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THE CHALLENGES OF THE AFFORDABLE CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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THE CHALLENGES OF THE AFFORDABLE CARE ACT

WEDNESDAY, DECEMBER 4, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to call, at 10:05 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
Wednesday, November 27, 2013
No. HL–09

CONTACT: (202) 225–3625

Chairman Brady Announces Hearing on the Challenges of the Affordable Care Act

House Ways and Means Health Subcommittee Chairman Kevin Brady (R–TX) today announced that the Subcommittee on Health will hold a hearing on the status of the implementation of the Affordable Care Act (ACA). This hearing will allow the Subcommittee to focus on the immediate and long-term challenges Americans face in finding affordable, quality health coverage as a result of the ACA. **The hearing will take place on Wednesday, December 4, 2013, in 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The American people are understandably concerned and focused on what the Obama Administration has called the "fumbled" rollout of the healthcare.gov system used to enroll American individuals and families into the Federal health insurance exchanges. The Administration has responded with a "tech surge" in an attempt to fix the consumer, security, verification, billing and payment flaws plaguing the healthcare.gov Web site. However, the ACA is more than a Web site and many of the law's major provisions, which are scheduled to go into effect in just under a month, will both impact the ability of individual Americans to maintain health care they can afford and access to their current doctors.

Millions of Americans have received notices from their insurers informing them that because of the ACA their current plan is being cancelled, and they must now find a new health plan. Americans are also discovering that the premiums offered in the exchanges are higher than the Administration originally promised and for many, more expensive than their current plans. Employers are increasing out-of-pocket costs, dropping spousal coverage and reducing hours for their workers. Enrollment in the new exchanges has fallen well below the Administration's projections and many analysts have expressed concern that the young and healthy will not sign up in sufficient numbers to prevent premium spikes in 2015. Additionally, serious concerns also remain that the healthcare.gov system is incapable of securely handling an expected surge in volume in December while accurately verifying eligibility and fulfilling the necessary steps to carry out billing and payment functions.

The hearing will examine and analyze the impact of the ACA on the healthcare system and explore ways to mitigate the adverse impacts of the law on the American people.

In announcing the hearing, Chairman Brady stated, **"We are no longer debating what will happen when the President's healthcare law goes into effect. The Affordable Care Act, as it was written and is being implemented, is having the negative consequences on the American people we long predicted it would. Despite the President's many promises to the contrary, they are being forced to find a new and more expensive plan because the plan they have and like has been canceled. Individuals are being forced to**

buy coverage from a Web site that does not work. This is unfair to the American people. But let's be honest—the problems we are seeing today are likely to get even worse. Some people will face a gap in coverage, premiums will likely spike even higher in 2015, and more and more people with employer-provided coverage will be adversely affected by the law. This hearing provides all of us an opportunity to get a better perspective on these challenges so that we can facilitate solutions to mitigate some of this pain."

FOCUS OF THE HEARING:

The hearing will focus on the challenges of the ACA on the healthcare system and explore ways to mitigate the adverse impacts of the law on the American people.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, December 18, 2013**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TDD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Chairman BRADY. Good morning, everyone. The Subcommittee will come to order.

Another day, another chance for the White House to fix their controversial healthcare law. Today families and patients abandoned by the new law learn that the Obama Administration launched a new and improved marketing campaign for the troubled law. Strange use of resources, given that the problems are with the policy, not with the politics. What is needed are real solutions, not more spin.

The Affordable Care Act's fundamental problem can't be fixed with better marketing. The flaw is not the Web site; the flaw is the law itself. Improving the defective Web site won't make ObamaCare premiums more affordable. Improving the defective Web site won't prevent millions of Americans from walking to their mailbox only to find the healthcare plan they have and like is canceled because of the Affordable Care Act. Improving the defective Web site won't keep President Obama's promise that Americans will see a $2,500 reduction in their healthcare premiums, and won't prevent middle-class families from experiencing more expensive premiums and higher deductibles they simply can't squeeze from their already stretched budgets.

And as one fellow Texan wrote to me, we are a family of three that paid $753 a month for health insurance when ObamaCare was enacted. We are now paying $1,117 a month for the same plan, a 48 percent increase.

My Democratic colleagues repeatedly promised the ObamaCare exchanges would deliver a new, competitive marketplace that made it easy to shop for insurance, but the reality is far from that. In the several thousand counties served by the Federal exchanges, over half have plans offered by just one or two insurance carriers. In about 530 counties, American families have only one choice, just one insurer in the exchange. So fixing a defective Web site won't create competition and choice where none exists today.

Now our small businesses have been told that the online shop exchanges they were told would come on, that they could count on for affordable healthcare options, has been canceled for next year. Does fixing a defective Web site restore that broken promise to our local businesses?

We are all hoping for the best, but that November 30th deadline to fix the Web site problems has passed, and no one yet knows if the system has the capacity to enroll, actually determine subsidies, and complete a new insurance policy for all the millions of Americans abandoned when their policies were canceled by the President's new healthcare law. To do so, the new improved Web site will need to enroll close to 100,000 people per day every day this month, and that is how many who selected a plan in all of October.

Regrettably, at this point the American public has little confidence the Web site is ready for prime time and this latest promise will be kept. The clock is ticking. We are right in the middle of prime time for individuals, for families and small businesses to find affordable health care that begins on January 1st. What will these patients and families do when they show up to the hospital or need to reorder a lifesaving prescription on New Year's Day, and their ObamaCare care plan isn't yet available? This coverage gap is real, and the White House has said it has no plan B to prevent this frightening problem.

Looking forward, the flaws in the law may prove to be getting worse, not better. The young and healthy are not signing up, which is bad news. Connecticut, for example, 61 percent of the enrollees are between the age of 45 and 64; in California, 56 percent. And that is double their proportion of the State's population. But without the right mix of the young and old, the healthy and sick, healthcare premiums for 2015 will skyrocket, access to care will become more limited, and insurers may no longer offer coverage. Plus the mandate on local businesses slams into effect in 2015, forcing local companies to consider cutting hours, or workers, or healthcare benefits to comply with the onerous law.

Today's hearing is not about a new and improved marketing campaign. It is not merely about a defective Web site. It is about the real-life impact of a law that is not living up to the promises made to the American people by President Obama and my Democratic colleagues.

Before I recognize Ranking Member McDermott for the purposes of his opening statement, I ask unanimous consent that all Members' written statements be included in the record. Without objection, so ordered.

And I will recognize Ranking Member Dr. McDermott for the opening statement.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I want to welcome all our witnesses, and especially my fellow Washingtonian Congressman Kreidler, now Commissioner Kreidler.

As we look at the progress of the Affordable Care Act, I would like us to remember how it got here. With the way we talk about the ACA, one might wonder why would we ever abandon the old system in the first place? I will tell you why: It was unhealthy, it was unfair, and it was unsustainable. Healthcare costs, one of the largest contributing factors to our national debt, were out of control. People were going bankrupt. The cost of providing care to the uninsured added an extra $1,000 a year to each family's household bills through higher taxes, premiums, and healthcare costs. Coverage was dropped when customers needed it most, and over the country those with preexisting conditions were just out of luck. So let us keep those conditions in mind as we discuss our progress. It wasn't the Democrats that wanted a better system, it was America.

Are we as a society better off now? The answer is a resounding yes. We have made huge improvements in the system. It hasn't been perfect, and I am sure we will hear some interesting and upsetting testimony today about our witnesses'—from our witnesses, though what I have read, many of their assertions are unreliable, if not untrue. Even with glitches, the ACA reforms are making the insurance industry more accessible, fair, and cost-efficient than ever before.

Looking at our progress, I am less concerned about Web sites than the reality that we are creating two separate Americas. While one-half of our country moves ahead with affordable health insurance, the other half is being left behind. Places like Indiana, Georgia, Florida have chosen not to expand Medicaid, leaving hundreds of thousands of people who are most vulnerable with no help available. Texas has over a million people that could be insured at no cost to the State if the Governor chose to expand Medicaid. Instead,

Texans who need it most, the working poor, families on minimum wage, and veterans trying to get back on their feet get nothing.

It is hard to imagine a reason for this other than simple spite. It is cruel and fiscally irresponsible. Hospitals in these States will lose billions of dollars in revenue as they provide more uncompensated care instead of accepting a half a billion Federal dollars. Mississippi has transferred 4.4 million from its State budget, including education funding, to pay hospitals for uncompensated care. Some hospitals have had to close facilities and service lines.

And if that weren't enough, Republicans are urging constituents to turn down affordable care. Oklahoma has filed a lawsuit arguing that Oklahomans are not entitled to the tax credits through the exchange. Tennessee, among others, is trying to create penalties to make it as hard as possible for churches and nonprofits to help people sign up. A good Samaritan, even a friend or a neighbor, caught, quote, "facilitating enrollment," close quote, without being vetted, fingerprinted, and registered with the State, could be fined $1,000 for each offense. All this to make the President look bad.

Now, fortunately, we have an unbiased witness here today who is actually making this all work. Commissioner Kreidler can speak directly to what happens when a State cares about its people. He has actual experience in the front lines of implementation. Washington State has reached nearly 175,000 enrollments through our State exchange, and those numbers are growing every day. Each—our exchange is robust and, with the exception of a few issues, has run pretty smoothly.

I had a constituent call my office irate that his insurance company had canceled his plan and offered him a new one at double the price. The next day he called back. He went to the exchange and found a better plan with his old insurance company for less than he was paying before.

As the home of companies like Microsoft, Amazon, Starbucks, Washington State knows about launching big projects. The Boeing 787 wasn't built in a day. Success doesn't come without bumps. It takes commitment; it takes investment and patience. If Bill Gates had stopped at the first hiccup, where would the personal computer be today? We knew this wouldn't be easy, but it is worth it, and this is the reform that America wants and needs.

I yield back.

Chairman BRADY. Thank you, Dr. McDermott.

Today we will hear from four witnesses: Grace-Marie Turner, president and trustee of the Galen Institute; Dr. Scott Gottlieb, resident fellow at the American Enterprise Institute; Chris Carlson, principal at Oliver Wyman Actuarial Consulting, Incorporated.

And I would like to turn to our Ranking Member to introduce our fourth witness.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

I mentioned Commissioner Kreidler. He was a Member in 19—he came in in the sweep of 1992, when a lot of Democrats came in here, and the Clintons were elected, and we thought we were going to have health care. And he was here to work on that. He and I had worked in the legislature for a number of years on this whole issue and put together the Washington Basic Health Plan and other things.

Two years later, he was back in the State of Washington doing other things after the failure of the Clinton effort. He since then has become the longest sitting insurance commissioner elected—elected commissioner in the country, and knows all the ins and outs of this issue, and will be a good witness today for people to find out what happens in a State where they went from the first day to make it happen, and they have done a very good job. So it is my great pleasure to introduce Mike Kreidler.

Chairman BRADY. Right. Thank you, Doctor.

Ms. Turner, you are recognized. And we reserve 5 minutes for each of the opening statements.

STATEMENT OF GRACE-MARIE TURNER, PRESIDENT AND TRUSTEE, GALEN INSTITUTE

Ms. TURNER. Thank you, Mr. Chairman. Thank you, Chairman Brady, Ranking Member McDermott, distinguished Members of the Committee, for the opportunity to testify today.

All eyes have been focused recently on the Web site, but there are many challenges that I would like to talk about that are in store that will impact tens of millions of Americans who are not affected directly by the law, according to the President. He says 85 to 90 percent of Americans who already have health insurance, for them their only impact is that their insurance will be stronger, better, more secure than it was before; they don't have to worry about anything else. But that is really not their experience.

I will focus primarily on the impact on the 150 Americans who have coverage through their employers; employers have been providing health insurance voluntarily for more than 70 years. They see it as a way of attracting good workers. But the ACA places significant burdens on them that are really forcing them to rethink their arrangements.

Small businesses are hit especially hard. An estimate in the June 2010 Federal Register predicted that up to 80 percent of small business plans could be lost because they don't comply with the ACA's requirements. Many employees will find that their new ACA-compliant coverage is more expensive and less attractive, higher premiums, higher deductibles, and narrower networks.

The Congressional Budget Office estimated that as many as 11 million workers could lose their health insurance simply because their employers find that they have no choice but to pay the fine and drop their health insurance coverage. The American Action Network suggests the number could be as high as 35 million people, in small businesses primarily.

Many employers also are being forced to cut hours so that they can stay under the 50-employee, full-time employee cap. This is a significant income loss, obviously, for the employees, but it is also a painful decision for employers who really want to keep full-time workers and is disruptive for their businesses.

I have spoken with the owners of many small businesses who say that the $2 to $3,000 fine would basically consume their entire profit margin, not just providing health insurance. And the 1-year delay really isn't helping because they have to plan longer term for their—for business planning. A delay in the shop exchange was

really—that the chairman mentioned was yet another blow to them.

I describe in my testimony, my written testimony, many of the new taxes and other mandates and penalties that employers face. In particular, the tax on individuals, a $63-per-person tax, that adds the cost of every health insurance policy, the tax that will cost families an additional $360. These add taxes and no new benefits, and it is simply pushing up the cost of coverage.

Susan Carrick, who is head of human resources at the University of Virginia, described what her choices are. She said, when medical expenses go up, which they have and which they are, we can either increase premiums, or we can reduce what we pay out in the way of benefits. She said, the law is expected to cost $7.3 million to the University of Virginia's health plan in 2014 alone.

In addition, of course, millions of people with individual policies are really among the first targets of this law. They are losing their coverage. Five percent of Americans represents 15 million Americans that we think we really do—must attend to are having a difficult time finding coverage.

I do believe that there are some near-term policy fixes that are going to be required. There—the House passed, of course, the Keep Your Coverage Act. The Senate has a similar measure that Senator Johnson is offering. And I think that if we can encourage the Senate to take that up, we need to give people a chance who have coverage that they like, who can't get onto the exchange, who find the exchange coverage is more expensive, that they find that they are able to keep their policies.

Second, and I think this is crucially important, those who are on high-risk plans now, either the 200,000 or so who are on the 35 State high-risk pools, many of which are being closed, or the about 100,000 who are on the Federal temporary high-risk plan, are desperately trying to get new coverage. Many of them have chronic illnesses, they are in the midst of chemotherapy, and they have a child with significant health problems. They need someplace to go for coverage. And I strongly encourage us to think about what we can do to extend those high-risk programs to make sure people who desperately need care are not forced to leave coverage.

I see my time is up, Mr. Chairman.

[The prepared statement of Ms. Turner follows:]

A not-for-profit health and tax policy research organization

*****TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING AT 10:00 AM, WEDNESDAY DECEMBER 4, 2013*****

Testimony on

Challenges of the Affordable Care Act

Subcommittee on Health
Committee on Ways and Means

Kevin Brady, Chairman

Jim McDermott, Ranking Member

Wednesday, December 4, 2013

Grace-Marie Turner, President
Galen Institute

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Challenges of the Affordable Care Act

Subcommittee on Health
Committee on Ways and Means

December 4, 2013

Thank you, Chairman Brady, Ranking Member McDermott, and distinguished members of the committee for the invitation to testify today on the impact of the health law and for your diligent oversight of the implementation of this law. My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization that I founded in 1995 to advance free-market ideas for health reform.

All eyes have been focused recently on the functionality of the HealthCare.gov website, but many challenges are in store that will impact tens of millions of Americans who are being told their coverage is not affected by the law. They will face significant and costly changes to their health plans and access to doctors, either due to the health law itself or because of subsequent regulations written by the Obama administration.

President Obama said this spring: "…for the 85 to 90 percent of Americans who already have health insurance…their only impact is that their insurance is stronger, better, more secure than it was before. Full stop. That's it. They don't have to worry about anything else."[1]

But that will not be their experience. I will focus primarily in my testimony today on the impact on the 150 million Americans who have coverage through employers.

Small businesses are hit especially hard: An estimate in the June 2010 Federal Register predicted that up to 80% of small business plans could be lost because they do not comply with the ACA's requirements.[2]

Many will find that their new ACA-compliant coverage is more expensive and less attractive, with higher premiums, higher deductibles, and narrower physician networks. Others will lose their employer coverage altogether as employers just give up because they can't afford to provide coverage that complies with the law's expensive mandates.

A recent survey, conducted by Public Opinion Strategies (POS) for the U.S. Chamber of Commerce and the International Franchise Association,[3] found that 28% of the businesses offering health coverage plan to drop it in 2015.

More than half of businesses with 40 to 70 employees said they will make personnel decisions to stay below the 50 full-time threshold at which the health law requires them to provide health insurance to workers or pay a penalty. They will cut full-time staff and cut hours of part-time workers. New hires will be temporary or part time, and they will

strictly monitor hours. And the owners say they will stop making efforts to grow or expand their businesses. The survey found that 64% of franchise owners and 53% of non-franchise businesses say the law already has had a negative effect on their businesses.

That means some workers will lose their jobs, others will never get hired, and still others will have their hours cut. These employers report that, even with the one-year delay in the employer mandate, many already have reduced worker hours, cut staff, and/or replaced full-time employees with part-time workers.

Employer mandate: Employers have been providing health insurance for their workers voluntarily for more than 70 years. It's good business because offering health insurance attracts good workers and helps to keep workforces healthy. But the ACA places significant new burdens on employers, including onerous reporting requirements and higher costs because of new mandated benefits, which are forcing many employers to rethink this arrangement.

Most employers want to provide health insurance but not all can afford it and still keep their prices competitive. For companies that operate with very tight profit margins, the mandate to provide health insurance can send their bottom line from black to red. Many of them have no choice but to restructure their businesses to avoid the added costs of either the fines or providing expensive mandated health insurance.

I have spoken with many owners of small businesses, especially businesses in the retail and hospitality industries, facing penalties of $2,000 to $3,000 for not providing ACA-compliant health insurance. They tell me that just the penalties will more than consume their profit margins. "It wouldn't even make sense for me to open the doors," one restaurant owner told me.

Companies are being forced to cut hours so they have fewer than 50 full-time workers to avoid the penalties. The health law redefines a full-time work week as 30 hours rather than the traditional 40. Because there is a look-back period, many employers already had begun scaling back employee hours early this year. And many of them cut workers back to 25 hours a week to provide a cushion in case employees' shifts run over.

That is a significant income loss for workers, many of whom are at the lower-end of the income scale. This is a painful and disruptive decision for employers, but they say the law gives them no choice if they want to stay in business at all.

Mandate delay: Businesses got a one-year reprieve from the Obama administration from the reporting requirements involving the employer mandate. But that has not altered their plans to restructure their businesses to comply with the law.

The Congressional Budget Office estimated that as many as 11 million workers could lose their health insurance from employers who pay the penalty rather than the cost of insurance.[4] Other estimates, such as one from the American Action Forum, suggest that

the number could be as high as 35 million.[5] Clearly this law is having far-reaching implications.

A one-year delay in the employer mandate will not significantly change the hiring behavior of employers. They won't hire full-time workers while knowing they would have to let those workers go a year from now. If anything, the delay gives employers more time to figure out how to restructure their businesses and workforces to avoid the added costs of the health law.

Does it matter? Some critics have argued that if all businesses are forced to provide health insurance and raise prices, they will not lose customers because all of their competitors will be operating under the same requirements. But customers are smarter than that: They will buy less, substitute more, and more business transactions will simply vanish.

Delay in SHOP exchanges: In yet another blow, the Small Business Health Options Program was supposed to open this year and provide businesses with more choices of health insurance from competing plans. But the administration announced just before Thanksgiving that the online SHOP tool is being delayed for a year and won't be ready until November of 2014. This affects businesses in the 36 states that are relying on the federal government's exchanges.

New taxes increase health costs: In addition, starting next year, virtually every person covered by a health plan will be taxed $63 – their part of a $25 billion fund designed to help cushion adverse risk among plans participating in the exchanges.

The ACA also imposes an annual "fee" on health insurance companies that is expected to raise $8 billion next year and up to $14.3 billion by 2018. The Congressional Budget Office and industry experts say the tax will largely be passed on to small businesses and consumers buying individual policies in the form of higher premiums.[6] A report by Oliver Wyman consulting says that the fee will increase premiums by $150 per employee and $360 per family in 2014, and that the costs could rise to $360 per employee and $890 per family for small businesses.[7] Self-insured companies are exempt from this tax.

All businesses are impacted: The law is impacting even those with coverage through larger companies: Spousal coverage is being curtailed, deductibles are soaring, and premiums are rising as businesses prepare for the law's taxes, mandates, and regulatory distortions.

Businesses are forced to begin restructuring coverage now in anticipation of the "Cadillac tax" on rich health plans that starts in 2018. The tax will require insurance companies to pay a tax of 40% on the amount by which the total costs of health plans exceed $10,200 for individuals and $27,500 for families. The tax is set to take effect in 2018 and will, of course, be passed along in the form of higher premiums. One way that companies already are reshaping their insurance plans is by increasing the amount that employees must pay before their insurance kicks in – from $1,000 to $3,000, for example.

The International Foundation of Employee Benefits Plans released a survey in August that showed nearly 17% of those responding already had begun to redesign their health plans to avoid the "Cadillac" tax and another 40% are considering action. Sixty percent of these firms say the looming tax is already having a "moderate" or "significant" influence on benefits decisions for 2014 and 2015.[8]

While I believe that the unlimited tax exclusion for employer-provided health insurance does need to be capped, the ACA does it in a way that exacerbates the distortions by taxing the insurance company providing the coverage. If employers had more flexibility in structuring their health benefits to accommodate a tax cap, they would be able to engage their employees as partners rather than adversaries in finding more affordable health insurance arrangements.

Large employers who self insure are exempt from the health insurance tax, but they are subject to this $63 per-person tax to raise $25 billion to cushion the risk of health plans operating inside the exchanges.

Other provisions, such as allowing adult children to stay on their parents' policies up to age 26, no lifetime or annual limits on policy payouts, and providing "free" preventive care, are costing large companies tens of millions of dollars a year in added health costs.

The ACA's mandates and rules impacting businesses, on top of the higher costs resulting from the new taxes, give employers added incentive to drop coverage for their workers and simply pay the penalties.

Other provisions aren't delayed: The delay of the reporting requirements for the employer mandate does not mean that businesses can take a year off from other provisions of the law slated to go into effect in or before 2014, including:

- New federal rules on deductible maximums and out-of-pocket maximums
- 90-day maximum on eligibility waiting periods
- Elimination of lifetime and annual limits (including expiration of waivers that permitted certain "mini-med" plans and stand-alone Health Reimbursement Arrangements to stay in place through plan years beginning in 2013)
- New wellness plan rules
- Fair Labor Standards Act notice to employees informing them of the availability of the new health insurance exchanges
- Summary and benefit coverage notice that must meet rigid federal standards
- $2 fee to fund the Patient-Centered Outcomes Research Trust Fund
- Preventive care services with no cost sharing

These businesses are receiving no relief from these requirements, which add compliance costs and distract them from their core activities. This is severely hampering the jobs recovery our economy so desperately needs.

Business response: Businesses clearly are struggling to respond to the mountain of costs and new compliance rules imposed by the ACA. Susan Carrick, head of human resources at the University of Virginia, said: "When medical expenses go up, which they have for us, then we have two choices: We can either increase premiums, or we can reduce what we pay out in the way of benefits." The law is expected to add $7.3 million to the cost of the university's health plan in 2014 alone.[9]

Individuals impacted: While I have focused primarily on those with employer coverage, it is important to recognize the millions of people who are individually insured and feel the rug has been pulled out from under them. The president repeatedly has disregarded the 5% of people with "junk," "substandard," "sub-par" and "bad-apple" insurance – people who purchase individual health insurance policies for themselves and their families. These are people who have taken the initiative to seek out policies and pay premiums with after-tax dollars to provide health insurance for themselves and their families. They are the first targets of the health law.

The president says they represent "only" 5% of Americans. But that is about 15 million people – hardly an insignificant number.

And finally, the uninsured. The 15% of Americans who are uninsured are the *raison d'etre* of the law's coverage expansion. But even they don't fare well. Of the 48 million people in the U.S. who are without health coverage, at least 30 million will remain uninsured by 2016. The others are either going to be enrolled in Medicaid or forced to navigate the exchange maze.

The problems with enrollment in the federal and most state exchanges make it increasingly likely exchanges will have a disproportionate number of enrollees who are sicker and who have higher health costs.

The exchanges could well become default high-risk pools. Premiums likely will become even more expensive next year (and beyond), driving out the young, healthy people needed to subsidize older, sicker people. The Obama administration signaled this concern when it announced it will delay the beginning of the 2015 enrollment season until after the 2014 elections, apparently to hide the next wave of sticker shock.

Near-term policy fixes. I believe that the ACA will continue to face serious problems and cause continuing dislocations in our health sector and economy, but this is not the forum for a discussion of long-term solutions. There are immediate problems and dislocations which I believe call for congressional action:

1. **Keep your coverage**: Many people are genuinely frightened about the loss of their private insurance policies and the difficulty of finding an affordable alternative. People

who are in the midst of chemotherapy, who have a child with chronic illness, or have other serious health needs are desperate. The House has passed the "Keep Your Health Plan Act," and Sen. Ron Johnson has introduced companion legislation in the Senate. The legislation would grandfather all existing plans, a vital step in protecting millions of people from losing the coverage they have now.

2. **Temporary safety net**: High-risk pools operate in about 35 states and insure about 200,000 people, typically those with medical conditions that make it hard for them to find other coverage. In addition, an estimated 100,000 people have enrolled in the ACA's Temporary High Risk Pool Program, which closes at the end of this year. People receiving coverage through those plans will not have anywhere to go if they cannot enroll on the exchanges.

Many states have closed their state risk pools, but are considering reopening them, at least temporarily. The federal government also hasn't ruled out extending its federal risk pools, but doing so would require congressional approval for the additional funding required. On average, state high-risk pool participants incur about $11,000 a year in medical claims, according to the National Association of State Comprehensive Health Insurance Plans.[10] Those enrolled in the federal high risk pools incur an average of $32,108 a year in medical costs.[11]

I believe Congress and the states would be well advised to keep these safety-net programs in place while a better and more sustainable system is created for people with pre-existing conditions.

3. **Consumer-centered health insurance**: One of the things we see from this rollout is that people like and value the private health plans they have chosen, balancing cost against benefits. But we need to more competition and flexibility in policy design as well as sensible rules that get the incentives right for both companies and consumers. Insurance rules that guarantee renewal of policies at affordable rates tighter with restructuring existing tax credits could begin to build a bridge to a market-based system.

I thank you for the opportunity to testify today and look forward to your questions and discussion.

ENDNOTES

[1] A transcript of the News Conference by the President on April 30, 2013, can be found at http://www.whitehouse.gov/the-press-office/2013/04/30/news-conference-president

[2] "Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule," Federal Register, June 17, 2010 (http://www.gpo.gov/fdsys/pkg/FR-2010-06-17/pdf/2010-14488.pdf)

[3] "Presentation of Findings from National Research Conducted Among Business Decision-Makers," Public Opinion Strategies, September-October 2013 (http://www.uschamber.com/sites/default/files/reports/IFAChamberFinal.pdf)

[4] "CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance," Congressional Budget Office, March 2012 (http://cbo.gov/sites/default/files/cbofiles/attachments/03-15-ACA_and_Insurance_2.pdf)

[5] "Labor Markets and Health Care Reform: New Results," Douglas Holtz-Eakin & Cameron Smith I, American Action Forum, May 27, 2010 (http://americanactionforum.org/sites/default/files/OHC_LabMktsHCR.pdf)

[6] "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act," Congressional budget Office, November 30, 2009 (http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf)

[7] Carlson, Chris, FSA MAAA, "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans," Oliver Wyman, October 31, 2011 (http://ahip.org/Issues/Documents/2011/Oliver-Wyman-Study--Estimated-Premium-Impacts-of-Annual-Fees-Assessed-on-Health-Insurance-Plans.aspx)

[8] "2013 Employer-Sponsered Health Care: ACA's Impact," International Foundation of Employee Benefit Plans, August 2013 (http://www.ifebp.org/pdf/research/2103ACAImpactSurvey.pdf)

[9] Needleman, Sarah, "For Small Businesses, a Hidden Tax in Health Care?" Wall Street Journal, November 22, 2013 (http://online.wsj.com/news/articles/SB10001424052702304607104579210133556240634)

[10] Radnofsky, Louise, "High-Risk Patients Fuel More Health-Law Worry, Wall Street Journal, November 17, 2013 (http://online.wsj.com/news/articles/SB10001424052702303559504579202953343942182)

[11] "Covering People with Pre-Existing Conditions: Report on the Implementation and Operation of the Pre-Existing Condition Insurance Plan Program," Centers for Medicare and Medicaid Services, January 31, 2013 (http://www.cms.gov/CCIIO/Resources/Files/Downloads/pcip_annual_report_01312013.pdf)

Chairman BRADY. Yes. Thank you, Ms. Turner, very much.
Dr. Gottlieb.

STATEMENT OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, THE AMERICAN ENTERPRISE INSTITUTE

Dr. GOTTLIEB. Mr. Chairman, Mr. Ranking Member, thank you for the opportunity to testify today. My name is Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute. I previously served at the FDA and CMS, and I also sit on the policy advisory boards to the Society of Hospitalist Medicine and the Leukemia and Lymphoma Society, as well as being a clinical assistant professor at the NYU School of Medicine.

In time, the existing parts of this Web site will be fixed, but more significant challenges remain related to issues around provider access and the quality of the medical care. I fear many consumers who enroll in these plans will find themselves disappointed by the resulting health plans, or, worse, get caught in difficult financial and medical binds. And I want to focus on three significant but remaining challenges that I believe will lower the quality of the resulting care and hinder consumer access to needed medical services. I believe there are steps we could take today to mitigate these challenges, but unless we act quickly, the law does not provide flexibility to address some of these problems.

First, the information infrastructure required for reconciling someone's coverage with his health plan or his providers has not been constructed; in some cases, simply does not exist. As a result, it is likely that there will be delays in enabling premiums to be collected and paid to health plans, and, in turn, health plans are likely to withhold payments to providers. People signing up for coverage may not, as a practical matter, be covered starting January 1st. This needs to be addressed by Congress immediately to avoid significant potential hardships.

Second, it is now well established that more than 50 percent of the plans sold on healthcare.gov are narrow network options that offer a very limited choice of providers. I don't think the full scope of how restrictive these networks have become is fully appreciated or the extent of the costs that will get transferred to patients. This is going to put particular hardship on patients with special medical needs and serious illnesses. And, once again, the statute and regulations do not afford easy ways to mitigate these challenges.

To give you some context for how this is playing out at a practical level, we are providing from AEI today some data we developed on Blue Cross Blue Shield—one Blue Cross Blue Shield plan that operates in nine different States. We compared the exchange network to their commercial individual market PPOs, just six categories of specialists. We consistently found that the exchange-based plans offered just a fraction of the specialists available in competing non-exchange PPOs, and we looked at the most populous counties to give them the best chance at coming out ahead.

Among some of our other anecdotal findings, we found a plan in Florida that currently has only 7 pediatricians in its network that serves a county that has 260,000 children, according to census data. In San Diego, we found a health plan doesn't have a single pediatric cardiologist in its network. In San Bernardino County, we

found a plan with the nearest urologist that was offered was 80 miles away, and the same plan has nine dermatologists in it, but none of these doctors seem to perform mole surgery for skin cancer, and most of them are at least 100 miles away from the county.

The problems are made worse by incomplete oversight that has been applied to resulting plans. Review of plan design, network adequacy was rushed and done poorly. With lax oversight there is a risk that plans can inadvertently or sometimes intentionally game the risk pool by their choice of providers and their design of networks.

And, finally, keep in mind that these narrow networks do not just affect providers. The same constructs will also hamper patient access, especially drugs. If you are on a non-formulary medicine, you could be saddled with much or all of the cost of the medicine. This is going to be a particular burden to patients with significant conditions, like cancer. These cuts won't count against out-of-pocket limits, deductibles, or lifetime caps.

Third and finally, there is already evidence that providers are reluctant to sign contracts with the ObamaCare plans, and when they do, reimbursement is being reduced even off the levels that were initially negotiated under some ObamaCare contracts. There should be every reason to expect that the same sort of problems with access and quality that challenged the Medicaid program will also challenge ObamaCare.

People who will make out worse under ObamaCare seem to be getting short shrift in a lot of the policy discussions. There seems to be a perception among some that these folks are mostly wealthy or upper-middle-class families. That is not entirely true. Many of these families are solidly middle class, and many struggle financially. Nor are the misperceptions of their relative wealth an excuse to ignore their plight.

The fact is that in aiding those who are burdened in the old insurance markets, and some people will clearly be helped under ObamaCare, it didn't require us to harm those who were doing reasonably well under those old structures. And even those who were previously uninsured or only intermittently insured will find many of the bronze plans that they are being incentivized to join providing lower-quality access.

Thank you.

[The prepared statement of Dr. Gottlieb follows:]

TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING AT 10:00 AM WEDNESDSAY, DECEMBER 4, 2013

Testimony before the Committee on Ways and Means
Subcommittee on Health

Challenges of the Affordable Care Act
December 4, 2013

Scott Gottlieb, MD
Resident Fellow
The American Enterprise Institute

Mr. Chairman Brady, Mr. Ranking Member McDermott: Thank you for the opportunity to testify today before the Committee on Ways and Means, Subcommittee on Health.

My name is Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute. I previously worked at the Food and Drug Adminisration as the agency's Deputy Commissioner and at the Centers for Medicare and Medicaid Services as a senior advisor to the Administrator during implementation of the Medicare Modernization Act.

I am on the policy advisory boards to the Society of Hospitalist Medicine and the Leukemia and Lymphoma Society; and a member of the advisory board to the National Coalition for Cancer Survivorship. I am presently a Clinical Assistant Professor at the New York University School of Medicine. I remain active in the capital markets related to healthcare, and I am closely engaged with a number of the life science and healthcare services companies through a variety of consulting relationships and board assignments.

Right now, all eyes are on healthcare.gov, the troubled electronic portal designed to let consumers purchase health plans sold on the various state exchanges. In time, the existing parts of this web site will be fixed. But more significant challenges remain. These lingering problems relate to issues around provider access and the quality of medical care.

Many consumers who enroll in these new plans will find themselves disappointed by the resulting health plans, or worse yet, get caught in difficult financial and medical binds.

I want to focus today on the medical care that the Obamcare health plans will offer. I want to focus on three significant but remaining challenges that I believe will lower the quality of the resulting care, and hinder consumer access to needed medical services.

I believe there are steps we can take today to mitigate the worst of these challenges. But unless we act quickly, the law as it's presently written (and the exchanges as they are presently designed) does not provide the flexibility to address these woes.

First, the information infrastructure required for reconciling someone's coverage with his health plan, or his providers, has not been constructed. It simply doesn't exist. As a result, it's likely that there will be delays in enabling premiums to be collected and paid to health plans, and in turn; health plans are likely to withhold payments to providers. People signing up for Obamacare coverage may not, as a practical matter, be covered starting January 1. This needs to be addressed by Congress immediately to avoid significant hardship.

Second, it's now well established that more than 50 percent of the plans sold on healthcare.gov (including the lower-cost plans that consumers are being most encouraged to purchase) are "narrow network" options that offer a very limited choice of providers. I don't think the full scope of how restrictive these networks have become is fully appreciated, or the extent of the costs that are going to get transferred to patients. This is going to put particular hardship on patients with special medical needs or serious illnesses. Once again, the statute and regulations do not afford easy ways to mitigate these challenges.

Third, and finally, there is already evidence that providers are reluctant to sign contracts with the Obamcare plans, and when they do, reimbursement is being reduced – even off of the levels that were initially negotiated under some of the early contracts. This is how the plans are going to accommodate the higher costs they are encountering as a result of the challenging risk pool that is taking shape in this market. There should be every reason to expect that the same sort of problems with access and quality that challenge the Medicaid program will also challenge Obamacare. In fact, participating health plans have been calling Obamacare "Medicaid Plus." We ought to take these insurers at their word.

Reconciling Coverage with Medical Care

It's been revealed that the information architecture to enable reconciliation of the coverage that people sign up for with payment of premiums and subsidies to the plans they select (and in turn, the provision of payments to providers) hasn't been constructed, or is not working.

Politico reported Sunday and the Wall Street Journal reported similarly on Monday, that the focus of efforts to fix the web site continue to be on getting the registration process resolved so that people can go on-line to enroll.[1] That decision has meant that insurers are still getting faulty reports on consumers who have signed up for coverage. Consumers may believe they have signed up for coverage, but are not actually enrolled into the plan.

Insurance industry sources say that they believe that they can receive the premium payments consumers have to make after they enroll, but that the system isn't in place to deliver the federal subsidies to health plans for beneficiaries who are eligible for these payments.

The New York Times reported Monday that for insurers, the process is maddeningly inconsistent. Some people clearly are being enrolled. But insurers say they are still getting duplicate files and, more worrisome, sometimes not receiving information on every enrollment that's taking place. "Health plans can't process enrollments they don't receive," said Robert Zirkelbach, a spokesman for America's Health Insurance Plans.[2]

This won't be resolved by January 1. It raises a series of troubling question for consumers:

Will the insurers honor the coverage that consumers have purchased in situations where the companies have not been paid for providing those health plans? If the insurers do honor these contracts, what will they do about making payments to providers? It's hard to imagine that the insurance companies will release funds to doctors, to compensate them for delivering care, in circumstances where the insurers themselves have not been paid. There are ways to address this, perhaps through government guarantees to backstop gaps.

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[1] Carrie Budoff Brown. Inside the War Room, Watchful Eyes as D-Day Hits. Politico, November 30, 2013. http://www.politico.com/story/2013/11/obamacare-website-deadline-100486.html#ixzz2mBlO8UC5

[2] Robert Pear and Reed Abelson. Insurers Claim Health Website Is Still Flawed. The New York Times, December 1, 2013

But right now, there is no obvious fix in place, and these problems will soon go live. One anonymous, insurance industry source framed the problem this way in a recent article published on Politico: "If people are enrolling, but the back-end systems are not working, their coverage could ultimately be disrupted. They may think they're enrolled in a plan and they're not. They may show up at the doctor's office and not be covered."[3]

Network Adequacy

On the second point, the narrow networks that will be the hallmark of the majority of the Obamacare plans: A number of factors have encouraged very restrictive health plans that will place painful burdens on some consumers. It didn't have to be this way.

At a high level, Obamacare effectively bars or restricts plans from engaging in the traditional tools that insurers use to manage trend (the cost of providing care under the terms of their contracts). These traditional tools include underwriting for risk (charging more to older members, or those with certain health risk factors); adjusting benefit design, or changing co-pays or premiums to modify consumer incentives and consumption of services.

All of these standard tools are tightly regulated under Obamacare. I don't want to get into a debate on the merits of these decisions, but merely make an observation about one consequence of these regulations. The resulting benefits offered under Obamacare are largely prescribed by regulation. Co-pays and premiums are largely fixed. So there is only one cost-control tool that remains, that insurers are largely free to adopt: adjusting networks, and coinsurance. Since this is, for the most part, the only significant leverage that plans have to manage costs; they have used their discretion over provider networks to its maximum extent.

To give you some context for how this is playing out at a practical level, we are providing some data we developed on one BlueCross, BlueShield plan that operates in nine different states, where we compared the exchange network to their commercial or individual-market PPO for six specialist provider categories. We looked at the plans being sold in each state's largest county. We consistently found that the exchange-based plans offered just a fraction of the specialists available in the PPO plan offered by the same insurer in the same region.

Among some of our other, anecdotal findings across different plans and different markets:

We found one low cost plan in Florida that currently only has seven pediatricians in its network, to service a county that has 260,000 children according to census data[4].

In New York City, we found a plan that doesn't list a single gynecologist in its current provider network[5], and another plan that doesn't have a single cardiologist.[6]

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[3] Jessica Meyers. Tech official: Up to 40% of Obamacare work left. November 19, 2013. http://www.politico.com/story/2013/11/tech-chief-didnt-see-march-obamacare-memo-100058.html#ixzz2mBqhiiAJ
[4] Humana Florida HMO, Bronze Plan
[5] Health Republic Insurance Primary Select EPO
[6] Emblem Health Select Care Bronze

In San Diego County, we found a health plan that doesn't have a single pediatric cardiologist in its network. In San Bernardino County, the nearest urologist offered by one plan is 80 miles away. The same health plan has 9 dermatologists but most of these doctors are at least 100 miles away and none appear to do specialized skin cancer surgery.[7]

Even in most cases where plans offer choice among a larger complement of providers, the networks are still granting their Obamacare plan enrollees access to just a fraction of the providers available in their commercial plans. Statewide in California, Blue Shield of California reports that its exchange customers will be restricted to about 50 percent of its regular physician network offered in its commercial plans.[8] This seems fairly consistent across different plans and different markets. Some plans appear to offer much less. The lack of contracted providers may strain the ability of patients to get non-urgent appointments.

In Kentucky, to take another example, Anthem BlueCross BlueShield offers consumers in the states third most populous county access to 141 cardiologists in a typical commercial plan. The Obamacare bronze plan only includes access to about 61 cardiologists. In the states most populous county (Jefferson) consumers enrolled in Anthem's commercial PPO will get access to a network that includes 113 different oncologists. Those enrolled in the company's bronze Obamacare plan can only access 52 of those providers.

With most of these plans, if consumers go outside their health plan's prescribed network of doctors, the co-insurance is very high. In some cases (especially with lower-cost "bronze" plans) consumers will be saddled with the entire bill when they go outside their network, and these outlays won't count toward their deductibles or out of pocket caps. It's now been well documented that specialty hospitals like cancer centers and most of the academic hospitals are being excluded from these networks, largely because these top tier institutions – which often deliver the highest levels of care – are nonetheless seen as too costly.

For routine health matters, this may be of less concern. But if patients develop more serious conditions requiring expert attention, the cost of going "out of network" to seek care at one of these specialty institutions is likely to be prohibitively expensive for many consumers.

It didn't have to be this way. Moreover, there are ways to alleviate some of these challenges. But as the law is now written, most of the problems will only grow worse next year, not only because of marketplace challenges, but also because of the way in which the plan subsidies get "re-priced" year-over-year – off the second cheapest silver plan that operates in a particular market (which may well be an extremely narrow network plan). Year over year, this will put substantial downward pressure on the pricing of the plans, and their quality.

There is a fundamental problem with how these plans were designed that leads to these narrow networks. By limiting the ability of plans to adjust other aspects of the coverage, the insurers are forced to ratchet down their networks (and cut reimbursement to providers) as

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[7] Molina Healthcare Covered California Bronze HMO

[8] Chad Terhune. Insurers Limiting Doctors, Hospitals in Health Insurance Market. The Los Angeles Times, September 14, 2013

their only tool to control costs. This is precisely how the economics of Medicaid operates, and there should be every reason to expect that the outcome for the Obamacare plans will be similar to the experience under Medicaid -- if not in magnitude, than certainly in scope.

Some states, such as Washington, are taking steps to try and ensure that consumers have access to a particular specialist when a doctor with the required skills or training isn't already included in their network. But the state is struggling to define in regulation exactly how such a safeguard would operate. For example, how would you define when a network doctor lacks the requisite skills – would it be by virtue of their training, or their practical experience?

The problems are made worse by the poor oversight that has been applied to the resulting plans. Review of plan design and network adequacy was rushed, and done poorly. The career staffs at CMS generally have incomplete criteria and argue that they don't have a basis to judge network adequacy given their lack of experience in commercial markets. It's an accurate self-assessment. CMS has imperfect criteria for ensuring network adequacy. They have little experience with these tasks, and have not had time to develop proper regulations.

With lax oversight, there is a risk that plans can inadvertently or intentionally game the risk pool by their choice of providers and their design of networks.

For consumers, information about the resulting networks is generally hard to find and many of the networks haven't been fully established, or are suffering from provider cancellations. The best news for consumers may be that they can probably enroll in a plan for January, and then cancel it once they test the network and enroll in another plan before the end of March. All they would loose in such a scenario is probably the first month's premium they paid.

Finally, keep in mind that these narrow networks don't just affect access to providers. The same constructs will also hamper patient access to specialty drugs. If you are on a non-formulary drug, you could be saddled with much (or all) of the cost of that medicine.

This is going to be a particular burden to patients with significant conditions like cancer, where the formularies are likely to be more restrictive and not include the full complement of new and costly drugs. Moreover, these out-of-pocket costs will not count against a patient's out of pocket limits, their deductible, or their lifetime caps.

Patients will have the option to appeal these non-formulary decisions, and if they win, the cost of the out-of-pocket spending will count against their deductible and out-of-pocket limits. But this is a last ditch reprieve that not many families are going to be able to take advantage of. For one thing, these appeals take time, and they may not be able to wait. The patient could be out-of-pocket for a significant amount of money before they win an appeal.

Moreover, even if there is a high chance that a patient might win an appeal, the prospect that they could lose might present such a substantial hardship that they will not be willing to take the risk. On a risk-adjusted basis, the costs will be too high. This is likely to be especially true for the lower-income families that will comprise the bulk of Obamacare enrollees.

In the end, many middle class consumers are being forced to make a choice that consumers already rejected in the 1990s when they jettisoned restrictive HMOs in favor of PPOs and

other more flexible arrangements. In making these choices, consumers demonstrated that they valued flexible networks over the breadth of benefits and, moreover, were willing to trade higher co-pays and deductibles to have access to a wider range of providers.

For patients who were previously uninsured, these narrow network plans may be a reasonable tradeoff for the promise of secure health coverage. There is no question that some people – particularly the uninsured or those who were episodically insured -- will benefit under Obamacare. This is especially true for lower-income families who will benefit most from the subsidies. But a lot of people will also be put at a significant disadvantage, especially many of those who were previously insured in the individual or small group markets, who find themselves moved from PPO-style plans to restrictive HMOs and EPOs.

Middle class consumers are also likely to face higher costs. By my rough calculations, unless you are below 250% of the Federal Poverty Level, then even with the benefit of subsidies, the Obamacare plans are likely to be more expensive than a comparable plan available in the individual market. This, of course, varies by state. But it is a reasonable rule of thumb.

Here is Washington we can talk in an abstract fashion about the advantages of the new plans that cover maternity care and pediatric dental and broaden the distribution of risk sharing, but for consumers who neither wanted or needed this coverage, these paper benefits cannot compensate for what they have given up. The simple question I think we all need to ask ourselves is whether it was necessary to degrade the opportunities enjoyed by some Americans, to improve the circumstances of others. I don't believe this is a tradeoff that was necessary, and I don't believe it is a tradeoff that we need to accept.

Challenges Facing Providers

Challenges are also emerging in the provider space. These problems will, in turn, affect patient care. There's evidence that health plans are already reducing the rates that they pay to providers under the Obamacare plans, and trying to re-negotiate existing contracts.

On the one hand, these rates are generally being set low, typically as a discount to Medicare. In some cases, there are reports that the rates are commensurate with those paid under Medicaid. There should be every reason to expect that, as a consequence, the networks for these plains will suffer from the same access problems that plague the Medicaid program.

Worse still, there are some reports that health plans are seeking to re-negotiate some of the existing contracts with providers, and lower rates still further. No doubt, this is a response to the challenging roll out, and a perception that the resulting risk pool (and cost to insurers) will be higher than originally anticipated. Insurers are trying to offset some of the anticipated losses by reducing the amount of money they spend on their nascent networks.

For all of these reasons, we should expect that the networks will continue to erode. Doctors that have signed contracts with Obamacare plans will start to drop out. Estimating how many is difficult. Providers who have not signed contracts will be unlikely to do so, not only because of the low payment rates, and the uncertainty around that reimbursement, but the prospect that payments could be put on hold until the back-end problems with the web site and the reconciliation process are resolved; and because the risk pool is likely to be older,

more sick, and therefore more costly than anticipated. Providers who are being offered capitated contracts under HMO models are going to be rightly nervous about committing to these pools. They will be unsure of the eventual risk they are taking and the resulting costs.

Conclusion

The rollout of Obamacare has been challenging. But the registration issues are likely to be resolved in time. The real problems will emerge once people try to access the health coverage, and seek care under these plans. For some, mostly lower middle class and lower-income consumers too wealth to qualify for Medicaid, the chance to access affordable and durable private coverage will be an important opportunity. But for every consumer that is made better off under this scheme, there will be other consumers that are harmed.

These people who will make out worse under Obamacare – the Obamacare losers -- seem to be getting shorter shrift in political discussions. There's a perception among some policy observers that these folks are mostly wealthier, upper middle class families. That's not entirely true. Many of these families are solidly middle class, and many struggle financially. Nor are the miss-perceptions of their relative wealth an excuse to ignore their plight.

These problems are likely to get worse as this "market" evolves. The risk pool experience this year is going to cause premiums to rise next year. Even in California, which has been held up as a model of early success, there are some obvious challenges emerging.

Data released by Covered California shows that, so far, 34 percent of total enrollment is comprised of people aged 55-64, the highest mix among age brackets. Another 22 percent of enrollees were aged 45-54. Therefore, 56 percent of California's total exchange enrollment in October was people aged 45-64. Yet California's total population of residents that are aged 45-64 is only 25 percent. Individuals aged 34 or under comprised just 28 percent of October exchange enrollment. This is below the 49 percent of Californians in this age range.[9]

Even more worrisome should be the fact that the vast majority of people who are enrolling in the plans are not eligible for premium subsidies. So they are paying hefty fees for the coverage. It would seem to suggest that the older folks who have enrolled so far have concluded that they are especially likely to tap the healthcare services offered by the plans, making it worth the high cost. In total, only 16% of the people who enrolled in Covered California in October were eligible for premium and cost-sharing subsidies.

How much premiums will need to rise next year to offset the financial costs of the year-one experience is still a source of speculation, but its becoming clearer that the risk adjustment will not be able to fully offset the bad initial experience. The big commercial insurers have largely sat out this launch. There is no reason to expect that plans not entering the market this year will get into the market for 2015. The choices that patients have are not likely to

[9] The figures include enrollment through October 31. The one piece of good news California officials were touting: 18- to 34-year-olds made up 22.5% of the enrollment in October. The same age group makes up 21% of the state's population.

change that much as a result. So far, it has mostly been the Blues and the Medicaid HMOs that have offered the most products on the exchanges. This will probably remain the case.

Among other things, there are incentives for private insurers to remain completely outside Obamacare. By doing so, they are able to adjust the premiums that they change to the risk pools that they are able to solicit outside the exchanges. Middle class families that have been dropped from their existing coverage, and don't benefit from the subsidies, may do better by staying out of the exchanges. When the insurers start to adjust their financial models to accommodate this new reality, the costs of the exchange-based coverage could rise further.

The fact is that in aiding those who were burdened in the old insurance markets, it didn't require us to harm those who were doing reasonably well under those structures.

The biggest challenges lie ahead of us, when people start to tap their new coverage. Many of those who previously had commercial coverage will find the new arrangements constraining. Even those who were previously uninsured or only intermittently insures will find many of the bronze plans that they are being incentivized to join deliver low quality access.

Chairman BRADY. Thank you, Doctor.

Mr. Carlson.

STATEMENT OF CHRISTOPHER CARLSON, PRINCIPAL AND CONSULTING ACTUARY, OLIVER WYMAN ACTUARIAL CONSULTING, INCORPORATED

Mr. CARLSON. Good morning, Chairman Brady, Ranking Member McDermott, and Members of the Subcommittee. My name is Chris Carlson, and I am the principal and consulting actuary at Oliver Wyman. I would like to thank you for affording me an opportunity to share my perspective on the Affordable Care Act.

My testimony will focus on the consequences of the difficulties encountered in implementing the ACA. The specific issues that I will address are, first, the enrollment issues which have led to initial enrollment in individual policies falling well below original estimates; second, the extension of current individual policies that do not meet the requirements of the ACA's minimum coverage requirements; and, third, I will discuss the premium rates that are available to individuals on the exchanges.

First, regarding the low initial enrollment, it is too early to make any speculation about the final enrollment numbers for 2014, but given the low enrollment numbers that we have seen, there is an expectation that the enrollment will be less than expected. In fact, Goldman, Sachs & Company has revised down projection estimates of the Federal exchange enrollees from 7 million to 5 million.

Also, early indications are that the younger enrollees, who are crucial to the goal of having a balanced risk pool, may be enrolling in rates less than expected. If younger individuals do not enroll at the expected levels, the subsidies that are built into the rates that allow for premium rates to be lower at the older ages will not be realized, putting a strain on the overall risk pool.

Next I will briefly discuss the President's use of non-enforcement of existing law to allow for the extension of current policies that do not meet the minimum coverage requirements under the ACA. There are a number of potential outcomes that could result from this extension. First, studies prepared by the Society of Actuaries show that those currently insured in most States have better morbidity risk than the new enrollees expected for 2014. Therefore, it was expected that premiums would go up because of this increased morbidity risk. Furthermore, many current policies do not provide sufficient benefits to meet the minimum coverage requirements of the ACA. Therefore, individuals who are currently insured in less than sufficient policies would see further increases due to an increase in benefits for the exchange policies. While this generally is a trade-off between premium for additional benefits, those opting to drop current, less generous policies are those that are likely to need that additional benefit coverage. Both of these factors lead to an expectation that the pool of members enrolling in the ACA-qualified plans on the exchanges will have higher morbidity risk than if the extension of policies was not allowed.

In addition, since insurers have not been given the opportunity to revise the premium rates on the exchanges, it is likely that these policies will be underpriced. As a result, we have seen hesitation

from some State insurance regulators to allow for the extension of these policies.

It is too early to provide any empirical data to estimate the impacts of the exchanges on the expected costs for 2014; however, the American Academy of Actuaries has identified three primary consequences of the extension of current policies. One, premiums for 2014 may not adequately cover the cost of providing benefits for an enrollee population with higher claims than anticipated; costs to the Federal Government could increase as higher-than-expected average medical claims are more likely to trigger the risk-corridor payments; and, third, relaxing the plan cancellation requirements could increase premiums for 2015. Insurers could not increase premium in future years to make up for prior losses; however, assumptions regarding the composition of the risk pool would reflect this plan experience for 2014.

There has been much written and said about the premium rates on the exchanges. Depending on the point of view, premium rates are either much higher than expected or much lower than expected. However, I will repeat what was said in the hearing of the House Energy and Subcommittee on Oversight and Investigations by Cori Uccello, an actuary of the American Academy of Actuaries: "How premiums will change depends on many factors. The new benefit requirements that may lead to higher premiums but lower out-of-pocket costs, how each State's current issue and rating rules compare to those beginning in 2014, and each individual's demographic characteristics and health status."

All of these things remain true. I will highlight a couple of these items that merit specific attention. First, individuals who are seeing the greatest increases in premiums are those who had the least amount of coverage; therefore, the initial premiums for additional benefits.

Second, any consideration of the increase in premium rates is considered prior to the availability of the premium subsidies that would reduce the actual out-of-pocket costs for individuals.

That concludes my oral testimony, and I thank you for inviting me, and I look forward to answering any questions.

[The prepared statement of Mr. Carlson follows:]

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TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING AT 10:00 AM WEDNESDAY, DECEMBER 4, 2013

Testimony of

Christopher Carlson

Principal and Consulting Actuary

Oliver Wyman

Before the United States Committee on Ways and Means
Health Subcommittee

"Challenges of the Affordable Care Act"

December 4, 2013

Washington, DC

Good morning Chairman Brady, Ranking Member McDermott and members of the Subcommittee. My name is Chris Carlson, and I am a Principal and Consulting Actuary at Oliver Wyman, a business unit of Marsh & McLennan Companies (MMC). I would like to thank you for affording me an opportunity to share my perspective on the Affordable Care Act (ACA).

My testimony will focus on the consequences of the difficulties encountered in implementing the ACA. The specific issues that I will address are:

- First, the enrollment issues which have led to initial enrollment in individual policies falling well below original estimates.
- Second, the extension of current individual policies that do not meet the requirements of the ACA's minimum coverage requirements.
- Third, I will discuss the premium rates that are available to individuals on the exchanges.

I. Low Enrollment

First, regarding the low initial enrollment, it is too early to make any speculations about the final enrollment numbers for 2014, but given the difficulty for individuals to enroll through the online portal, and the low enrollment numbers that we have seen, there is an expectation that the enrollment will be less than expected. For example, the initial enrollment in the federal exchange for October was about 27,000 members versus an initial goal of 500,000 enrollees for the month. In November, it has been reported that 100,000 individuals have been enrolled. However, according the

Associated Press, private insurers have complained that the enrollment data contains errors and duplications, which means any estimate needs to be considered with caution. Further, analysts at Goldman, Sachs & Company have revised down projection estimates of federal exchange enrollees from 7 million to 5 million for 2014.

Also, early indications are that the younger enrollees, who are crucial to the goal of having a balanced risk pool, may be enrolling at rates less than expected. According to an article in the Wall Street Journal, several health plans have reported that the proportion of members older than age 50 has exceeded their expectations. If younger individuals do not enroll at the expected levels, the subsidies that are built into the rates that allow for lower premium rates at the older ages will not be realized, putting a strain on the overall risk pool.

II. Extension of Current Policies

Next, I will briefly discuss the President's use of non-enforcement of existing law to allow for the extension of current policies that do not meet the minimum coverage requirements under ACA. There are a number of potential outcomes that could result from this extension. First, we have seen in studies prepared by the Society of Actuaries that those currently insured in most states have better morbidity risk on average than the new enrollees expected in 2014. Therefore, it was expected that premium rates would go up because of the increased morbidity risk. Furthermore, many current policies do not provide sufficient benefits to meet the minimum coverage requirements of the ACA. Therefore, individuals who are currently insured in less than sufficient policies would see further rate increases due to an increase in benefits. While this

generally is a tradeoff of swapping premium for additional benefits, those opting to drop current, less generous policies, are those that are likely to need that additional benefit coverage. Both of these factors lead to an expectation that the pool of members enrolling in the new ACA-qualified plans will have higher morbidity risk than if the extension of policies was not allowed. In addition, since insurers have not been given the opportunity to revise the rates on the exchanges, it is likely that these policies will be underpriced.

As a result, we have seen hesitation from some state insurance regulators to allow for the extension of these policies. For example, the state of Washington chose to decline the opportunity to allow current policyholders an extension because of the disruption that it would cause in the marketplace.

There are certain protections in the ACA that mitigate this risk, such as the reinsurance provision, which has been expanded due to the lower expected enrollment, and the risk-sharing corridors. However, even with these risk mitigating programs, the insurers stand to be at risk if the morbidity risks are higher than expected.

Unfortunately, it is too early to provide empirical data to estimate the impact of these changes on the expected costs for 2014. However, the American Academy of Actuaries has identified three primary consequences of the extension of current policies:

1. Premiums approved for 2014 may not adequately cover the cost of providing benefits for an enrollee population with higher claims than anticipated in the premium calculations.

2. Costs to the federal government could increase as higher-than-expected average medical claims are more likely to trigger risk-corridor payments.

3. Relaxing the plan cancellation requirements could increase premiums for 2015. Insurers cannot increase premiums in future years to make up for prior losses. However, assumptions regarding the composition of the risk pool would reflect plan experience in 2014.

III. Premium Rates on Exchanges

There has been much written and said about the premium rates on the exchanges. Depending on the point of view, premium rates are either much higher than expected or much lower than expected. However, I can repeat what was said in the hearing of the House Energy and Commerce Subcommittee on Oversight and Investigations by Cori Uccello of the American Academy of Actuaries: "*How premiums will change depends on many factors…the new benefit requirements that may lead to higher premiums but lower out-of-pocket costs…how each state's current issue and rating rules compare to those beginning in 2014, and each individual's demographic characteristics and health status."* All of these things remain true. I will highlight a couple of these items that merit special attention. First, individuals who are seeing the greatest increase in premiums are those who had the least amount of coverage. While I have read of examples of individuals seeing 150% or more rate increases, many of these individuals had substandard coverage and at least part of the increases are due to increased benefits and lower cost-sharing. Second, any consideration of the increase in premium rates is considered prior to the availability of premium subsidies which would reduce the actual

out of pocket costs for individuals. Finally, without substantial increase in enrollment in the exchange, consistent with original expectations, consumers could expect higher premium rates than they otherwise would see in 2015 due to the composition of the risk pool.

As the Subcommittee and the Congress deliberate further on this important issue, I and my colleagues at Oliver Wyman are ready to collaborate with you to offer our experience and expertise on this key public policy matter.

Chairman BRADY. Thank you, Mr. Carlson.

Congressman Kreidler, welcome back.

STATEMENT OF THE HONORABLE MIKE KREIDLER, INSURANCE COMMISSIONER, WASHINGTON STATE OFFICE OF THE INSURANCE COMMISSIONER

Mr. KREIDLER. Thank you, Chairman Brady. Thank you, Mr. Chairman, and Ranking Member McDermott, and Committee Members.

I would like to try to cover a couple of topics here, the challenges that we have in the State of Washington, the—how it is currently working in the State of Washington, and the need going forward for collaboration.

My name is Mike Kreidler. I am the Washington State insurance commissioner, and in this capacity as insurance commissioner for the State of Washington, I have had lots of conversations with people that contact—we get 100,000 phone calls a year through my office. Over the years this became clear that there were a lot of people out there that were really hurting, who were with limited access to health insurance. It was either unaffordable to them, or they would find out the existing policy they had when they had a major incident in their life, having bad luck that their policy was significantly inadequate to meet their needs.

What I see right now with the Affordable Care Act are the tools, the tools that we need in order to help make sure that people have access to health insurance that is affordable to them. And that is partly because of subsidies that are available to them; also increased access in the State of Washington to the Medicaid program. All of these are making it possible to help. If it isn't the Affordable Care Act, then let us name something else that is going to accomplish essentially the same purposes as the Affordable Care Act.

Washington has significant problems with the current system without the reforms. We have got over a million people without health insurance. In addition to that, we have got 2- to 300,000 people who do have insurance, but it is inadequate insurance, meaning that when they have a medical crisis in their lives, it is not going to meet their needs. Such things as pharmacy coverage, 80 percent, approximately half—80 percent of the individual market in the State of Washington doesn't cover pharmaceutical, much less maternity.

Going forward, as you look at the Affordable Care Act, there are a lot of people that refer to it as somehow a government takeover of our health insurance system. This is built on the private insurance system. It is built on what I saw when I was a Member here, Mr. Chairman, that was put forward with the Dole-Chafee bill that had 20 Republican sponsors in the Senate on it. It is very—very comparable with the philosophy that came forward with the Heritage Foundation in the late 1980s. It really is not a Democratic proposal; it is built on the private insurance system.

Now, Washington does have an exchange. It is up and operating. It is enrolling—as Ranking Member McDermott pointed out, we have got 100,000 people enrolled, 175,000 people who are queued up right now to be enrolled. It is proceeding quite nicely. And for those reasons I said no to the opportunity to extend existing poli-

cies. It would have been very disruptive, as Mr. Carlson pointed out, to our market if we had allowed that to take place, because the Affordable Care Act is working in the State of Washington.

You know, I know that we have had some problems. Whether we talk about the canceled policies, or whether we are talking about Web site's operability, those are challenges, and those are good things to bring up. But it is also important to take a look at major programs historically, whether it is Social Security, whether it is Medicare, or whether it was the pharmaceutical benefit under the Medicare program. They have all had challenges as they started up, particularly when we look at the pharmaceutical program and some of the problems they had. I saw that because I was the insurance commissioner at the time.

What I would like to urge people to do is to be patient. This is in the early stages of enrollment. Don't just look right now and say, this issue right now is an impediment. And the headline of the day is not what we need to be doing. It is being patient and going forward. Focus on the benefits of the Affordable Care Act to consumers. If you can take the name of "Obama" out of ObamaCare and just focus on the benefits, you find the benefits are widely popular in virtually every district in the United States.

Rome wasn't built in a day. And I can tell you right now the problems with our current existing healthcare system didn't occur in a day. We need to be patient, move forward, and focus on enrollment. It is—enrollment is only in its early stages at this point. States like mine need you. I would urge you to be a critic; that is fair, that is reasonable, it is expected, particularly from the party that did not advocate for the Affordable Care Act. But at the same time we need to solve problems, because going forward we are talking about people that are hurting. We need to make changes not just for these people, but also to address the challenges for the U.S. economy if we don't make these changes.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Kreidler follows:]

*****TESTIMONY IS EMBARGOED UNTIL THE START OF THE HEARING AT 10:00 AM WEDNESDAY, DECEMBER 4 2013*****

Testimony of Mike Kreidler

Office of the Insurance Commissioner

On behalf of the State of Washington

Regarding:

Challenges of the Affordable Care Act

Before the Committee on Ways and Means

Subcommittee on Health

House of Representatives

Kevin Brady, Chairman

Jim McDermott, Ranking Member

December 4, 2013

Introduction

Chairman Brady, Ranking Member McDermott, and members of the Committee, thank you for the opportunity to testify today. My name is Mike Kreidler. I serve as the elected insurance commissioner for the Office of the Insurance Commissioner in the State of Washington. It is on the behalf of the citizens of the state of Washington and my office that I present this testimony today.

As the longest-serving elected insurance commissioner in the United States, I would like to share my thoughts on how health care reform is working in the other Washington, the challenges that are indeed before us, and the success that we can create in reforming a broken system if we commit to putting people before politics.

I am a former member of the House of Representatives. I served in 1993 and 1994, representing the Ninth Congressional District. I have a doctorate in optometry and practiced for 20 years with Group Health in the Pacific Northwest.

I also served 16 years in the Washington state Legislature. I am now in my fourth term and approaching my 14th year as Washington's insurance commissioner.

All my years of working as a health care provider, an elected official at the federal and state level, and now as insurance commissioner, have put me in touch with thousands of individuals with no access to health care, other than a hospital emergency room. I have spoken with many others who thought they had health insurance, only to discover that the coverage they believed they had was denied to them when they got sick, had an accident, or had a child.

These experiences have made me an advocate and proponent of health-care reform. No one can doubt that the health-care system we had in this nation was broken and failing our citizens. Without changes, our system would have only become worse.

That is true in the state of Washington. My office has done studies that show that a million of Washington's residents have no health-care coverage.[1] About half of

[1] State of the Uninsured, Health Coverage in Washington State. Costs, trends and projections 2008 to 2014: http://www.insurance.wa.gov/about-oic/commissioner-reports/documents/2011-uninsured-report.pdf[1]

these residents without coverage are employed, often in the lower-wage or part-time jobs that unfortunately became increasingly common during the recent great recession. About 200,000 to 300,000 individuals in Washington are paying for insurance that, for the most part, leaves them without comprehensive coverage in a time of need. The lack of prescription drug coverage and maternity care in many of these plans are but two of the most glaring concerns.

I believe the Affordable Care Act is the first major step toward making changes that will improve the lives of millions of our fellow citizens. The Act has already extended coverage to children with pre-existing conditions. Young people can remain on their parents' plans until age 26.

The Act eliminates lifetime and annual limits on benefit coverage. This is especially important since lifetime and annual limits have bankrupted many Americans, who, through no fault of their own, have been diagnosed with a serious illness such as cancer or multiple sclerosis.

In less than a month, all Americans will have access to health insurance in the individual market – even if they have a pre-existing condition. No longer can an insurance company reject them or ask a lengthy list of probing questions about their health.

Insurance in the individual and small-group markets will not be priced on health or gender. Rates for older Americans will be limited to a proportionate amount. And subsidies will be available for millions of Americans to help them pay for insurance.

From my view – and from the pleas of countless individuals I have met over the years – these reforms are long overdue. And from my view, the Affordable Care Act uses the right tools to achieve these reforms, coupling the existing private, state-regulated insurance market with minimum federal protections and measures to promote more coverage.

Though the path to implementation has not and will not always be smooth, I remain committed to the Affordable Care Act as our pathway toward national health-care reform.

Decision on discontinued policies

It was that commitment to the Affordable Care Act that guided my decision-making three weeks ago, when President Obama announced a state option to permit health insurance companies to maintain existing "non-grandfathered" health plans in 2014. Though I appreciated the reasons behind the President's decision to allow increased flexibility, I declined the President's option for Washington State.

I made this decision for several important reasons.

First, this option was not in the best interests for the Sate of Washington because our state's implementation of the Affordable Care Act is well underway. Washington State recognized the promise of the Affordable Care Act early on and moved forward with bipartisan support.

Our health-insurance marketplace has been preparing for a 2014 implementation date for several years. Our office has already approved premium rates and plans for 2014, and policy holders started receiving notices about coming changes to their plans months ago.

Allowing discontinued plans back into the market at this late date would have only created uncertainty and disruption for our entire health insurance marketplace. Insurance companies would have had to roll back the protections they have already implemented, and re-communicate with consumers who have already begun to assess their new coverage options.

If consumers then chose to stay in the old plans, it could skew the careful calibrations about enrollment and risk that insurers have made, which could lead to higher premiums next year.

Second, allowing discontinued policies to continue for another year only would have only prolonged a failing system. For many years, insurers have raised premiums by double digits while at the same time cutting back on benefits and forcing consumers to pay higher levels of out-of-pocket costs.

Consumers for years have been paying a lot more for a lot less. Retaining the discontinued plans would preserve this status quo.

My decision to decline the President's option does not mean I oppose the President. I believe the Affordable Care Act can and will work. I support the efforts of the President and many others to reform the broken and failing health-care system in our country.

I simply believe that the option offered does not work for the State of Washington — a decision the President permitted by giving insurance commissioners flexibility to make a state-level decision.

To keep the consumer protections we have enacted and ensure that we keep health insurance costs down for all consumers, we are staying the course in Washington. I know it will be difficult for some Washington residents in the short term, as they research the new health-insurance options and transition from the old plans. But over the long term, this is the decision our state needed to make.

Although I was one of the first to make this decision, I am not alone. About 20 other states have decided against the renewal of discontinued policies. The reasoning is the same: Implementing consumer protections in some plans but not others would deny consumers the benefits of the Affordable Care Act while destabilizing the insurance market, increasing the risk of high premiums for those plans that do comply, and further confusing consumers.

Washington's experience

In Washington State, our Legislature took full advantage of the coverage opportunities and flexibility in the Affordable Care Act by deciding to expand Medicaid and run our own Exchange. Unlike the 36 states that surprisingly decided to cede this responsibility to the federal government, Washington has an online Exchange that is functioning. Almost 100,000 individuals to date have enrolled through our Exchange. Another 160,000 have started applications and are working on completing the enrollment process. Many of these individuals will have health coverage for the first time in their lives.

Washington's Exchange got off to a rocky start. Its website had glitches during the first days of operation. People were unable to sign on at first, and the website also experienced some early errors in calculating eligibility. However, those issues have now been resolved. Others cropping up are being worked on successfully. In fact, we are observing that daily enrollment numbers continue to increase as the online

experience and customer assistance capacity increase. We expect that December will be our busiest month yet.

Washington's Exchange, like other state-based exchanges in Kentucky, Vermont and Connecticut, to cite a few examples, are demonstrating how bipartisanship delivers results.

I cannot overemphasize the importance of bipartisan support for improving the health care of our citizens. In Washington, I am a member of the board that oversees the state-based Exchange. The board members represent a rainbow of political views. While we may disagree at times about the best course of action, we share a commitment to making health-care reform work. The Affordable Care Act has been successful in our states because our leaders grasped the importance of expanding coverage and have avoided the temptation to use health-care reform as a political football. Partnership from many different corners has been necessary to achieve the best results.

For example: Last summer, my office had the responsibility for reviewing plans from insurance companies that had applied to be included in the new Exchange marketplace. At one point, I had to disapprove plans from several insurance companies because our initial review showed the plans did not meet key consumer protection standards. I took a lot of heat for this. I even received a letter signed by almost 20 members of the Republican Party, including congressional representatives. They urged my office to approve more plans for the Exchange in order to offer greater competition for consumers.

Given our state's history of working on Affordable Care Act reforms in a bipartisan fashion, my office took these concerns seriously. As part of my office's process for reviewing plans that were initially denied, we worked with the disapproved insurance companies. They were eventually included in our state-based Exchange.

Today, there are 46 plans in the Exchange for consumers to consider. And in the individual market outside of the Exchange, consumers have another 51 plans to choose from.

In Washington, representatives from all political persuasions, from the insurance industry to consumer advocacy groups, understand that providing real coverage to our citizens is a shared commitment. Our key goal is to encourage all consumers, young and old, healthy and ill, and everyone in between, to participate in the insurance pool so that insurance will be affordable and available to all.

A time for patience

As a former member of Congress and a longtime legislator and elected official, I understand that you want to make sure that the Affordable Care Act meets the needs of your constituents. I know that it is concerning when you hear from constituents who are confused by changes to their insurance policies or experiencing issues in the enrollment process.

But I also know that it takes time for laws and regulations to work smoothly. That was true for the creation of Social Security in 1935 and for Medicare following its enactment in 1965.

The expansion of prescription drug coverage for Medicare under former President George W. Bush is the most recent example of a new program that did not have a smooth rollout. I note highlights from this news report in the Washington Post on January 18, 2006:

"President Bush's top health advisers will fan out across the country this week to quell rising discontent with a new Medicare prescription drug benefit that has tens of thousands of elderly and disabled Americans, their pharmacists and governors struggling to resolve myriad start-up problems."

"Even as federal leaders touted the enrollment figures, state officials and health care experts continued to report widespread difficulties, especially for the poorest and sickest seniors who were forced to switch from state Medicaid programs to the new Medicare plans on January 1."

"In a letter to Bush, 14 Democratic governors wrote that while well-intended, the new Medicare drug benefit has caused confusion, mismanagement, and a bureaucratic nightmare."

In 2006, the secretary of Health and Human Services at the time said that starting an enormous insurance program for 42 million people is “bound to entail bumps.”

That is similar to what we are hearing today about the Affordable Care Act. Again, we are experiencing a quick rush to judgment. We are also seeing that our political system is not very patient.

But it should be.

We do not remember those headlines from 2006 because, as a nation, we fixed the problems encountered during the initial rollout. We took the time to listen to one another and then worked together to make the necessary changes.

We are now in just the early stages of enrollment for the Affordable Care Act. We are encountering the same types of challenges that arise when other changes in policies have occurred in our history.

I speak often to citizen groups in my state. I am always asked: “Can we make the Affordable Care Act work?”

My response is always the same: Yes, we can – if we remain committed to the long-term goal of improving the lives of so many people.

As the insurance commissioner from the other Washington, I respectfully urge you to exercise patience, work together to resolve the challenges before us, and transform a broken health-care system into one that provides real and lasting benefits for all the citizens of our nation.

Chairman BRADY. Thank you, Commissioner, Congressman, appreciate your testimony.

One, congratulations on running a model exchange. Two things stand out. One is that you did testing, extensive testing, of your Web site and exchange before the deadline hit. I wish Washington would have followed your lead, because this has led—despite repeated assurances to this Committee and all of Congress, both parties, that was not done.

And the second thing that stands out really drives my first question, which is the coverage gap. You are running as good as exchange as exists in America, yet so far have only signed up a fraction of those in Washington State who have received cancellation notices. We are all concerned about the potential coverage gap on January 1st as a result, again, of this defective rollout.

So, Ms. Turner, let me start with you. How significant could that coverage gap be for families in America? How significant could it be that families show up on New Year's Day in the hospital needing that lifesaving prescription and find that what they signed up for didn't actually make it all the way through the process, they don't have that coverage? How concerned should we be?

Ms. TURNER. One hundred percent concerned. It is absolutely going to happen. When we have a deadline of December 23rd for people to enroll, and all of that paperwork has to be processed that people think that their coverage will start on January 1, I think it is just—it is impossible for everyone that signs up on—by December 23rd to get coverage and to have that work through the system.

And in particular we see that the data that is coming from the Federal hub, from the Federal Web site, that the 480—843—the 834 forms are inadequate and wrong. At least a third of it is inaccurate.

So I think it is a huge, huge concern that people are doing their best to try to sign up for this coverage and are not going to be able to get through the Web site and be able to be signed up, and may, even worse, think they are and have it not be processed.

Chairman BRADY. Thank you.

Dr. Gottlieb, you, in your testimony, point out something I don't think anyone has focused on, which is the payment gap, the part of the process where after you enroll—in your testimony, you say the system to ensure that our local healthcare providers are being reimbursed does not yet exist in the system. Could you talk a little more about—and why should we be concerned about that?

Dr. GOTTLIEB. Well, the issue is whether or not people who think they have enrolled in a plan on the exchanges are actually enrolled in those plans. With the information—we know that the back end hasn't been built yet, and we know that the subsidies that should flow to the insurers aren't going to flow on the insurers appropriately or on time. And so the question becomes what do the insurance plans do if they don't have someone either appropriately enrolled in their plan or that they have been paid for? And while I think they are going to be hard pressed not to honor the contract that they—or the, you know, purported contract they have with that consumer, I am hard pressed to believe that they are going to

allow money to flow to providers when they haven't been paid on those policies. They are going to hold up those payments.

It is not clear exactly what they are going to do, frankly. That is why we should be thinking about this and worried about this, because people are going to start to try to access care in January, and either the providers aren't going to get paid on time, and they could very well drop out of these plans, or the contracts might not be honored at all.

Now, I know the Administration made an announcement last night that they are going to effectively guarantee those payments. I don't think that fully resolves this problem, because it doesn't resolve the issue of what the insurers are going to do with the providers when they haven't been paid yet, they haven't either received the premiums, appropriate information to enroll the beneficiary, or haven't received the subsidies.

Chairman BRADY. So if Washington doesn't pay its bills on time, the insurance company—they are going to be in a bind in paying those local doctor bills and hospitals as well. Is that——

Dr. GOTTLIEB. That is right. We have seen the insurance companies do this in the past. If they are not getting paid, it is a reasonable expectation that they are not going to let money flow out to pay bills.

Chairman BRADY. I don't think many of us are worried about the insurance companies. We are really worried about the process of does that local doctor—are they assured that they are actually going to see reimbursement. And I think that is the concern.

Dr. GOTTLIEB. And if they don't, they might not continue providing care. They might have to drop out of these contracts, and it is just going to further strain the access issue.

Chairman BRADY. Let us talk about that. Let us talk sort of about the doc shock, which may be—after sticker shock may be our biggest challenge for our families, which is in your testimony, you pointed out that many of these plans are a very narrow network. And so the affordable ones—at least those with the lower prices. So a family may find they can't see a doctor that they have seen, or they see multiple doctors, can't see both a local hospital or provider, and may well be forced out of network. And in your testimony you make a case that when that occurs—not if it occurs, when that occurs—that patient will be maybe required to carry the entire cost of that treatment, and it won't count toward their deductible, or out-of-pocket caps, or any of that. So, in effect, you are saying they almost are going to see a HMO experience with them paying extremely steep bills under these plans; is that correct?

Dr. GOTTLIEB. Well, that is exactly right. I think—you know, conceptually, in the 1990s, when HMOs were first introduced, people rejected them. We had the Patients' Bill of Rights introduced into Congress. And most consumers demonstrated that they prefer PPO-style plans, which afforded flexibility on providers, and they were willing to trade away some benefits and higher copays and deductibles for that flexibility.

I think what the Affordable Care Act really does is force us back into that old option, the HMO-style option, where you are trading away the flexibility in favor of this government-guaranteed benefit package and really not lower copays or deductibles. The copays and

deductibles are fashioned off of catastrophic plans here. So they are still quite, quite high. But it is a foregone conclusion that you won't be able—if you have multiple doctors, it will be very hard to envision patients being able to keep their full complement of providers.

Now, the fact is that it is very hard to get a handle on what these networks look like. We tried hard. And a lot of the networks aren't even formed yet, which begs the question how these even—these plans even got through the review process at CMS. But that said, they are not even formed. So patients are enrolling in plans where they really don't know what the full network is.

We did a study. We put out an analysis on Anthem Blue Cross Blue Shield. And, frankly, we chose that plan because they are the most transparent. They provide their full network not only for the exchange-based plans, but also for their commercial market. Also, they are highly regarded. So we dealt with one of the better plans. And we picked the most populous county in each State to look at, and looked across six specialty areas, and the numbers were pretty grim. And I think that this represents the high watermark. This is probably the best you are going to see. When we looked at Molina Health, for example, a Medicaid plan, it looked far worse, but it was much harder to get data because the network information wasn't available in all of the States. But this is going to present a lot of challenges to patients.

Chairman BRADY. Could that doc shock also apply to medicines? You know, if you—you are a patient using either new or specialized medicines, could that formulary also be narrower in those plans so that you are faced with the same very high out-of-pocket costs that don't apply to any of your deductibles or your caps?

Dr. GOTTLIEB. Yeah. It absolutely does apply to medicines. It hasn't been as acute of an issue so far, one, because people haven't tried to tap the insurance, and, two, because a lot of the States benchmarked off State plans that had reasonably good formularies. But if the drug isn't on your formulary, then you are going to have to pay out of pocket for it. And, again, the coinsurance applies. You could pay all of the money out of pocket. So you could be out a lot of money.

Now, there is a way to appeal to CMS to try to get that overturned, to get the drug paid for, but most patients aren't going to be able to go at risk if it is an expensive cancer drug, for instance. First of all, they are not going to be able to go out of pocket for the 3 or 4 months it might take to appeal. And even on a risk-adjusted basis, even if their doctor says, look, there is an 80-percent chance I will win the appeal, that 20-percent chance might be too much for them to take because the money would be so substantial that they would be forced to pay. So I think that this will be prohibitive.

Where this is going to become a much more acute issue, first of all, some States that don't have good model formularies, but also going forward, new drugs, it is going to be slow to see new drugs introduced into those formularies because of the process that is being put in place. So access is going to be inhibited for newer therapies as we go forward and as these formularies should adapt over time to new—to new treatments.

Chairman BRADY. Right. I think this is an important issue, it hasn't been highlighted much, but it is a real concern for the families who don't fit into the box, as Washington likes to do.

You are right about the uncertainty back home. I met roundtable with our local hospitals. One of them—they don't know which plans they are in. One of them has figured out that they are in 23 of 56 plans in Texas. Two of the other hospitals had no clue what they are included in. The doctors talked about really the return of the HMOs. One of them sort of jokingly called this "HMObamaCare" because of those narrower networks and the concern that those out-of-network costs will be so high.

Let me ask, you know, aside from the sticker shock and potential doc shock our family could face, the testimony today, we saw, really lays out next year as sort of an aftershock to where we are right now, because of the enrollment problems, because of the mix of those who are enrolling that are—families may well face much higher premiums next year and end the mandate their local businesses offer.

Mr. Carlson, can you address that for a moment?

Mr. CARLSON. Well, I mean, I think it has been, you know, clear in some of the statements the actuarial community has made that there are a lot of forces that are changing premium rates. Obviously, I speak of this prior to any consideration of the premium subsidies. But, you know, most of the changes in the benefit requirements and most of the change—you know, you have the insurer piece and those other factors that are driving up the premium rates. Then when you look at the gender rating and other market reforms, again, specific populations that are targeted there create a premium rate increase for that particular population; for example, younger individuals. So, you know, that is a concern to individuals buying insurance on the exchange.

Now, another concern, and I talked about it in my testimony, you know, we need to get our premium rates filed by sometime at the end of spring or toward the end of spring, but then we are going to have very little information to work with. So, if our enrollment is not enough to provide any valid data, again, we are going to be kind of, I don't want to say guessing, but having to make some pretty significant assumptions about what premiums are going to be in 2015, which makes our job a little more difficult. And if the risk pool is not a broad and balanced risk pool, which is going to put upward pressure on the premium rates for 2015 as we try to work with the data we do have.

Chairman BRADY. And I think this point: One, to be fair, we need to allow the White House to finish their push to see what that enrollment mix will be. But I think the point we have heard today in a number of the testimonies is that if the younger don't sign up and the healthier don't sign up, in significant amounts, and if the White House misses the $7 million goal significantly, it could well lead, depending on that mix, to higher rates in 2015.

Well, thank you all very much for your testimony.

Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman.

As I listen to this testimony, there are two countries. There are those States where they put up a State exchange, and then there

are all the rest that sat back on their hands and said, let the Federal Government do it so we can throw rocks at them later because it isn't working.

Mr. Kreidler, I would like you to talk about how you got bipartisan support to put together and begin a long time ago. Nothing that we have heard testified here today is unknown. It has been known for 3 years. So you knew in 19—or 2005 that you were going to have—or 2009 you would have certain problems, and you started working on them, the narrow networks and all the rest. I would like to hear how you went through the process of putting together an exchange that works.

Mr. KREIDLER. Thank you, Congressman McDermott.

Let me say that, you know, I sit as a board member of the Health Benefit Exchange in the State of Washington, and as such I can tell you right now that the makeup of the board looks like a rainbow coalition, so to speak, of political views. We don't always agree on the best course of action, but we always have from—our primary focus and interest is making sure that it works, that people have access to health care, that it has affordable.

And from the standpoint of looking at the networks that are out there right now, that has been a job for our office, and inside the exchange, obviously, one part of the change that we are seeing right now are narrower networks. And as a part of that right now, we are taking very seriously to make sure that if there is a problem from the standpoint of making sure that there is an essential benefit, and it is not in part of the network, that they will be treated as in network and from the standpoint of the patient and the consumer. So that they wind up getting the benefit of the doubt when they do have those exclusive types of benefit, whether it is cancer treatment, or whether it is hemophilia, or whatever it might be, we make sure that they are going to still be—if the promise has been made in the policy, we are going to make sure the insurance company lives up to that promise.

So we are working to endeavor to make sure that that happens so that as we go forward, we see health carriers that are playing a much more active role now in plan management, something that all of us thought was really important going forward to see that that happened, and we are starting to see it right now. We want to make sure that it is not something that disadvantages the consumer. And from the standpoint of services that can be bought competitively in the market, that are comparable quality and outcomes, that is desirable if it offers a better price and reasonable access.

Access is what we—we are concerned about. We want to make sure that policy performs and offers the access that has been guaranteed in that policy, and we are going to work together to make sure that happens, whether it is through the exchange, or whether it is outside of the exchange. Because the—all of the plans in the individual market and the small-group market have to meet the same standards, whether they are in the exchange or outside of the change. And we have got a lot of plans out there, a lot of carriers, and we offer some real opportunity for consumers.

Mr. MCDERMOTT. Dr. Gottlieb talked about the fact that doctors might not get paid, or that somehow payments would be held

back by insurance companies. Have you ever had a complaint to your office from a physician's office that the insurance company wasn't paying their bills?

Mr. KREIDLER. We have had—Congressman McDermott, we have had lots of complaints about that over the years, well before the Affordable Care Act.

Mr. MCDERMOTT. Really? Before ObamaCare?

Mr. KREIDLER. Oh, way before ObamaCare.

Mr. MCDERMOTT. Oh.

Mr. KREIDLER. And that has always been an issue. And when we hear those complaints, and it is a fully regulated plan that we have authority over, we contact that company right away, and we make sure that they are living up to their promises that they are paying on those claims. If there is a problem out there, we are going to go after that carrier to make sure that they are complying. And, quite frankly, we have received a remarkable amount of good-faith work with the health insurance carriers in the State of Washington when we bring it to attention. Everybody makes mistakes. They can make mistakes as well as anybody else, and when they do, they are quick to make the correction of that.

So I don't look forward to them holding back. Now, again, we are talking about a State-driven exchange. We didn't cede the power to the Federal Government. We said we wanted to make sure our plan worked to the benefit of Washington consumers, that it wound up being styled to what we are used to in the State of Washington, so we took control of it. We did not defer to the Federal Government. So it made a big difference.

Mr. MCDERMOTT. Could I just ask you to talk a little bit about the change? In my understanding, insurance regulation has always been done at the State level. Federal Government has never put its hand into it before. Now we are putting our hand into it sort of—I don't know exactly how it feels or what it looks like. Tell me—I mean, some States clearly have insurance commissioners that aren't doing their job, but the clear—the question I have is what is it like to have us start telling you what to do?

Mr. KREIDLER. Well, to some degree we have already had some of that because of ERISA and HIPAA and some of the other standards that were out there well before ObamaCare.

We had some guidance from the Federal Government. When it came to regulation, you are absolutely right, Congressman McDermott, that we have been for the fully insured market the ones that have been in charge of this, so that we have been driving it at State level. So that hasn't—that is something that we are used to.

As we look at the Federal involvement right now, it is one that provides some bottom-line guidance so that there aren't low-ballers out there, that consumers are protected; they get the services they want.

Chairman BRADY. Thank you, Commissioner.

Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman.

Dr. Gottlieb, you mentioned in your testimony it has been reported that the focus has been to fix the Web site registration process, but that means insurance—insurers are still getting faulty re-

ports on individuals who believe they have signed up for coverage, but aren't actually enrolled.

Yesterday the Texas Health and Human Services Commissioner sent a letter to Secretary Sebelius stating he has serious questions about the validity of the data we have received from CMS. While electronic account transfers have been delayed, CMS has provided States with spreadsheets of individuals the marketplace determined would be Medicaid or CHIP eligible as of January 2014. Our review of the spreadsheets for Texas found individuals with addresses from other States, including as far away as New York; fields that were left blank; and people who are already receiving Medicaid or CHIP.

Given all the problems and mistakes that are still ongoing, how can the Federal Government force people to buy a product they don't want? And businesses have been given a year reprieve from this onerous law. Shouldn't individuals be treated fairly and be given a delay from this complicated mess as well?

Dr. GOTTLIEB. Well, I am one who believes that at some point the Administration will announce that they are not going to enforce the individual mandate, and they will just wait perhaps until after the enrollment deadline. I find it hard to believe that they are going to enforce the penalty on people in a situation where it is, you know, nearly impossible in certain situations to sign up, and certainly difficult.

So, yes, I don't think there should be an individual mandate. We should also keep in mind that since the data being transmitted to the plans is wrong, most of that—a lot of that revolves around determination of eligibility for the subsidies. So it is fair to assume that some of those subsidy calculations are wrong. And it is also fair to assume that you are more likely to enroll in a plan if the subsidy calculation is wrong in your favor than against you. And so there is going to be a percentage of people, and it could be potentially high, who were told they were eligible for subsidies and enrolled on the basis of that assumption where their subsidy calculations were wrong.

It is unclear how that is going to be handled, whether that money is going to be clawed back, or there is going to be some kind of grace given for this year since the mistake is on the part of the Web site and the Federal Government. But I think it is fair to assume that—and who knows how big the number is—that there is a certain percentage of people who enrolled who have wrong calculations.

Mr. JOHNSON. Well, maybe we need a delay to figure it all out.

Ms. Turner, I want to do just a simple comparison. Let us compare what we know about 2014 to what will happen in 2015. One, will premiums be higher or lower in 2015 than 2014?

Ms. TURNER. I think we have heard that that greatly depends upon all the young, healthy people signing up for coverage and getting the 7 million enrolled. That looks increasingly unlikely. And I think if we start to see enrollments decline, you get—the exchanges become basically high-risk pools instead of the broader plan that you are going to see premiums only go up, and I think that is going to significantly impact enrollment in 2015.

Mr. JOHNSON. Yeah. Well, will individuals have more or fewer choices of doctors?

Ms. TURNER. And as Dr. Gottlieb has shown in his new study, across the—the one plan that he was able to get good data on, that we see that the—the choice of physicians is dramatically reduced, and the limited networks are really a result of trying to have so many benefits in the plan. But providers and especially hospitals are very limited.

Mr. JOHNSON. In your opinion, will more or fewer insurers participate in the exchanges?

Ms. TURNER. If I were an insurance company, I would be looking very carefully at this and thinking, if you didn't get in one of these exchanges, you are thinking, I am so glad. And I think they are going to go about it very carefully.

Mr. JOHNSON. Walk softly and carry a big stick.

Will insurers expand or decrease the number of counties where they offer plans?

Ms. TURNER. We are starting to see much more not only limitations in the number of physicians and hospitals, but also geographic limitations in what the plans are offering. So I think you are going to continue to see more limits, fewer benefits, and ultimately higher costs.

Mr. JOHNSON. Wow. Well, will the individual mandate be more or less popular as we go downstream?

Ms. TURNER. There was a recent study just this week showing that the more that people knew about the law, the more unpopular it was. And I think a number of people don't understand the—the individual mandate. It is not being promoted by the Administration, and it is—the penalties are significant, and people feel it is of an affront to their freedom.

Mr. JOHNSON. You bet.

And will more or fewer employees—employers offer coverage for their employees.

Ms. TURNER. If you are a big company, and you are looking at the possibility of paying a $2,000 fine per employee instead of $11,000 for employee health insurance, they are likely to have to drop coverage.

Mr. JOHNSON. Thank you, ma'am. Thank you.

Chairman BRADY. Thank you.

Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman.

Ms. Turner, you mentioned that some folks are going to be hit with more expensive and less attractive policies. What is a less attractive policy?

Ms. TURNER. As Dr. Gottlieb described, the limit—more limited network, the hospitals——

Mr. THOMPSON. The which?

Ms. TURNER. More limited networks and the fewer number of doctors that are providing. There were a number of people that are saying even when they get on the exchange, they find to have to make a choice between the hospital that they have been going to or the doctor that they have been seeing. So the limitations on networks and the—I think they are also going to be very surprised at

the high deductibles in many of these policies. The most affordable plans have deductibles of 3- and 4,000——

Mr. THOMPSON. So you weren't talking about what is covered; you weren't talking about preventive care, mental health, drug and alcohol addiction, all of the—all of the—the fact that they can't drop you for a preexisting condition. That is not what you were talking about as less attractive.

Ms. TURNER. I am talking about the consumer's actual experience in accessing that care.

Mr. THOMPSON. And tell me, you just responded to Mr. Johnson's question about whether or not insurance companies would want to get on the exchange. Why wouldn't an insurance company want to get—have access to that marketplace?

Ms. TURNER. I think initially they felt that this would not only be something that they should do as insurance companies, insure people, but also that this was going to be a large new pool of potentially healthy people that they could get on their—on their plan. But they are finding now that the—the Web site is so difficult to get on and has been, that only——

Mr. THOMPSON. Which—you mean the one in the 36 States that have tried to——

Ms. TURNER. Well, no one has been able to sign up on the Oregon exchange either. A number of others are still having trouble. You—Vermont, Oregon, others.

But just the risk pool that they are now seeing of people who are going to get on exchanges. As I said, I think that the exchanges could very well become high-risk pools, and the policies are not priced for that.

Mr. THOMPSON. So the effort to discourage young people from signing up is having an effect as to whether or not people will—insurance companies will get on the exchange?

Ms. TURNER. Well, the law itself really discourages young people by charging them more.

Mr. THOMPSON. Thank you.

Dr. Kreidler, thank you for being here and for your testimony. I was impressed with what I heard you say and what I have been able to read in regard to what Washington is doing. And I am from California, a State has had similar success. We have—we were out—California was, I think, the first State to go after setting up its exchange and to get everything in place so this would work.

We have had over 80,000 people sign up already. Twenty-five percent of those who have signed up are young people between the age of 18 and 34, and I think that is important to note, and we are getting about 10,000 applications a day. So it is working pretty well in California. And when I talked to the insurance folks—one was in my office today—they think it is going to be only improving as time goes on. It sounds like you are having similar success in Washington.

I would like to ask you about the authority that your office carries in the State of Washington. Are you able to negotiate prices for the policies that are on your exchange, or is that done in another arm of the government?

Mr. KREIDLER. No, it is done through the Office of the Insurance Commissioner.

Mr. THOMPSON. And so you regulate rates. What other regulatory authority do you have? If an insurance company—if there is a complaint about the cost of a policy, do you investigate that? And do you have some authority to regulate that?

Mr. KREIDLER. Congressman Thompson, absolutely. We rely very heavily on getting consumer complaints about insurance companies' behavior in the market, so you can do the targeted examinations of those companies to correct where we see deficiencies, such things as making sure that if you have a policy that says we are going to cover certain specialties, we are going to make sure that they live up to those promises.

The rates, when they are filed with us, they have to be shown that they are not excessive. If they are, we talk to the insurance company and are going to be reluctant to approve any rates that are going to prove otherwise.

So, yes, we look at it very closely.

Mr. THOMPSON. And you have used that authority; you have exercised that authority in the past?

Mr. KREIDLER. Use it very extensively.

Mr. THOMPSON. And how does that work? Does it work to the consumer's benefit?

Mr. KREIDLER. Absolutely. The companies have learned that we play a strong ball game in the State of Washington. They come in with much better rates just to start with. We didn't have the major issues around medical loss ratios, MLRs, as has been talked about.

Mr. THOMPSON. Do you have third-party interveners in your State laws? So can a third party intervene and request a review on your behalf?

Mr. KREIDLER. Not in the State of Washington do we have third parties. I am the person who is the third party protecting consumers.

Mr. THOMPSON. Thank you.

Chairman BRADY. Thank you, Commissioner.

Mr. Nunes.

Mr. NUNES. Thank you, Mr. Chairman.

Dr. Gottlieb, if you could, walk me through the process. Let's assume that I was able to log on to the Web site and it worked, and so in the last couple of weeks I have signed up. Do I receive an ObamaCare card in the mail? Or, like, what do I have for proof of insurance?

That is what people really want. They want to carry a card around so that when they walk into the doctor's office January 1st, they show them their card. So what am I receiving?

Mr. GOTTLIEB. Well, there are not many people who we can ask. But presumably you are going to receive notification from the insurance company, just like you would in the individual market. And so I am sure there are some people who were able to get on early who have already received that notification, but a lot of people haven't.

Mr. NUNES. But I am supposed to get a card, right?

Mr. GOTTLIEB. Yes.

Mr. NUNES. Most Americans carry a card.

Mr. GOTTLIEB. Yes.

Mr. NUNES. So do they have the cards yet?

Ms. TURNER. I think that is going to have to come from the insurance companies.

Mr. GOTTLIEB. Yeah, it will come from the insurance companies. But have they mailed them out yet?

Mr. KREIDLER. I don't know if they have mailed them out yet or not.

Mr. GOTTLIEB. I haven't heard of anyone, yeah.

Mr. KREIDLER. Obviously, it would be a card that wouldn't be valid until the 1st of January.

Mr. GOTTLIEB. But you would want it by now, right?

Mr. NUNES. So let's assume that I do get this card before January 1st, I walk into the doctor's office, and I show them my card. Is that doctor going—do all the doctors have to accept my ObamaCare card?

Mr. GOTTLIEB. No. I mean, you bring up a critical issue, which is it is very hard for a consumer right now, depending on the plan they are in, to find out what the network looks like. A lot of these plans haven't even made network information available to people who have enrolled.

I think the only way certain consumers are going to find out what their network is, is to enroll in a plan, try to test it in January, and if they find out it is not good for them or their doctor doesn't take it, they can disenroll and enroll in a new plan before March. And I suspect you will see consumers doing that.

This information isn't available. We looked hard for it.

Mr. NUNES. So it is likely that I am going to walk into a doctor's office—Americans will walk into their doctor that they have went to for years and doctors are going to reject the insurance?

Mr. GOTTLIEB. It is possible. I mean, presumably, you would hope that most Americans would check if their GP is going to be taking the new policy. But, certainly, you won't be able to do that with your full complement of providers.

Mr. NUNES. But how are they going to check if they haven't received the card yet?

Mr. GOTTLIEB. Call up the doctor's office, and hopefully the doctor knows if he is enrolled in the network.

I mean, this is not easy; you are right. And, again, these plans are not, even to people after they have enrolled, making available the full network information yet. In a lot of cases, they don't have the networks yet. They haven't fully formed them. They are still putting them together.

Mr. NUNES. Sounds like a lot of people aren't going to have insurance coverage come January 1st.

Mr. GOTTLIEB. Yep.

Mr. NUNES. Do you agree with that, Ms. Turner?

Ms. TURNER. [Nonverbal response.]

Mr. NUNES. Mr. Carlson, do you agree that a lot of people are not going to have insurance coverage that think they are entitled to it or were dropped off of their employer's plan?

Mr. CARLSON. Well, I think the critical issue is, with the extension of the enrollment, people are going to wait longer to get the coverage than they would have otherwise.

Mr. NUNES. Now——

Mr. MCDERMOTT. Would the gentleman yield?

Mr. NUNES. Mr. Kreidler, now, in Washington, everything is great; everybody has got their cards?

Mr. KREIDLER. Congressman, they do not have their cards, but what they do have—and that will, of course, be through a private insurance company. But people are going to wind up going to any doctor; what they have an interest in is knowing whether they are in-network or not.

And Dr. Gottlieb identifies, one of the challenges we have is making it easier for people to find out if their provider, the one that they rely on the most, which is often going to be a family practice provider, that that provider is in-network or not. And that information isn't as readily available right now, either through the Federal exchanges or, for that matter, even in the State of Washington, but we are working to correct that.

One of the things we encourage people to do——

Mr. NUNES. But you have 3 weeks left.

Mr. KREIDLER. Well, it means calling the insurance company. If you have gone through the enrollment process and you have identified your insurance company, let's say it is a Blue Cross or a Blue Shield plan or whatever it is, you give them a call and say, hey, is my provider in-network for this particular plan, and they are going to communicate. If they contact the exchange, they are going to have information too, probably not as readily available as calling the insurer themselves, but people can find out.

It is just a little bit more challenging right now. It is one of the glitches in the system that we are going to work out and make it a much more consumer-friendly——

Mr. NUNES. So if I have a Washington State utopian Obama card, does that allow me to get into any doctor in Washington State, or are there going to be some that are going to reject the card?

Mr. KREIDLER. Well, if you have an Obama card, you probably wouldn't get into any doctor's office, because they will all be private insurance companies. But if you come in with a private insurance company's card, you can go anyplace you want to, but if it is out of network, you are going to expose yourself to considerably more cost to you as an individual.

It is important to make sure that when you go in, that you are going to maximize your benefits. And one of the ways you do that is to find out if you are in-network, and that is where you have the protections.

Mr. NUNES. Thank you.

I yield back.

Chairman BRADY. Thank you.

Mr. Pascrell.

Mr. PASCRELL. Thanks, Mr. Chairman.

Mr. Chairman, I just have to begin by taking exception to something that you said earlier to my good friend. You said that there was no plan B to correct the myriad of problems—you didn't use the word "myriad"; that is my word—that exists with the ACA. And our panelists have defined some of those problems very nicely, and I think some of them are undeniable. Some of them need to be addressed beyond the rollout of the plan. We all know that.

But it took us 6, 7 years to respond to Plan D back in 2005 to make sure people who were paying premiums were getting some benefit. Remember? Between $2,200, $2,300, and $5,200, those people paid premiums, right, Mr. Carlson, Ms. Turner? They paid premiums and got no benefits. Remember that? Oh, it took us 6, 7 years.

Ms. TURNER. There was a coverage gap.

Mr. PASCRELL. Mr. Chairman, here is what you said. You said that there was no plan B from the Obama Administration to correct these problems. I think some are legitimate concerns, and we should all have them.

But, Mr. Chairman, you have no plan. In fact, if you watched the last 2 weeks, I see many of my good friends on the other side of the aisle scrambling to put a flawed erector set of disjointed proposals together, many of which have already been rejected. So we are still waiting to see your plan A.

I don't want to minimize these problems, as I said. I voted for the Affordable Care Act. I am proud of it. I want the law to succeed.

And, remember, we came together after 2005, and we worked together across the aisle even though many of the folks on the Democratic side voted against it. And the reason why I think it succeeded over years is that we worked together.

You don't want to hear that. You don't want to hear that we worked together. We had the choice—we had the choice to turn our backs, go back to our districts, and tell seniors this was all baloney. We chose not to do that, Mr. Chairman. We chose to use the legislation to help educate the people as to what the benefits were from Plan D reform. That is what we chose to do. You chose not to do that.

In fact, we have example after example—and I am glad our good friend from Washington is here today. The fact is that since October the 1st, there have been improvements made to the Web site. Some States have shown, like Mr. Kreidler's home State of Washington, once these technical problems are corrected, it doesn't mean the other problems go away, but it is a smoother sail to the object.

Everyone wants the law to succeed. Or do they? My friends on the other side, while they may feign concern now, have been actively working to make healthcare reform fail. And you can't deny that, Mr. Chairman. You just can't deny that. You want to deprive millions of Americans of health insurance. And I don't think you care any less than I do about those millions of people, but let's be straight about the whole situation.

Our Governor in our great State of New Jersey, the Ranking Leading Member now in the polls that he is going to be the next President of the United States, he accepted the Medicaid money from the Federal Government. He got it half-right.

But I used to be a teacher, and in my classes you didn't get a passing grade for doing the bare minimum. The Governor refused to set up a State marketplace—we need to look at every one of these States—and has left millions of Federal dollars in outreach and education funding unspent.

If you remember, in the ACA, $3.6 billion in Federal money for grants. New York State, which has a similar population in terms

of the target here as New Jersey, New York State received $369 million. Imagine a Governor turning that down to inform and educate the people in his State on something as dramatic as Social Security and Medicare, to at least inform the folks—at least inform the folks what they should be doing and what their options are. It would seem to me to be fair.

I ask you, Mr. Chairman, as a leader within your party and on this great Committee, come over, help us make it right——

Chairman BRADY. All time has expired.

Mr. PASCRELL [continuing]. Or give us your plan A.

Chairman BRADY. I think the witnesses got off easy on that question.

Mr. PASCRELL. Yeah, I didn't get to them.

Chairman BRADY. Mr. Gerlach is recognized.

Mr. PASCRELL. Are we going to have a double round? Can we come around again, Mr. Brady?

Mr. GERLACH. Thank you, Mr. Chairman.

Dr. Gottlieb, in your testimony, on page 8, under the conclusion section, you state that, "for every consumer that is made better off under this scheme, there will be other consumers that are harmed."

And then you go on to state that "these people who will make out worse under ObamaCare—the ObamaCare losers—seem to be getting shorter shrift in political discussions" that are going on here. "Many of these families are solidly middle-class, and many struggle financially."

Can you expand on that a bit more? Who will be the ObamaCare losers under the current scenario of the existing law?

And is there any way to calculate, for every one person that ends up with an insurance policy that he or she did not have before, how many are actually getting worse policies relative to what they want as a citizen, as a consumer, relative to what they have to pay in a premium each month and what the deductible is going to be and whether the policy provides coverage they don't even want or need?

How many of the folks out there are going to end up being losers because they are going to be worse off compared to every one person that will have a better situation?

Mr. GOTTLIEB. Well, all great questions. It is really hard to quantify. It depends on the State you are in, certainly. But you can make an assumption that many of the people who are losing their coverage and are going to be forced into the exchanges are being disadvantaged in some way. Certainly, they made a conscious decision to purchase a certain style of plan in the individual market. They are being forced into the exchange and buying a plan that they didn't necessarily want.

Now, for many of those folks, they are going to encounter higher costs. In certain States, they might see comparable costs or lower costs, but those are the exceptions. Those happen to be States that had a lot of insurance regulation previously, and now, you know, the sort of exchange environment is comparable to what they were experiencing. But most people are going to see higher costs and have to pay for benefits that they didn't necessarily make a decision that they wanted.

We have done some, you know, rough math at the American Enterprise Institute, and, generally speaking—and this is a sort of a

crude statement, blanket statement—if you are above 250 percent of the Federal poverty level, chances are you are going to be paying more in the exchange, even with the benefit of the subsidies. The subsidies won't be rich enough to offset the higher costs.

Mr. GERLACH. And how much is 250 percent of Federal poverty? About how much is that in income?

Mr. GOTTLIEB. $30,000 for an individual, $60,000 a year in annual income for a family of four.

So anyone above that level, there is a high probability that they are going to be in a more difficult financial situation, notwithstanding the fact that some people might argue, well, they are getting more benefits. But they are getting benefits they didn't necessarily want.

You know, this goes right up through the continuum. So you think about, for example, a family of four earning $95,000 a year forced off their employer-provided coverage into the exchange, that family is now using after-tax dollars to buy a policy in the exchange. If they buy a silver plan in the exchange, they might be looking at a situation where they are spending almost 25 percent of their after-tax income on health care. Now, clearly, they are not going to be able to do that. But that is a lot of hardship.

And I think, you know, we are worried about the people at the lower income bands, but we shouldn't give short shrift to the people who are middle-income, higher-middle-income, who are also being badly hurt here.

Mr. GERLACH. Mr. Carlson, with your actuarial background, what is your thought on that question? Who are the ObamaCare losers in all of this process?

Mr. CARLSON. Well, I think if you look at the—from a premium rate perspective, and that is kind of the way I look at it, you have made market reforms that have kind of changed how the private insurance, healthcare insurance, is being funded.

Basically, with the essential benefits, you have required that all policies cover maternity and all policies cover prescription drugs. So, you know, if an individual doesn't need those benefits, they are still going to share in the cost of that. You know, from an actuarial perspective, that is a policy decision: How do we want to spread the cost of health care across individuals who purchase health care? You know, tell me how you want to do it, and the actuary will price it.

But, you know, to the extent there are individuals who don't need those benefits, they are going to be paying for something that, you know, is spreading the cost to somebody who doesn't need it beyond what they would actually use for benefits.

Mr. GERLACH. Congressman Kreidler, if you look at it from the perspective that we are going to have losers in this entire system once it is implemented, and then you look at the fact that the enactment has 21 new taxes in it that will raise over a trillion dollars over 10 years and take that out of the private-sector economy, you will have a whole new governmental regulatory regime that will impact physicians and other healthcare providers, and at the end of all that, according to the Congressional Budget Office, you will still have about 30 million uninsured people in the United States, which is around the same figure we started this discussion with

back in 2008 and 2009, how can any rational person support the Affordable Care Act?

Mr. KREIDLER. What I am seeing with the current insurers right now, I am not seeing the kind of rate problems that are being described here. In the King County metropolitan area, or King County, the most populated county in the State of Washington, we went through one of the major carriers there. They had 31 plans. We found that all 31 plans would have wound up—only 1 of the 31 plans would have actually wound up costing more.

I think if you ever tried to identify some people that would perhaps see the price shock that comes along, it would be somebody that is relatively healthy, that doesn't care about having prescription drug coverage, doesn't care about pharmaceutical coverage or maternity coverage and things of that nature. But, you know——

Chairman BRADY. Commissioner, I apologize. All time has expired by a long way.

Mr. GERLACH. Thank you.

Chairman BRADY. So Dr. Price.

Mr. PRICE. Thank you, Mr. Chairman. And I want to thank you for holding this hearing.

The President and the Administration apparently came out yesterday and said they were going to come out every single day for the next 3 weeks with a new benefit of the Affordable Care Act. And so having this hearing is incredibly important because the American people know that there is not a new benefit to this law every single day.

And yet he said something yesterday that he says virtually every single time he stands up, and that is that there are no other ideas. "If somebody has got a better idea, then come talk to me."

Well, Mr. President, we have had a better idea for over three Congresses. H.R. 2300 is the bill that gets patients covered, solves the insurance challenges, saves hundreds of billions of dollars, and doesn't raise taxes by a dime, and doesn't put Washington in charge of health care.

So, Mr. President, here we are. We have a better idea. So give me a call. We have asked, haven't heard a word. So my phone number in the office, 225–4510, Mr. President. Thank you. Thank you.

The problem is the President's plan now, as we heard yesterday, is to go on offense and blame the Republicans. Well, there is a great plan. If this was pension care or worker's comp or even unemployment insurance, maybe that sounds, politically, like what ought to be done at the White House, but, Mr. Chairman, this is people's lives.

I spent over 20 years taking care of patients. People hurt when they can't get medical care. People's health care is compromised when they can't get medical care. People lose lives when they can't get medical care. This is serious stuff.

And so it is not just distressing, to quote my friend from Washington State, it is cavalier and arrogant to have the Administration do this. It is cruel and irresponsible to have the Administration move in this direction.

We talk in Washington-speak here a lot, and so I want to drill down a little bit, if I may, with some of you on the panel. We have talked about "coverage gap." What does that mean?

Dr. Gottlieb, what does "coverage gap" mean?

Mr. GOTTLIEB. Quite simply, people might not be covered, they might not have insurance.

Mr. PRICE. They don't have insurance, they don't have insurance. They had it before, they don't have it now. That is a coverage gap. That means you can't see a doctor, you can't go to a hospital and have the procedure or the service covered.

What about "back end"? We have heard, "The back end hasn't been completed." Sounds like a medical term.

But, Dr. Gottlieb, what is "back end"? What does that mean?

Mr. GOTTLIEB. Well, that would be my jargon again. That is a reference to the systems to allow payments to the insurance companies and to the providers. So the front end, people can enroll, but then all the stuff that should happen after that hasn't been built out yet.

Mr. PRICE. So it means doctors and hospitals and other providers aren't yet—there is no mechanism to pay them yet for the services they provide?

This ties in to a committee hearing in another committee a couple weeks ago that 40 percent of the Web site wasn't completed, that they haven't even done it, haven't even done it.

That is the back end. So, folks at home listening, what that means is your doctor won't get paid. If your doctor doesn't get paid, you know what happens. He or she can't see you.

"Network information." Mr. Kreidler used "network information," "We didn't have the network information complete."

Ms. Turner, what is "network information"?

Ms. TURNER. Well, one would assume that that is the networks of doctors and hospitals that people would be able to see if they were to sign up for various health plans.

Mr. PRICE. So we are asking the American people to make a decision about the most important thing in their lives, their health care for themselves and for their family, and we don't even have the information available to them to allow them to make a responsible decision. You talk about cruel and irresponsible.

Ms. Turner, another question was asked of you about young people being discouraged to sign up, and you weren't allowed to continue your answer. I think you started, "The law discourages," and then you were cut off. Would you expand on why the law discourages young people?

Ms. TURNER. I think this is such an important issue, and it shows that the law needed to be thought through better because young people were the very people that the exchanges need to attract to the plan, because they are being told they have to pay a higher actuarial price for their health insurance in order to be able to have older people pay less.

So you need to have them in, but they are figuring this out, first of all. If they are young and healthy, they are not going to spend 3 or 4 days, a week, trying to get through a Web site for insurance when they find that they are going to have to pay more for it than their actuarial rates.

Mr. PRICE. So a huge financial disincentive——

Ms. TURNER. Yes.

Mr. PRICE [continuing]. For young, healthy people to sign up. And that is in the law. Republicans didn't make that up.

Ms. TURNER. Right.

Mr. PRICE. That is in the law.

So, Mr. President, we have a better idea, H.R. 2300. I look forward to your call.

Thank you.

Chairman BRADY. Thank you.

Mr. Smith is recognized.

Mr. SMITH. Thank you, Mr. Chairman.

And thank you to our witnesses today.

I know that as we deal with what has been noted by many as a very serious issue, I hope that we can bring about a system that is patient-centered, where the government doesn't stand in the way of patients and their care. And some patients find care in different ways or at different levels, but the patients, I hope, would be in charge.

And so I am very concerned on the very topic that was just mentioned, about the need actuarially for younger, healthier folks to sign up who were not previously signing up, to spread that risk, and yet there are indications that these younger folks are not signing up.

Commissioner Kreidler, could you disagree with that? Is that not the case?

Mr. KREIDLER. Congressman, I would agree right now that we are not attracting as many of the young and the healthy that really need to be a part of the Affordable Care Act because insurance only works if you have good risk and bad risk. And if they have good risk, you need to balance it out. That is the only way insurance works.

Mr. SMITH. And do you think that those targets are being met?

Mr. KREIDLER. The targets currently are not being met. And one of the challenges that make it more difficult is all of the controversy around the Affordable Care Act. Such things as cancelled policies and the like only wind up offering more distraction. And we need to make sure that people are incentivized, realize they have an obligation for personal responsibility, and do the signup for health insurance so they don't have to have their rates paid for, effectively, by other people who are insured.

Mr. SMITH. Mr. Carlson, if these folks aren't signing up, ultimately, what is at risk?

Mr. CARLSON. Well, I think what is at risk is the future of that risk pool. The premiums that were set for 2014 assumed a certain mix of younger and older individuals. If that mix is not met, you have an issue that the insurance company is not going to be collecting enough premiums relative to the claims they expected. And that also is going to drive their pricing for 2015.

So, you know, unless they can see that the risk pool will change to be a more balanced risk pool, they have to build in to their pricing the assumption that they are not going to be able to enroll those younger individuals and are going to have to increase their premiums to reflect that difference.

Mr. SMITH. Are there any numbers that you could maybe point to in terms of what expectations—I mean, it is probably difficult to do, but any rule of thumb?

Mr. CARLSON. You know, I think at this point it is way too early to make any judgment. I think it is certainly a positive number and not a negative number; I will put it that way.

Mr. SMITH. Okay.

Well, I just have such extreme concern that if young people weren't signing up before and they will be faced with a higher premium yet because of all of the new mandates and the government, and the heavy hand of government, I would add, intervening, that will result in a higher premium, I can't imagine that human beings would be more anxious to sign up for that, even with some of the penalties in place.

Commissioner Kreidler, do you see any objection there?

Mr. KREIDLER. You know, one is that there is the opportunity up to the age of 26 of staying on your parents' policy. The other is that there are catastrophic plans up to the age of 30 that are much more affordable that are possible for younger and healthier individuals to sign up for.

So there are some options out there to help bend that cost curve down for the individual—cost curve from the standpoint of how much it costs them.

But nobody is immune from bad luck. A good friend wound up with her son having a skiing accident in Utah and wound up costing her something like $20,000 because of a broken leg, and he didn't have health insurance. Well, mom went out there to pay for it. Now, it is going to be easier for her to make sure that he has reasonable coverage than it has been in the past.

But, yes, it means exhibiting personal responsibility so that we work to avoid the fact that, if you wind up with bad luck, you don't have to cost-shift to other people.

Mr. SMITH. Okay. Thank you.

I will yield back.

Chairman BRADY. Thank you.

Mrs. Black.

Mrs. BLACK. Thank you, Mr. Chairman.

I want to go to the topic of security.

And so, Ms. Turner, this question is going to be for you. We are learning that HHS never built security into the Web site. As a matter of fact, there was a top security expert yesterday on CNBC that stated, and I quote, "Putting your information on there is definitely a risk," and he was talking about the Web site.

As a matter of fact, there was a piece on there that actually said, and I paraphrase, that there was no expectation of security of your information. It has since been removed from the Web site. I don't know that we can be confident now that something has changed since the removal of that.

But is it fair to force people to use this Web site, the individual mandate that forces people to buy insurance that maybe they don't want and to expose them to the fear of having their most personal information hacked? Do you think that would be a concern?

Ms. TURNER. That is a huge issue, and it is yet another deterrent for people to go on to the Web site. I am not an IT expert,

but I certainly have read—a number of them have said that, even with this last push, this last row of fixes, that they did nothing to improve the security of the information that people are required to put on this Web site.

This is a huge amount of personal information that people are required to disclose in order to see what subsidies are available, et cetera, as well as ultimately credit card information, bank account information. And if hackers can so easily get at a system, it is yet another deterrent from people enrolling in this coverage. I think that needs to be—that has to be a priority.

Mrs. BLACK. Thank you. And I would say, given the many problems that have already been identified, that this may be another one that would indicate there is a reason for a delay in the individual mandate, as there was for an employer delay.

Mr. Kreidler, I just want to go to you because you have built a Web site. And what did you do to ensure that there was security information on your Web site?

Mr. KREIDLER. We had a number of protocols that were required of us. One, even receiving the Federal grant was there an obligation to be able to demonstrate that this information would be treated confidentially. And going forward, we had an obligation to make sure that the system operated.

But, you know, all Web sites—I mean, we have certainly seen it with some of the major Web sites in this country where there have been compromises that have taken place, private Web sites that have had problems with personal information. I think it is an ongoing obligation and a challenge in the new era of Web sites and the kind of information that can be accessed, is to build in as much security as possible.

Mrs. BLACK. So you say that, in order to receive the government grant to build the Web site, you had to ensure that you would use, I would say, probably standards that are accepted within the industry to ensure that, such as the end-to-end testing. Did you do end-to-end testing on your Web site?

Mr. KREIDLER. We did do testing. I wish we would have done more testing, just from the consumer perspective more than the privacy issue.

But part of this is, even though we have our Web site at the State of Washington level, you have the Federal hub that you also interact with, which goes to a lot of the more critical personal information that you are describing, whether it is IRS information for eligibility or whatever. So it is a complex system, and confidentiality is something that we take very seriously.

Mrs. BLACK. Well, and thank you for that. And I would say, given the fact that the Federal Government required you to use industry standards to ensure that you did end-to-end testing and to ensure the folks that are using your Web site, that they could be confident in putting that material in, that at least you did all you could to protect them, that is certainly a disappointment, that the Federal level did not follow those same standards. Because we know that they did not do end-to-end testing. And so this is a big concern.

With the little bit of time that I have left, verification, income verification, has been something that I have been very concerned

about. Because the two planks of the ACA was that if someone did not have employer-sponsored insurance, they could apply, and when they applied, we would have to verify income to be sure that their income was at a level where they were eligible for these tax credits.

We learned yesterday that the Inspector General for the Tax Administration—and I quote: "The IRS's existing fraud-detection system may not be capable of identifying the ACA's refund fraud or schemes prior to the issuance of tax return funds." So now we have another situation that was not set up or being followed, where we don't know how much fraud is going to take place here.

So thank you very much, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Reichert is recognized.

Mr. REICHERT. Thank you, Mr. Chairman. Thank you for allowing me to be a part of this hearing and pose some questions.

And I would feel a little bit guilty, Mr. Kreidler, if I didn't attend—I am not on the healthcare Subcommittee. I now am on Human Resources and Trade. But I think, as a fellow Washingtonian, I wanted to be here, along with Jim McDermott and yourself. So thank you for coming.

Thank all of you for your testimony.

And I know you are proud of the product, and I know you put a lot of hard work into the Washington State exchange system, but I just want to be here to bring a little bit of reality to it. And I think you have touched on some of those things, but I want to highlight some of the issues that we have had.

You know, my good friend from New Jersey has said, look, you know, we are looking for this to work. And what we want, though, really, is quality health care, affordable health care. We want access, and we want the freedom to choose. And I think that, in the ObamaCare plan, which we oppose because it hasn't lived up to any of those promises, in our opinion—that is why we are working to correct this. Because these are the things we should all be—it is not just about making the law work. These are the things that we should be after, right, for our constituents.

So I know you are proud of your work and proud of the fact that over 176,000 people have enrolled in the Washington exchange program. But out of those 176,000, 158,000 of those are Medicaid enrollees; only 18,000 are individual enrollees.

And isn't it true that if that number doesn't go up by 2015, that the health insurance providers will have to increase their premiums for the losses that they are going to incur if they don't get those individual enrollments up?

Mr. KREIDLER. It is an ongoing concern because we obviously want to get as many people enrolled through qualified health plans through the exchange, people who will be eligible for subsidies and some that are not eligible for subsidies also signing up for plans.

Mr. REICHERT. But isn't it true, though, sir, that premiums will probably go up if those numbers don't rise?

Mr. KREIDLER. You know, as Mr. Carlson has pointed out——

Mr. REICHERT. Is that a "yes"?

Mr. KREIDLER. As an actuary, the answer is it is too early to say. Because you are only going to have about a quarter of a year in order to make those determinations.

Mr. REICHERT. Okay.

Mr. KREIDLER. There are a lot of other pressures that apply, such as market share and competition, that are going to drive insurance companies that help to hold down the rates.

Mr. REICHERT. I agree that there is some time yet, but it looks like, from the information that we have been able to gather, the premiums will go up if those enrollments don't go up.

The other issue is the 8,000 people who had a subsidy issue. They enrolled in programs, discovered that their subsidies were incorrectly calculated. I think you are trying to address that problem. But once they have discovered that their subsidies are less than what they supposed in the first place, now their premiums go up, and they have insurance plans that they didn't want or it doesn't provide the service that they need. I think that is a huge issue.

Eight thousand people—you talked a little bit earlier about glitches. Glitches mean people to me. That is 8,000 people that are in a glitch. That needs to be fixed. Two hundred and ninety thousand people in Washington State received notices that their insurance plans were cancelled—290,000 people—in this glitch.

The President said, after he made these promises, you can keep your healthcare plan, which was really not totally truthful, finally came out and said, you can keep your healthcare plan. The House of Representatives here in the United States Congress passed a law that said you can keep your healthcare plan. Harry Reid did not bring that bill to the Senate floor.

You decided, sir, to separate yourself from the President on that request and decided not to allow those 290,000 people to keep their health insurance. Did you speak to any of those health insurance carriers to see whether or not they could continue their coverage before you made that decision for those 290,000?

Mr. KREIDLER. The answer to that, Congressman, is, no, I did not.

Mr. REICHERT. Why not?

Mr. KREIDLER. I regulate. I regulate the——

Mr. REICHERT. Why did you not contact those insurance companies?

Mr. KREIDLER. We had a statement from the American Health Insurance Plans, AHIP, that was very clear that they were distressed by it.

The irony of it is they were distressed about what the President proposed, but they privately would have said that the Upton measure that passed here——

Mr. REICHERT. Well, before my time runs out——

Mr. KREIDLER [continuing]. Would have been much more——

Mr. REICHERT. Before my time runs out, Mr. Kreidler, I want to make a couple more points.

Soon to hit will be the employer mandate—the employer small businesses association plans, they are going to get their notices for cancellations. I know that some already have.

The other thing that really bothers me is this narrowing network issue that you spoke of earlier in your testimony. Look, we have

plans, and only one insurance company covers Cancer Alliance, Children's Hospital, University of Washington's Hospital——

Chairman BRADY. All time has expired.

Mr. REICHERT. Thank you, Mr. Chairman.

Chairman BRADY. No, thank you, Mr. Reichert.

First, let me recognize Dr. McDermott for a unanimous-consent request.

Mr. MCDERMOTT. Mr. Chairman, thank you.

I ask unanimous consent that we enter into the record a letter from the Association of Washington Healthcare Plans dated December 2nd, 2013.

It responds directly to what Mr. Reichert is saying. It says: Accordingly, if the Administration of Congress chooses to make additional policy changes in the ACA, we ask that you advocate for allowing States with a functioning State-based exchange like Washington to continue with implementation as currently required under ACA.

Chairman BRADY. Right. The time——

Mr. MCDERMOTT. The insurers in Washington State ask him not to make the change.

Chairman BRADY. Thank you.

Without objection.

[The information submitted by the Honorable Jim McDermott follows:]

The Association of Washington Healthcare Plans

December 2, 2013 Sent By Electronic Mail

To: Washington State Congressional Delegation

The Honorable Maria Cantwell U.S. Senator	The Honorable Patty Murray U.S. Senator
The Honorable Rick Larsen U.S. Representative	The Honorable Jaime Herrera Beutler U.S. Representative
The Honorable Derek Kilmer U.S. Representative	The Honorable Jim McDermott U.S. Representative
The Honorable Doc Hastings U.S. Representative	The Honorable David Reichert U.S. Representative
The Honorable Cathy McMorris Rogers U.S. Representative	The Honorable Adam Smith U.S. Representative
The Honorable Suzan DelBene U.S. Representative	The Honorable Denny Heck U.S. Representative

Re: Impact of Potential Affordable Care Act (ACA) Policy Changes

Dear Representative McDermott:

I am writing on behalf of Association of Washington Healthcare Plan (AWHP) members regarding additional policy changes to the Affordable Care Act (ACA) we understand are being contemplated by the Administration or Congress prior to January 1, 2014.

AWHP is an alliance of Washington State's 15 leading licensed Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), and Disability Insurers. Its diverse membership is comprised of local, regional, and national healthcare plans of varying size, serving the needs of consumers, employers, and public purchasers. Together, they provide health care coverage to over 4 million residents of our state.

AWHP member healthcare plans are committed to working together and with other stakeholders to help assure Washington residents meaningful access to affordable quality healthcare coverage choices. Accordingly, we offer the following comments and recommendations.

It is our understanding consideration is being given on a national level to extend the open enrollment period, as well as delay the individual mandate. For Washington State, changing significant health reform requirements at this point in time would result in destabilizing the state's healthcare market and higher premiums for consumers.

Throughout the established ACA open enrollment period our state-based Exchange, with its robust offering of 46 individual health plans, has been continuously enrolling individuals and helping those who are eligible to secure financial assistance to purchase coverage through premium tax credits. In addition, there are 51 individual health plan offerings available to consumers outside the Washington Health Benefits Exchange. As of November 14th, nearly 100,000 residents of our state have successfully enrolled through the Exchange, and over 159,000 applications are in process.

Accordingly, if the Administration or Congress chooses to make additional policy changes to the ACA, we ask that you advocate for allowing states with functioning state-based Exchanges, like Washington, to continue with implementation as currently required under the ACA.

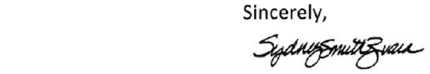
Over the past three years, Washington healthcare plans have worked collaboratively with the Washington State Insurance Commissioner to implement the ACA with the specific needs of Washingtonians in mind. Additionally, we have worked with the Commissioner's office to ensure the individual health plan market remains stable and consumers continue to have a variety of health coverage options in 2014. This work has included setting premiums for 2014 health plans based upon, among other things, assumptions that the individual shared responsibility requirement will be in effect in 2014 and that the annual open enrollment period will conclude on March 31, 2014.

A few weeks ago, Commissioner Kreidler decided Washington State should continue to implement the ACA under the original timelines and requirements, and did not allow carriers to extend their 2013 policies --- something the Administration had offered. Extending 2013 policies in Washington State at this late date would have destabilized the market and caused significant consumer confusion. Consistent with other state flexibility allowed in the ACA, this recent opportunity for state flexibility confirms that there is not a one-size-fits all implementation of the ACA.

We believe it is not in the best interest of Washington residents to extend the ACA open enrollment period or delay the individual mandate. It is important that our state be allowed the flexibility to continue with implementation as currently required under the ACA.

Thank you for the opportunity to provide this input for your consideration. Please do not hesitate to contact me with any questions or to discuss.

Sincerely,



Sydney Smith Zvara
Executive Director

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AWHP is an alliance of licensed Health Maintenance Organizations (HMO), Health Care Service Contractors (HCSC), & Disability Insurers. Its diverse membership is comprised of local, regional, & national healthcare plans of varying size, serving the needs of consumers, employers, & public purchasers. Together, they provide health care coverage to over 4 million residents of Washington State. AWHP members include Aetna, Amerigroup, Cambia Health Solutions, CIGNA, Columbia United Providers, Community Health Plan of WA, Coordinated Care,Group Health Cooperative, Kaiser Permanente, Molina, HealthNet, Premera Blue Cross, Providence Health Plan, SoundPath, & UnitedHealthcare.

Chairman BRADY. One, I would like to thank our witnesses for their testimony today.

There are a lot of concerns about this law. A lot of families and patients and local doctors have concerns. We are going to continue. I think your testimony was insightful, your answers were thoughtful, we think, I think, very helpful in this whole discussion. We will continue to do oversight, vigorous oversight, over this law for Republicans and Democrats to be able to make sure we know what that impact is.

As a reminder, any Member who wishes to submit a question for the record will have 14 days to do so. So if any questions come your way, I would ask that the witnesses respond in a timely manner, as I know you will.

With that, this Subcommittee is adjourned.

[Whereupon, at 11:44 a.m., the Subcommittee was adjourned.]