actuary also projects that the rate of growth in per capita health care spending will begin to slow down after 2014 as a result of the Affordable Care Act, producing only a 0.1 percent difference in the growth of national health expenditures over the coming decade.

Question 2. Additionally, can you explain the implications of these findings in relation to CBO's estimates of premiums under ACA?

Answer 2. The CMS actuary estimated that in 2014, the aggregate amount of spending on private health insurance premiums would increase by 9.4 percent due to increases in the insured population, inflation, and small real increases in average premiums. Since more Americans will be insured, more people will be paying private insurance premiums, which will cause the aggregate amount of spending on private health insurance premiums to increase. With respect to premiums paid, the actuary predicts a modest 5 percent increase in household private insurance pre-

miums in 2014, up only 0.1 percentage point from 2013, and the Actuary does not attribute this increase to the Affordable Care Act.[1]

In a letter to Senator Bayh dated November 30, 2009,[2] the Congressional Budget Office (CBO) provided an estimate of the Affordable Care Act's impact on average premiums paid. CBO estimated that the Affordable Care Act will lower average premiums for comparable plans in the individual market due in part to the improved health of the risk pool and by eliminating administrative costs such as medical underwriting. In total, the average premium in the individual market for the same amount of coverage will decrease between 7 and 10 percent due to better risk pooling and another 7 to 10 percent decrease through competition and administrative simplifications after the Affordable Care Act takes effect. CBO also estimated that the effect of the Affordable Care Act for the average small group market premium varies from a 1 percent increase to a 2 percent decrease. Estimates of the effect on large group market premiums range from no impact to a 3 percent decrease in average premium.

[Whereupon, at 12:15 p.m., the hearing was adjourned.]

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[1] *National Health Expenditure Projections 2010–20, Table 16: https://www.cms.gov/nationalhealthexpenddata/downloads/proj2010.pdf.*

[2] *http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.*