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A NEW, OPEN MARKETPLACE: THE EFFECT OF GUARANTEED ISSUE AND NEW RATING RULES

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING AN OPEN MARKETPLACE, FOCUSING ON THE EFFECT OF GUARANTEED ISSUE AND NEW RATING RULES

APRIL 11, 2013

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A NEW, OPEN MARKETPLACE: THE EFFECT OF GUARANTEED ISSUE AND NEW RATING RULES

THURSDAY, APRIL 11, 2013

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

The committee met, pursuant to notice, at 10:07 a.m. in room SD–430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Alexander, Franken, Whitehouse, Baldwin, Murphy, Roberts, and Scott.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will come to order.

We meet today for the eighth in a series of hearings in this committee on the Affordable Care Act.

We have been through a trying political season since we last met about this law. As everyone here is keenly aware, the law was a major topic of discussion during the Presidential campaign, as well as the campaigns of many House and Senate colleagues. But, hopefully, that political season is over. Our priority now must be implementing the law as smoothly and quickly as possible so that all Americans can share in its benefits.

For the last 3 years, millions of Americans have been protected, for the first time, against some of the most notorious and abusive practices of the insurance industry. Thanks to the health reform, Americans now have the same protections that every Senator on this dais has had for years.

Before the Affordable Care Act, millions of Americans had health insurance policies with lifetime limits. The health reform law permanently eliminated these limits for 105 million Americans. It phases out annual limits by 2014.

The law requires every insurance plan to cover evidence-based preventative services that will head-off many illnesses. Over 105 million Americans have already taken advantage of these protections.

These preventative services are of particular importance to women, who can now receive well-woman visits, contraceptive services, and gestational diabetes screenings without co-pay. The law guarantees 27 million women access to these vital services at no charge.

Before the Affordable Care Act, millions of young adults went without health insurance because their jobs did not offer it, or be-

cause they were ineligible for coverage on their parents' policy. Now, health reform allows young people—more than 3.1 million so far—to stay on their parents' policy through age 26.

This is a record, I think, to be proud of. It is a record to build on. Even with all of this progress, the best is yet to come. Starting in 2014, the Act's most fundamental and significant reforms will become effective.

These reforms will finally deliver on a long overdue promise to all Americans. The promise that if you work hard, play by the rules, and pay your fair share, you will never have to stay awake at night worried that you cannot pay your family's medical bills.

The primary mechanism for these changes is a new Health Insurance Marketplace in every State, open for business on October 1st of this year. Most importantly, the almost 130 million Americans who have a pre-existing condition will, at long last, have peace of mind. Their health status will never again be a factor when they apply for insurance.

In addition, the new rules prohibit insurers from denying coverage or charging more based on gender. No longer will women be charged more than men simply because they are women. And the law limits insurers' ability to charge more based purely on age, making coverage accessible and affordable for folks closer to my age, but who are not lucky enough to have the same coverage that I do.

These protections are vital for Carol from Ankeny, IA, who wrote me this. She said,

> "My daughter is 19 years old and was diagnosed with Type I diabetes 9 years ago. Now I don't have to worry about her pre-existing condition, and she can stay on my health care after she graduates from college, giving her a bridge to finding a job with benefits. In addition, the lifetime cap won't be an issue."

I should add, that her daughter will never be charged more just because of her condition and her gender.

For millions of people across our country, these reforms are transformational. They are making profound, practical differences in the lives of ordinary people, and I look forward to hearing the witnesses' perspectives on them.

I want to thank our Ranking Member, Senator Alexander, for being here today. I will turn to him for an opening statement.

But I want to request that the record remain open for 10 days from today for statements to be submitted to the record.

With that, I recognize Senator Alexander.

OPENING STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thanks, Mr. Chairman. Thanks for the hearing.

I look forward to the witnesses. I thank Mr. Cohen. Thank you for coming, and for the other witnesses.

I welcome this oversight hearing on the new health care law. It is timely because on January 1st, rhetoric turns into reality and we will see just exactly what we have.

Here is what we know we have: with few exemptions, individuals must purchase insurance or pay a tax of $95 to nearly $700 over time. Unless the business has 50 employees or fewer, employers must provide a certain type of insurance or pay a penalty of $2,000 per employee. There are $1 trillion new taxes as a result of the new health care law; that is according to the Congressional Budget Office and the Joint Tax Committee.

We are hearing today about new rules for allocating costs, which means that I may pay less and a young person may pay more.

More people are covered, as Senator Harkin has correctly pointed out, and some people will get subsidies to help pay for their insurance. All of that will become reality after January 1, 2014.

Now, there are some results from this other than the expanded coverage, and the results include individual costs; premiums for individual insurance are going up. Costs for younger Americans are going up, especially to buy insurance. Costs to employers of providing health care insurance are going up. Many who are self-employed, and those who have employer insurance—that is about half of us, half of Americans—will find they are not able to keep their current policy. In many cases, they will be thrown into the marketplace to buy a more expensive policy than they now have or they will go into Medicaid.

And as employers struggle, there will be more part-time jobs. We are already hearing many, many stories of employers who are going to hire people for 30 hours or less, so they are not subject to the penalty requirements of the health care law, and there will be fewer jobs.

I have said here in hearings before, the restaurant companies who have talked to me and said while before the health care law, their goal was to run their store with 90 employees, now their goal is to run it with 70 because of the costs of the law.

And then as a former Governor, I am especially sensitive to States who are struggling with Medicaid. We do not see it from this end as well, but you certainly see it if you are a Governor. That is why I said that any Senator who voted for the health care law ought to be sentenced to serve as Governor for 8 years and actually try to administer it. Medicaid soaks up 26 percent of the Tennessee State budget; that is up from 7 percent at the time I was Governor. And it is soaking up money that ought to be used to help the University of Tennessee, and other community colleges, and public institutions in the State.

And then there is one other result, and I have it with me here today. There are a lot of new regulations. This is a stack of the regulations that have been issued under the new health care law to date and it is 7 feet, 3 inches tall and still rising. And for a big or small business to think about how to deal with that number of regulations, that kind of complexity, has to be daunting.

We have many things we agree on in this committee, and I compliment the chairman for the way we work together, but this law is not one of them. We have a difference of opinion about it.

In my view, the law was an historic mistake. The reason was it focused on the wrong goal. Instead of expanding a health care delivery system that already costs too much, we should have worked to have as an overall goal reducing the total cost of health care and

expanding the consumers' role in going step by step in that direction.

I look forward to the testimony, and I will have some questions and I look forward to answers. I look forward to this coming period of time when America finds the rhetoric of the health care law turns into reality, I think there is going to be a number of shocked Americans, and it is going to start with what we call rate shock as the cost of individual insurance premiums go up.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander. We have a vote coming up at 11 o'clock. We will do it the best we can.

We have two panels, and we will start first with panel one and Mr. Gary Cohen, director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

Mr. Cohen is responsible for implementing many provisions of the Affordable Care Act including the consumer protections reforms already in effect, and those that will start in 2014. His office also works with States to set up Health Insurance Marketplaces in the States.

Mr. Cohen comes with a distinguished insurance background. He has led the Center's Division of Insurance Oversight. He also returned to his home State of California to serve as general counsel for its Health Insurance Marketplace.

Mr. Cohen served as chief of staff to Congressman John Garamendi, both here in Congress and when Mr. Garamendi was Insurance Commissioner of the State of California.

Thank you for joining us this morning sharing your experience and expertise with the committee. Your statement will be made a part of the record in its entirety. If you could sum it up in 5 minutes or so, I would sure appreciate it.

Welcome, Mr. Cohen.

STATEMENT OF GARY COHEN, J.D., DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES, WASHINGTON, DC

Mr. COHEN. Thank you, Chairman Harkin, Ranking Member Alexander, members of the committee.

CCIIO is working to transform the Health Insurance Market to protect consumers, provide new coverage options for them, and give them the tools and resources they need to make informed choices about their health insurance.

Most Americans receive health insurance in connection with their jobs, and for many of those Americans, particularly those who work for larger employers, this system has worked well. But for the approximately 10 percent of Americans who do not have employer-sponsored coverage or do not have coverage through a Government program such as Medicare, Medicaid, or the Children's Health Insurance Program, the system has been broken.

I would like to describe for you a few of the ways the Affordable Care Act has already made it better and some others that will transform it beginning in 2014.

First, before the ACA, millions of Americans could not get health insurance in the individual market at all. If you became sick or if you had been sick some time in the past, insurers either would not give you a policy or they would charge so much that you could not afford it. Today, children cannot be excluded because of pre-existing conditions, and beginning in 2014, no one can.

In the past, health insurers could place annual or lifetime limits on the amount of medical care they would pay for. Some of these limits were so low that if you became seriously ill, you would soon find you had no insurance at all. Now, most insurers are prohibited from placing annual or lifetime limits on coverage for essential benefits such as doctor's visits, prescription drugs, or hospital stays.

In the past, insurers could drop young adults over the age of 19 from their parents' insurance plans. Now, most health plans that have covered children must make coverage available up to age 26. Today, more than 3.1 million additional young adults are covered under their parents' plans.

In the past, often because of cost, Americans used preventive services at about half the recommended rate. We know that chronic diseases such as heart disease, cancer, and diabetes often are either preventable or, with early detection, treatable. Now, most plans must cover certain preventive services without applying any deductible co-insurance or co-pay, and nearly 71 million Americans have expanded access to preventive services at no charge through their private insurance plans, and 47 million women now have guaranteed access to additional preventive services without cost sharing.

In the past, when consumers shopped for health insurance, they had to read a patchwork of confusing disclosures, making it hard to compare plans and make informed choices. Now, health insurers and group health plans are required to provide a clear summary of benefits and coverage in a uniform format and in plain language.

Americans have been used to seeing their premiums rise faster than their wages, but for the past 2 years, premiums have gone up by the lowest amount in decades. Two provisions of the ACA have contributed to this.

The law requires that insurance companies must justify rate increases of 10 percent or more, shedding light on arbitrary or unnecessary costs. The percentage of rate increases above 10 percent has dropped significantly, and Americans saved an estimated $1 billion in 2011 on their health insurance thanks to Rate Review.

Rate Review works in conjunction with the 80/20 rule or the Medical Loss Ratio rule which requires insurance companies to spend at least 80 percent of premiums on health care and no more than 20 percent on administrative costs and profits. If they fail to do so, they must provide rebates to their consumers. Thanks to this provision of the Affordable Care Act, 15 million Americans received $1.1 billion in rebates from insurers in 2012.

For some Americans, the cost of health insurance is even higher than for others. Today, women could be charged more for individual health insurance policies simply because they are women. A 22-year-old woman can be charged 50 percent more than a 22-year-old man, and older Americans can be charged as much as 5 times the rate for younger Americans.

Beginning in 2014, health insurance companies will no longer be able to charge women more than men, and they will be limited in how much more they can charge older Americans than younger Americans.

The Affordable Care Act will also guarantee that people get good value from the insurance they buy. Beginning in 2014, most health plans in the individual and small group markets must meet a certain actuarial value, which means the percentage that will be paid by the health plan of the estimated average total cost of health care. Plans will be assigned a tier-based level based on their actuarial value. What this means is that you can choose a plan based on what you expect your health care costs to be. If you are relatively healthy, you can buy what we call "The Bronze Plan," which will pay a lower amount of your total costs, but will be less expensive. If you are older and you expect to have more health costs, you can buy a Silver or a Gold Plan, which will cost a little bit more, but will cover more of your expected costs of care. And you will still have the security, in any case, of knowing that if you become seriously ill that coverage will be there to pay for the cost of your care.

Starting October 1, Americans will begin shopping for and enrolling in a wide variety of high quality health insurance plans for coverage in 2014. They will be able to use a single, streamlined application to determine whether they are eligible for Medicaid, or CHIP, or qualify for premium tax credits and reduced cost sharing for a qualified health plan purchased on the Marketplace.

We have been working hard over the past 3 years to improve the Health Insurance Market for all Americans. We are very proud of what we have accomplished so far, and we are excited about the new consumer protections that will be in place beginning in 2014.

Thank you.

[The prepared statement of Mr. Cohen follows:]

PREPARED STATEMENT OF GARY COHEN, J.D.

SUMMARY

In March 2010, President Obama signed the Affordable Care Act into law. Over the past 3 years, Americans have benefited from insurance reforms that have already gone into effect. Today, more than 3.1 million additional young adults under the age of 26 are covered under their parents' plans. Nearly 71 million Americans now have expanded access to preventive services at no additional cost through their private insurance plans, and 27 million women now have guaranteed access to additional preventive services without cost sharing.

Now, health insurers and group health plans provide a clear summary of benefits and coverage in a uniform format and in plain language that is designed to be easily compared across health plans by the millions of Americans shopping for private health insurance coverage.

Now, insurers must provide clear information so consumers can understand the insurer's reasons for significant rate increases. Since the rule on rate increases was implemented, the number of requests for insurance premium increases of 10 percent or more plummeted from 75 percent to an estimated 14 percent.

Today, in most States, adult consumers with pre-existing conditions can be denied individual health insurance coverage, can be charged significantly higher rates based on their conditions, or can have benefits for pre-existing medical conditions excluded by insurance companies. In 2014, Americans will no longer need to worry about this. Non-grandfathered health insurers in the individual and small group markets will no longer be able to use health status to determine eligibility, benefits, or premiums.

Before the Affordable Care Act, women could be charged more for individual insurance policies simply because of their gender. Before the Affordable Care Act, premium rates charged to older Americans could be more than five times the rate for younger Americans. In 2014, new rules will help make health insurance more affordable for more Americans.

At the same time that insurance prices become more fair, many individuals will also have new help paying for their health care coverage through premium tax credits and cost sharing reductions. When coverage through the Health Insurance Marketplace starts as soon as January 1, 2014, many middle and low-income Americans will be eligible for a new kind of tax credit that can be used right away to lower monthly health plan premiums.

CMS has been working with States and private insurance companies to ensure the establishment of Health Insurance Marketplaces. When consumers start to visit the new Marketplaces on October 1, 2013, they will experience a new way to shop for health coverage. The Marketplaces will also make it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality.

Good morning, Chairman Harkin, Ranking Member Alexander, and members of the committee. Thank you for the opportunity to speak about our work implementing the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans the additional tools to make informed choices about their health insurance. Thanks to the consumer protections and insurance market reforms in the Affordable Care Act, in 2014, millions of people without insurance will be able to obtain coverage, and millions more will have the peace of mind that the coverage they have cannot easily be taken away.

In March 2010, President Obama signed the Affordable Care Act into law, putting in place comprehensive reforms to improve access to affordable health insurance for all Americans and protect consumers from abusive insurance company practices. Over the past 3 years, Americans have benefited from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parents' insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance because someone gets sick.

In 2014, these protections will be greatly expanded. Discrimination by insurance companies against individuals with pre-existing conditions will generally be banned for Americans of all ages, and consumers will have better access to comprehensive, affordable coverage. Beginning on October 1, 2013, Americans may begin shopping for and enrolling in a wide variety of high-quality health insurance plans for coverage in 2014 through the Health Insurance Marketplaces (also known as Affordable Insurance Exchanges). Regardless of whether they plan to purchase their insurance through a Health Insurance Marketplace or are covered by insurance through their work, in 2014, more Americans will have access to more affordable health insurance.

WHAT WE HAVE ALREADY ACHIEVED: BETTER ACCESS TO HIGH QUALITY COVERAGE

The Center for Consumer Information and Insurance Oversight (CCIIO) at the Centers for Medicare & Medicaid Services (CMS) has implemented strong consumer protections that hold insurance companies more accountable, give consumers more coverage options, and improve the value of that coverage. Today, more than 3.1 million additional young adults under the age of 26 are covered under their parents' plans. Nearly 71 million Americans now have expanded access to preventive services at no additional cost through their private insurance plans, and 27 million women now have guaranteed access to additional preventive services without cost sharing.[1]

The Affordable Care Act has also helped provide consumers with more rights and protections. In the past, health insurers could refuse to accept anyone because of a pre-existing health condition, or they could limit benefits for that condition, but the Affordable Care Act will provide consumers with the security that their coverage will be there for them when they need it.

Now, non-grandfathered individual health insurance plans and group health plans and group health insurance plans are prohibited from denying children coverage based on their pre-existing conditions, protecting 17.6 million children with pre-existing conditions from coverage denials. Additionally, insurance companies cannot drop or rescind people's coverage because they made an unintentional mistake on

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[1] *http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib_prevention.cfm*.

their application[2] and cannot place lifetime limits on the dollar value of essential health benefits. Group health plans, group health insurance plans, and non-grandfathered individual health insurance policies also are restricted in the annual dollar limits they can place on essential health benefits, depending on the plan year. We further protected consumers by establishing a set of uniform standards for external review of individual health plan decisions restricting an enrollee's access to benefits. Now, consumers enrolled in non-grandfathered group health plans and group health insurance coverage and individual health insurance policies can ask for an independent third party to review decisions made by their plans and insurance companies to deny preauthorization or payment for a service.

In the past, often because of cost, Americans used preventive services at about half the recommended rate. Yet chronic diseases, such as heart disease, cancer, and diabetes—which are responsible for 70 percent of deaths among Americans each year and account for 75 percent of the nation's health spending[3]—often are either preventable or, with early detection, treatable. Now, all non-grandfathered plans cover certain preventive services without any cost-sharing for the enrollee when delivered by in-network providers. This protection will help Americans gain easier access to services such as blood pressure, diabetes, and cholesterol tests; many cancer screenings; routine vaccinations; pre-natal care; and regular wellness visits for infants and children.

In the past, when consumers shopped for health insurance, they had to read a patchwork of non-uniform and intricate disclosures about matters important to consumers, such as what benefits are covered under what conditions and the cost sharing associated with those benefits. That structure made the process inefficient, difficult, and time-consuming. Because of the difficulty in obtaining comparable information across and within health insurance markets, consumers had trouble finding and choosing the coverage that best met their health and financial needs, as well as the needs of their families or their employees.

Now, health insurers and group health plans provide a clear summary of benefits and coverage in a uniform format and in plain language that is designed to be easily compared across health plans by the millions of Americans shopping for private health insurance coverage. If people are looking to buy private health insurance, they can compare plans at *www.HealthCare.gov*, which provides information about what public and private health insurance coverage is available to consumers based on where they live. Starting in October 2013, consumers will also be able to use *www.HealthCare.gov* to shop for coverage beginning in 2014 under qualified health plans and to determine whether they are eligible for premium tax credits and reduced cost sharing, through the Health Insurance Marketplace.

Before the Affordable Care Act, Americans watched their premiums double over the previous decade, oftentimes without explanation or review. In an effort to slow health care spending growth and give all Americans more value for their health care dollars, the Affordable Care Act has brought an unprecedented level of scrutiny and transparency to health insurance rate increases by requiring an insurance company to justify a rate increase of 10 percent or more, shedding light on arbitrary or unnecessary costs.

Now, insurers must provide clear information so consumers can understand the insurer's reasons for significant rate increases. Since the rule on rate increases was implemented,[4] the number of requests for insurance premium increases of 10 percent or more plummeted from 75 percent to an estimated 14 percent. The average premium increase for all rates in 2012 was 30 percent below what it was in 2010. Available data suggests that this slowdown in rate increases is continuing into 2013.[5] Americans have saved an estimated $1 billion on their health insurance premiums thanks to rate review. Even when an insurer decides to increase rates, consumers are seeing lower rate increases than what the insurers initially requested. More than half of the requests for rate increases of 10 percent or more ultimately resulted in issuers imposing a lower rate increase than requested or no rate increase at all.

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[2] For an example see: *http://www.healthcare.gov/law/features/rights/cancellations/index.html*.

[3] CDC Report: Chronic Diseases: The Power to Prevent, the Call to Control *http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/chronic.pdf*.

[4] Health Insurance Rate Review—Final Rule on Rate Increase Disclosure and Review: *http://www.gpo.gov/fdsys/pkg/FR-2011-05-23/pdf/2011-12631.pdf*.

[5] ASPE Research Brief: Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act *http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm*.

Furthermore, the rate review program works in conjunction with the 80/20 rule (or the Medical Loss Ratio rule),[6] which requires insurance companies to spend at least 80 percent (85 percent in the large group market) of premiums on health care, and no more than 20 percent (15 percent in the large group market) on administrative costs (such as executive salaries and marketing) and profits. if they fail to do so, they must provide rebates to their customers. Insurers that did not meet the 80/20 rule in 2011 have provided $1.1 billion in rebates that benefited about 13 million Americans, at an average of $137 per family.[7]

LOOKING FORWARD TO 2014

We are proud of the accomplishments of the last 3 years, and we look forward to the most promising reforms of the Affordable Care Act that are set to start in 2014. Soon, a variety of consumer protections will take effect and will end many insurance practices that make health care coverage too expensive or unavailable for many consumers.

END TO PRE-EXISTING CONDITION DISCRIMINATION AND LIMITS ON CARE

Today, in most States, adult consumers with pre-existing conditions can be denied individual health insurance coverage, can be charged significantly higher rates based on their conditions, or can have benefits for pre-existing medical conditions excluded by insurance companies.

Beginning in 2014, new protections will help Americans of all ages maintain health insurance coverage, regardless of their health status.

As many as 129 million non-elderly Americans have some type of pre-existing health condition, and up to 25 million of those individuals do not have health insurance.[8] Pre-existing health conditions range from life-threatening illnesses such as cancer, to chronic conditions such as diabetes, asthma, or heart disease. Because of pre-existing condition discrimination by health insurers, many individuals with pre-existing conditions today have limited choices. For example, individuals may not be able to change jobs, start their own businesses, or retire because of fear of losing health insurance coverage. People with pre-existing conditions could also lose coverage if they get divorced, move, or age out of dependent coverage.

In 2014, Americans will no longer need to worry about this. Non-grandfathered health insurers in the individual and small group markets will no longer be able to use health status to determine eligibility, benefits, or premiums. With limited exceptions, all non-grandfathered plans and policies in the individual and group markets will be required to enroll individuals, regardless of health status, age, gender, or other factors and will be prohibited from refusing to renew coverage because an individual or employee becomes sick.

In addition, some people with cancer or other chronic illnesses today run out of insurance coverage when their health care expenses reach a dollar limit imposed by their insurance company or group health plan. Beginning on January 1, 2014, group health plans, group health insurance plans, and non-grandfathered individual health insurance policies will be prohibited from imposing annual dollar limits on essential health benefits. This change will help ensure that Americans will no longer worry about hitting a prohibitive dollar amount, which could force a consumer to either pay out-of-pocket for health care costs above the dollar limit or forgo necessary care.

GUARANTEED CORE BENEFITS AND COMPARISON SHOPPING

All non-grandfathered plans in the individual and small group markets will cover essential health benefits,[9] which include items and services in 10 statutory benefit categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These benefits must be equal in scope to a typical employer health plan. To this end, the essential health benefits will be defined in each State by reference to a benchmark plan.

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[6] MLR Final Rule: *https:www.federalregister.gov/articles/2012/05/16/2012-11753/medical-loss-ratio-requirements-under-the-patient-protection-and-affordable-care-act*.

[7] 45 CFR Part 158: *http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&SID=5872c7e9a4bcec4584dd3255841e647a&rgn=div5&view=text&node=45:1.0.1.2.74&idno=45*.

[8] ASPE Report: At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans *http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml*.

[9] Essential Health Benefits: *http://www.gpo.gov/fdsys/pkg/FR–2012–11–26/html/2012–28362.htm*.

Soon, consumers will be able to select an insurance plan with confidence that it will cover key health care services when they need them.

Beginning in 2014, non-grandfathered health plans in the individual and small group markets also must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage paid by a health plan of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer would be responsible for 30 percent of the costs of the essential health benefits the plan covers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, provider participation, and other factors, will help consumers make more informed decisions.

MORE AFFORDABLE COVERAGE

Before the Affordable Care Act, health insurance premiums had risen rapidly, straining the pocketbooks of Americans for more than a decade. Between 1999 and 2010, the cost of coverage for a family of four rose 138 percent.[10] These increases have forced families and employers to spend more money, often for less coverage. Before the Affordable Care Act, women could be charged more for individual insurance policies simply because of their gender. A 22-year-old woman could be charged 50 percent more than a 22-year-old man. Many young people and people with low-incomes often could not afford health insurance, leaving millions of Americans without coverage. Before the Affordable Care Act, premium rates charged to older Americans could be more than five times the rate for younger Americans.

In 2014, new rules will help make health insurance more affordable for more Americans.[11] Most health insurance companies will be prohibited from charging higher premiums to certain enrollees because of their current or past health problems. Most insurance companies will no longer be able to charge women more than men based solely on their gender. Most insurers will be limited in how much more they can charge older Americans than young Americans, so that insurance becomes more affordable for most Americans.

At the same time that insurance prices become more fair, many individuals will also have new help paying for their health care coverage through premium tax credits and cost sharing reductions. When coverage through the Health Insurance Marketplace starts as soon as January 1, 2014, many middle and low-income Americans will be eligible for a new kind of tax credit that can be used right away to lower monthly health plan premiums. The tax credit is sent directly to the insurance company and applied to the premiums, so consumers pay less out of their own pockets. The amount of the tax credit for which an eligible individual qualifies depends on the individual's household income. Individuals are eligible for premium tax credits if, among other things, they:

- Are not eligible for affordable health insurance coverage designated as "minimum essential coverage" (e.g., government-sponsored coverage and employer-sponsored coverage);
- Meet the requirements to enroll in a qualified health plan through the Health Insurance Marketplace [12];
- Are citizens of or lawfully present in the United States; and
- Have modified adjusted gross household incomes between 100 percent and 400 percent of the Federal poverty level (e.g., $23,550 to $94,200 for a family of four in 2013).

Many people will find that they can now buy more comprehensive coverage at the same, or often even lower, out-of-pocket cost than they previously paid. Additionally, young adults and certain other people for whom coverage would otherwise be unaffordable may enroll in catastrophic plans, which have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing affordable individual coverage options for young adults and people for whom coverage would otherwise be unaffordable.

Additionally, CMS recently finalized a temporary reinsurance program designed to provide market stability and premium stability for enrollees in the individual market by reducing the impact of high-cost enrollees on plans. The temporary risk

[10] Kaiser Family Foundation. Employer Health Benefits 2010 Annual Survey *http://ehbs.kff.org/pdf/2010/8085.pdf*.

[11] Health Insurance Market Rules: *http://www.gpo.gov/fdsys/pkg/FR–2013–02–27/pdf/2013–04335.pdf*.

[12] These include additional eligibility requirements, e.g., applicant is not incarcerated (45 CFR 155.305(a)(2)).

corridor program will provide issuers additional protection against inaccurate rate setting. The permanent risk adjustment program will provide increased payments to health insurance issuers that attract higher-risk populations. Taken together, these premium stabilization programs will make coverage more affordable.

SHOPPING IN THE HEALTH INSURANCE MARKETPLACE

CMS has been working with States and private insurance companies to ensure the establishment of Health Insurance Marketplaces through which millions of Americans will purchase affordable health care coverage. In order to build robust and competitive Health Insurance Marketplaces, CMS is working closely with issuers as they prepare qualified health plans that will be available to consumers within the Marketplaces. When consumers start to visit the new Marketplaces on October 1, 2013, they will experience a new way to shop for health coverage. The Marketplaces will make it possible for eligible consumers to use a streamlined application that can be completed online to apply for coverage through a qualified health plan, to qualify for premium tax credits and reduced cost sharing, or to apply for coverage through Medicaid or the Children's Health Insurance Program (CHIP).[13]

The Marketplaces will also make it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality. By pooling consumers together, reducing transaction costs, and increasing transparency and competition, the Health Insurance Marketplaces for individuals and small groups should be more efficient and competitive than the consumers' current health insurance choices.

CMS is working to ensure streamlined and secure access to a variety of information sources that will provide essential support to consumers as they fill out the streamlined application. Through these streamlined processes, consumers will be able to fill out the application, receive information about whether they are eligible for premium tax credits or cost-sharing reductions or Medicaid coverage, and begin shopping for qualified health plans, all in real time, in one sitting. Consumers will then be able to research and compare the available qualified health plan options in the Marketplace so they can make informed choices about their coverage. Consumers also can use either the Marketplace Web site or a toll-free call center to choose health coverage that best fits their needs. Marketplace Navigators and other consumer assistance programs will provide information to consumers in a fair, accurate, and impartial manner. Additionally, where permitted by the State,[14] licensed agents and brokers, as well as online brokers, may help consumers and employers enroll in a qualified health plan through the Marketplace.

CMS and our State partners are working hard to ensure that people are aware of the new tools that will soon be available to them. On *www.HealthCare.gov*, people can learn about the Affordable Care Act, review health insurance basics, such as understanding what their coverage costs, and access an interactive checklist to help prepare them to shop for coverage in the new Marketplaces. CMS also expects that other Federal agency partners and members of the private sector will be involved in efforts to reach, engage, and assist potential enrollees.

CONCLUSION

CMS has worked hard over the past 3 years to improve the health insurance market for all Americans. We are very proud of what we have already accomplished and are excited about the new consumer protections that will help Americans in 2014. More work remains to ensure Americans have access to high quality, affordable health coverage. We look forward to continuing our efforts to strengthen health coverage options with the help of our partners in Congress, State leaders, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.

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

We will now start a round of 5 minute questions. I want to first say thank you for your leadership at CMS on this and for really moving aggressively to make sure that we can have this up and going by October the 1st of this year.

Mr. Cohen, I just want to get right to the nub of something here. I would like to start right off. Discuss the status of your depart-

[13] Application Elements: *http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS–10440.html*.

[14] Per 45 CFR 155.220.

ment's work to reach out to currently uninsured populations—I am talking about the young and the healthy; and encourage them to enroll in coverage. We keep hearing about, well premiums are going up. People say, "Well, there's going to be a lot of young, healthy people that might have to pay more."

How is this campaign, how are these efforts you are doing being implemented in States where the federally facilitated marketplace is operating? What about States like my State of Iowa where the State and Federal Government are working together on a partnership-type marketplace?

So focus a little bit of your comments on that, on the young and the healthy, those that are currently uninsured.

Mr. COHEN. Thank you, Senator. I appreciate the opportunity to address that.

I think it begins, first, with some pretty extensive market research we have done to identify the different types of people that we need to reach and what are the best ways of reaching them.

Then what you will see, as we move closer to the time when people actually will be able to take action and sign up to get coverage beginning this summer, you will see a number of different types of activities happening ranging from a traditional media campaign to a social media campaign, again, geared at the specific types of target groups that we need to reach.

In addition to that, we just announced the other day a grant program for the Navigator Program. There will be community organizations in every State. It will be church groups. It will be advocacy groups. It will be all kinds of community-based organizations who already have ties to their community, and connections with their community, and have been serving their community. And we really think that is the best way to find the people and get them informed about what this law can offer them.

In addition to that, we are working very closely with the agent and broker community across the country to make sure that they understand the opportunity that this presents for them to bring millions of new people into coverage, and to make it possible for them to do that in a way that will be as simple and easy as possible.

It is really a multifaceted approach that we are taking. But specifically, as you point out, Senator, to target the groups that we need to reach and come up with the messages that are going to be most resonant with them.

The CHAIRMAN. Mr. Cohen, you mentioned this notice that came out the other day. I read it. I looked at it about grants to States to set up the Navigators. It is all well and good. Maybe I wish you hadn't mentioned that because of how you are paying for that.

This is above your pay grade, but I am sending a message to those above you through you. Robbing Peter to pay Paul, robbing the money from the Prevention Fund, the very thing that will really help to bend the cost curve in the future to keep people healthy, you mentioned that. To take money out of that to set up the Navigator system, to me, is illogical; totally illogical and self-defeating.

So I don't understand why those who implemented this, like I say, I am not talking at you. I just want to send a message that we are not going to accept that.

I believe the Navigators need to be funded. I believe that that needs to be done to help people get into the system, especially the young and the healthy that we are talking about; but to rob it from the Prevention Fund? That doesn't go and it is not going to go.

I just wanted to make that very clear. I agree on the goals, but not robbing that money from the Prevention Fund.

I think we do have to be clear that young people who are healthy who say, "Oh, my gosh. Now I've got to buy insurance." They have to understand that they are part of society too. They may have an accident. They may be riding a motorcycle without a helmet someday. They may get an illness. Who knows when cancer is going to strike or something like that?

So these so-called free riders that we have had in the past need to understand that they are part of the health care system too, and they are going to get older some day, and they are going to need to have other people in the pool.

As a former insurance salesman myself, a long time ago, there was one clear principle of insurance: people are better off the more people in the pool. The more you have in the pool, the better it is for everyone, whether it is car insurance, or life insurance, or health insurance. And young people need to understand that, that they are part of this system too.

With that, I thank you very much, Mr. Cohen. I have used up all my time.

I recognize Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman.

Mr. Cohen, welcome. I want to use most of my time to talk with you about the idea of churning. How do we stabilize those people who may be moving in and out of Exchanges in Medicaid?

But you mentioned benefits; somebody has to pay for those benefits. I mentioned to the President at our Health Care Summit in 2010 that the plan would, his plan, would increase individual insurance rates. He said it wouldn't. But the CBO said it would, and that has turned out to be right. BlueCross BlueShield of Tennessee says rates for individual policies are going up 30 percent, may be in excess of 100 percent.

The American Action Forum says premiums may triple if rates for older people like me are going to be stabilized, then younger people—my children or grandchildren—are going to be paying for it. If they are lower for women, they are going to be higher for men. Somebody has to be paying for it.

The Society of Actuaries has said that we are going to experience rate shock because costs are allocated differently because coverage is expanded because policies are richer. So there are more benefits, but there are more costs.

Now, let me turn to this subject of churning. I know that the Administration has had discussions, and been concerned, about people who might move in and out of the Exchanges and Medicaid. These would be the people who—maybe two groups of people, people who make 138 percent of poverty up to 150. These would be, what you might call, the working poor, lower income working people, but their income might go down and suddenly they will go into Medicaid, or they might go back from Medicaid; so back and forth.

The idea would be: is there some way to stabilize that to make it easier for those individuals to move back and forth, especially in those States that choose to expand Medicaid?

I notice that Arkansas has made an interesting proposal to the Secretary, which she seems to have approved in concept. Do you think that shows promise?

Mr. COHEN. I think, Senator, that one of the things that has been very encouraging throughout this process is that we do see very interesting approaches being taken by different States to try to solve some of these problems.

We have tried, throughout the implementation of the Affordable Care Act, to be as flexible as possible and to give States the ability to try different approaches as long as, obviously, they are consistent with the law.

I know we have had a lot of discussions with Arkansas about their proposal for premium assistance. There are some other States that are interested in that, and I think those discussions are ongoing. And I know there is an interest in seeing whether we can reach something that will make sense for Arkansas and for the other States.

Senator ALEXANDER. If other requirements of the law could be met, one of the benefits of such a plan could be more stability for this lower income American who moves from Medicaid back to outside Medicaid.

Is that not correct?

Mr. COHEN. That is right, as long as, I mean, obviously the cost equivalency is a significant——

Senator ALEXANDER. And that is part of the waiver decision that you have——

Mr. COHEN. Correct.

Senator ALEXANDER [continuing]. That the department has to make. But if that could be met, that would be an objective that is not inconsistent with the Administration's own objectives, it seems to me.

Mr. COHEN. That is true.

Senator ALEXANDER. And I know that Governor Haslam of Tennessee has recently made a proposal, and has been in some discussions with the department for a similar kind of proposal, that would affect 175,000 Tennesseans, many of whom might be in that churning group, who move in and out of Medicaid to the Exchanges.

Can you give me any status report on how well that proposal is being received by the department?

Mr. COHEN. I don't have a specific status report, but we certainly can look into that and get back to you. But I know there have been quite a number of conversations with Governor Haslam and the department.

Senator ALEXANDER. Well, it is not so much that you get back to me as that——

Mr. COHEN. Get back to him.

Senator ALEXANDER [continuing]. Get back to him. I think that is a good faith proposal by a Governor who, with his legislature, is trying to come up with a way to make sure these 175,000 Tennesseans, who otherwise would not receive Medicaid expansion, do

so in a way that, first, meets cost effectiveness. And, second, would meet the admirable goal, I think, of reducing the amount of churning.

I have heard some estimates that the number of Americans who might find themselves going back and forth between Exchanges in Medicaid might be as high as 40 percent.

Does that sound reasonable to you?

Mr. COHEN. I am always hesitant to pass judgment on estimates, particularly when they are being made by actuaries, since I am not an actuary. But obviously, we have seen a range of estimates on a number of subjects and everyone is giving their best guess and their best prediction. But I would hesitate to endorse any particular one.

Senator ALEXANDER. But it is a significant number.

Mr. COHEN. It is an issue.

Senator ALEXANDER. It is an issue. And financial literacy or literacy about how to purchase health care is always a problem for any of us of any station, but may be especially for some lower income people. And so, if they had a stable and secure insurance policy as they move back and forth from one part of the Government program to another, that might make their lives simpler, easier, and maybe even less expensive for the Government.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

Now I have Senator Baldwin, and then Senator Scott, Senator Franken, Senator Roberts.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I appreciate you and Ranking Member Alexander for convening this hearing.

In order for our country to thrive, we need a vibrant and growing middle class. We need an economy that is built to last. And we need laws that reflect the common belief that if you work hard and you play by the rules, you should be able to get ahead.

I was proud to work on and help pass the Affordable Care Act into law during my time serving in the House of Representatives because I believe it moves our country forward in these very regards.

The Affordable Care Act strengthens the economic security of families and businesses in Wisconsin, and all across the country by ensuring that quality health insurance coverage will be there for them.

And prior to passage of the health reform law, I heard from countless Wisconsin families and businesses about their struggles under the prior law. Far too many were squeezed literally out of the middle class because of health insurance prices that were too high or the inability to get comprehensive health insurance coverage.

I think about the many families that have seen their economic security shattered because no insurance company would insure their child. I think about how many people have been trapped in a job where they could not look at other opportunities or advance because of the insurance situation.

How many potential entrepreneurs were dissuaded from starting a business of their own because they were afraid they would not be able to find coverage? The Affordable Care Act is changing all of that.

And with many consumer protections already in place, and with the new guaranteed issue rule set to go into effect in just over 8 months, our families and businesses will be more secure knowing that quality, affordable insurance will be there regardless of a pre-existing medical condition, or sudden illness, or accident.

The law also unrigs our health insurance system to provide everyone with a fair chance and a fair shake. It will no longer allow health insurance companies to write their own rules about who is covered and who isn't, or who can be charged discriminatory premiums. I think about the fact that we now have 20 women serving in the U.S. Senate, and it is only fair that myself and our Chairman should be charged similar premiums. Being a woman is no longer going to be considered a pre-existing medical condition and it should not be treated as one.

But as much as I supported the passage of the Affordable Care Act, it is just as important that we make sure that this law is fully and faithfully implemented.

Mr. Cohen, I want to thank you for your work in enacting the laws, consumer protections, and overseeing the creation of Health Insurance Marketplaces. I have to imagine that your work has been greatly affected and, perhaps, frustrated by those States that have taken political, ideological stances against implementation of the law.

I think about my own State of Wisconsin where there is participation in the lawsuit, and then turned back early adopter grants, and then opted out of a State Exchange or a partnership Exchange, decided not to expand Medicaid.

Can you tell me how your work has been affected by the various States that have taken these other tracks?

Mr. COHEN. Thank you, Senator. I would be happy to.

I would say, first of all, that our approach to this all along has been to meet the States where they are, and provide them with the opportunity to do as much as they are willing and able to do. And I am heartened, actually.

Recently, I attended a meeting that we held with State insurance department officials from the States that will have the Federally Facilitated Marketplace. And when you get down to that level, they understand two things. They understand, first, this is the law of the land and the time for debating it is over. And second, that they want to make this work for the citizens in their States. So we are working very closely with insurance departments, departments of health around the country to help get this law implemented.

We have also begun a significant stakeholder outreach effort, which is separate and apart from anything that the State Government might be doing. We started with a national call that we had a couple of weeks ago with over 3,000 people on the phone, and we will be doing regional and State-by-State calls leveraging our presence at the 10 regional offices that CMS has around the country.

So I am not going to sit here and tell you that it wouldn't have been easier if everyone had fully embraced this from the beginning,

but I think we have made great progress. We are seeing now more of both a recognition that this is actually happening and a desire for it to succeed.

Senator BALDWIN. I particularly appreciate the outreach to stakeholders because, I think, some of that communication has been frustrated, again, by those who are politically opposing the implementation.

I guess I would ask you as a last question: what sort of differences in the Affordable Care Act benefits will be experienced or seen between States that are forging ahead with State Exchanges and those who will have to rely on the Federal Exchanges?

Mr. COHEN. Senator, I really think that it is going to be of little to no consequence to the average consumer which type of Exchange they are seeing. The set of benefits does not vary. I mean, it varies State-by-State, but not depending on who is operating the Exchange.

And when a consumer goes to a Web site and goes through the process of filling out the application, finding out if they are eligible for subsidies, and then choosing a plan, their experience will really be very much the same regardless of who is operating the Exchange.

So I am hopeful that while the political rhetoric and debate may be going on, over here on the ground, people will really have the opportunity to receive the benefits of this law everywhere across the country.

Senator BALDWIN. Thank you.

The CHAIRMAN. Thanks, Senator Baldwin.

Senator Scott.

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thanks, Senator Harkin. I didn't realize you were an insurance agent as well at one point in your career.

The CHAIRMAN. Long time ago.

Senator SCOTT. Long time ago? Like 5 years? Yes, sir.

The CHAIRMAN. You are going to be a big member of this committee.

[Laughter.]

Senator SCOTT. Yes, sir, Mr. Chairman. I appreciate that, sir. Thank you, sir. Thanks, sir.

Mr. Cohen, thank you for being here with us today. I know that we see ourselves sometimes from a partisan perspective, and I do not see the ACA from a partisan perspective. I see it as a perspective of an average person in our country having to absorb the additional costs that are going to be associated with the ACA.

What we hear a lot about is the price tag is going down for the purchase of individual insurance. I am not quite sure that is accurate because, at some point, the price will be impacted by the actual cost. And when we look at the actual costs of the health care bill, it is actually going to have a major impact on every single taxpaying American in the country; every single taxpaying American in the country.

There is $800 billion of new taxes and fees in the ACA. It includes a $123 billion excise tax, 3.8 percent, on high earners. That is on top of the tax reform that was just completed at the beginning

of the year. We are talking about an additional $29 billion on medical device taxes. We are talking about where does the $1.5 billion come for the Federal Government to help 33 States—33 States, more than half of our country—will need assistance in setting up these health Exchanges.

The cost of it will include not actually pricing-in pre-existing conditions from an actuarial perspective. The cost will include eliminating agents. There is a cost when you have the Medical Loss Ratio at 85 percent, or you said 20 percent for Navigators. The fact of the matter is when you eliminate the professional that assists people in making their health care decisions on an individual basis, there is an unintended consequence and a higher cost of that to the country.

There is an interesting concept that we are taking 10 years of premium and having 6 years of full benefits. There is an actual cost of a second decade for the actual expense of the health care mandate.

The $700 individual penalty, there is a cost associated with that. Not just simply paying the $700, but what we will see is what we call, in the insurance business, "adverse risk selection." Those folks who will pay the $700 penalty, the fine for not doing something in this country will actually not buy the insurance because it is cheaper to pay the penalty whether it is from the $95 or up to the $700. On an individual basis young, healthy Americans will say, "I'll wait until I need the coverage." It is just like jumping out of the plane and needing a parachute, and knowing that you can get it on the way down. There is a cost associated with a delayed purchase of health insurance for all Americans.

The $2,000 penalty for employers, there is a cost associated. Because what it does for employers—having owned a small business, not for very long, for about 14 or 15 years and having paid for the health insurance for my employees—there is a cost associated with the $2,000 penalty which is heading toward a single payer system, which will add another burden on to all Americans. In my State, the cost is over 61 percent, as an average increase, is the estimate for buying health insurance.

We are going to have fewer people in the pool, not more people because of adverse risk selection. The NFIB says that we will lose up to 262,000 employees by 2022. There is a cost associated with high unemployment.

The lower reimbursement rates, we will have fewer doctors and fewer providers of health care because of the cost of the plan. In South Carolina, the Exchange, while the first 3 years or 100 percent subsidized, it would have cost our State over $5 billion from the year 4 to the year 10.

The Oliver Wyman study shows that in the 10-year period beginning in 2014, we will see the cost of the average family for health insurance coverage go up by $6,800. Companies like Michelin are changing the way that they provide health insurance, from providing disincentives as well as incentives. There is a cost associated with this health care plan.

So my question, sir, is how do we factor in not simply the price that is dropping for the average person who is buying health insurance according to your statistics? Mine say that the price is actu-

ally going up. Mine also says that because of adverse selection, we will see the price go up even higher in the second decade. We are still writing the regulation, so no one really understands what it is that are in those pages 7 feet, 3 inches tall.

So my question is: how do we factor in not simply the price, but the cost?

Mr. COHEN. Thank you, Senator.

I would make a couple of points. We are paying that cost now in uncompensated care. We are paying. Every small business in America today is paying that cost. They are paying more for their insurance because there are people who do not have insurance, and they are showing up at the emergency room, and they are getting care, but it is not compensated, and the hospital has to absorb that and pass that along to all of us.

Second, we are paying more than we should be because people are not getting the kind of care that they should be getting. If they cannot afford to go to a doctor or to the hospital until they are really sick, it means they are not getting the preventive care that they will be getting and are getting now under the Affordable Care Act. They are not getting treatment. They are not getting managed care. And so, all of that is more expensive and we are paying that cost every single day.

So I think that when you look at the system as a whole, it makes a lot more sense to make sure that people have access to coverage, can get preventive care, and can get the treatment that they need because that is going to bring the cost down for all of us.

Senator SCOTT. I will just wrap it up with this, Senator Harkin. Having served on a couple of hospital boards, I have realized that the reimbursement rates are going down because of the ACA, not up.

The CHAIRMAN. Thanks, Senator Scott.

OK. I am trying to get everyone in before the 11 o'clock vote.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Director Cohen, thank you for your testimony.

As you discussed, the State Health Insurance Marketplaces will offer millions of families and small businesses affordable, comprehensive health insurance for the first time. That is an extraordinary promise, but we also know that we have to implement the Marketplaces carefully to avoid unintended consequences such as punishing States that are ahead of the game.

And as you know, I have worked closely with your agency to make sure that States like Minnesota would have an opportunity to offer a basic health program as we defined it in the health care law.

Over the past several months, I have spoken with senior members of HHS and the White House. I have talked to the President about the importance of helping Minnesota maintain Minnesota Care, which is the name of our public insurance program for low-income families, from the very families that the Ranking Member mentioned from 138 percent of poverty to 200 percent of poverty. We cover them in Minnesota. I have been talking to you, and to

the President, and the Administration about Minnesota being supported so we can implement the basic health plan.

After much uncertainty over whether, and when, your agency would release regulations on the basic health program, I was very pleased when your agency committed to getting the regulations out in time for the program to be up and running by 2015, and to working with Minnesota to protect Minnesota Care as the Marketplace takes shape. And I just want to thank you, all of you, for your work on this.

Mr. COHEN. Thank you.

Senator FRANKEN. Minnesota has led the country in providing health insurance to people with pre-existing conditions as well. Minnesota's State High Risk Pool, called the Minnesota Comprehensive Health Association, is both the oldest and the largest in the country with about 25,000 enrollees. The State has planned to carefully transition this group onto the Marketplace over 3 years in order to avoid driving up premiums or disrupting care for those in the high risk pool who are undergoing treatment.

I was disappointed when HHS in its final rule on the reinsurance program chose to exclude State high risk pools from the program. It is essential that Minnesota gets the support it needs to carefully transition our high risk pool onto the Marketplace.

How are you planning to support the Minnesota Comprehensive Health Association to prevent disruptions in care and help its enrollees transition smoothly to the marketplace?

Mr. COHEN. Thank you, Senator.

We certainly share your interest in making sure that that happens. And we have a plan set up to make sure that people who are in State high-risk pools become aware of the opportunities that will be available to them through the Marketplaces, obviously, to get coverage without pre-existing conditions. I would be happy to work with you with respect, specifically, to the Minnesota situation and see what solutions we can come up with.

Senator FRANKEN. Thank you. Thank you.

Many have expressed concerns that the health care law's requirements to strengthen insurance coverage such as no longer allowing insurance companies to deny coverage for people with pre-existing conditions will increase premiums in the State Marketplaces. However, the health care law also includes requirements that will keep premiums down.

For example, my Medical Loss Ratio provision, which you referred to in your testimony, requires that insurance companies spend 80 percent in the small group plans and individual plans, and 85 percent in large group plans of premium dollars be spent on actual health care. Not administrative costs, not profit, not marketing.

Mr. COHEN. Right.

Senator FRANKEN. Not on CEO salaries, but on actual health care.

We have seen nearly 13 million Americans, 12.8 million Americans, benefit from rebates because the insurance companies have to rebate when they don't get there. We have heard that insurance premiums cost more. Well, if they cost $1 more, they cost more.

But the fact of the matter is that they are costing less over the last 3 years than they otherwise would have.

Bending the cost curve does not mean that the President promised to bring premiums down. It means he said he was going to bring them down relative to what they otherwise would have been. And is it not true that over the last 3 years, we have seen premiums for health insurance go down relative to the way they have been in the last several decades?

Mr. COHEN. That is true.

Senator FRANKEN. Here are some of the statistics. The average premium increase for all rates in 2012 was 30 percent below what it was in 2010.

We really have to remember what we are talking about here. We are talking about bending the cost curve. Nobody was saying, nobody was saying that the cost of health care per person was going to go down. What the President was saying is that it will go down relative to what it otherwise would have been.

Do you have any comment on that?

Mr. COHEN. No, I think that is absolutely right, and I think that we have seen a real shift in the rate of increase of premiums as a result of a number of the provisions of the Affordable Care Act.

Senator FRANKEN. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Senator Roberts.

STATEMENT OF SENATOR ROBERTS

Senator ROBERTS. Sorry, Mr. Chairman. I was trying to fill out my form here.

The CHAIRMAN. Was that for your Government health insurance?

[Laughter.]

Senator ROBERTS. That is to join the Marine Corps, sir. I have been drafted.

[Laughter.]

I want to thank you for coming back, Mr. Cohen. Thank you for your previous answers on sub-regulatory guidance, and how we are to find out much more on how we are to comply with the Wilt Chamberlain-sized regulations here.

I appreciate your effort to get back to us, more especially with regard to the comment period that we would like to now turn to. The CMS Administrator, the new administrator, Marilyn Tavenner, who we really appreciate in terms of her partnership, just told me that from now on we are going to try to do the 60-day comment periods and not go to the sub-regulatory guidance because it is almost impossible to let the rural health care delivery system or, for that matter, any health care delivery system know what is going on.

Immediately after that, she issued an interim final rule, which we contacted her about, but we hope we can get to the committed 60-days. And I know you are going to make an effort to do that.

You mentioned throughout your testimony that the health reform law will allow for clear information—clear information—for consumers and make it easier for them when they purchase a plan.

But we also know about the application that CMS has drafted for folks to apply for coverage. I have it right here. It is 21 pages.

I have to tell you, I went to a land grant college. I think I can usually fill out forms. This is equally as challenging, or more so, than your tax return. And I know that you are going to have people trying to help the 7 billion people you are trying to get health insurance for and I think they are going to be called navigators.

Is that correct?

Mr. COHEN. Yes.

Senator ROBERTS. OK. And I asked the Secretary, who is a personal friend, "How are you going to do this? Are you going to hire 30,000 more people for IRS?" She said, "No, we are going to have navigators." "What do you mean by navigators?" "Well, some community organizations could be of help."

Well, this is, to start off here, it is 21 pages. This is just to apply. And if you apply, then you fill out 61 additional pages. And I defy anybody on this committee—and including yourself, any witness—to go through this and do it with any degree of efficacy, or efficiency, or knowledge that they have done the right thing.

Why do we ask for so much information? You say,

> "Well, we ask about income and other information to make sure you and your family will get the most benefits possible. We will keep all the information you provide private, as required by law."

And then you go in and say, it is sort of like a friendly person who is tapping you on the shoulder, "Tell us about yourself." There are about six or seven things down here. And then, "Tell us about your family." And then, "Tell us about the people who are in your family. Tell us about your spouse, partner, and children. Tell us about your job and your income. Tell us where you live for demographic purposes. Tell us if you come from Alaska or you are a Native American. Tell us," and I could go on, and on, and on.

Then there is a specific, if you get through this and you have a navigator, and I still don't know where those navigators are going to come from for a small community. Say it is Dodge City, KS. That is where I am from. I don't know which community organizations are going to help people with this, or if you have a navigator that has been trained to help people go through this, but I doubt it at this particular time.

But you can go online and by going online, it is supposed to be very simple. Here is the individual questionnaire and the outline. Where do I get to what you dial? It is 1–800-XXX, because it is a draft. I understand that. But I know that when people, and I am talking about health care providers, try to access the Web page of the Department of Health and Human Services, they get into a lot of difficulty.

At any rate, but there is one little item here that I am trying to find again that I was reading when the Chairman told me my time was now, and I am almost up on time here.

Basically it says if a person says they do not want to apply for financial assistance in any of the questions, in other words they say, "No, no, no, no thank you." The concept is to fill this out anyway, send it in, and they are going to capture a couple of responses

to assess whether or not it may be worth their time to apply anyway.

So if a person says, "I don't want to apply," they have to apply to tell people why they do not want to apply. That does not seem to me to be very helpful either.

I mention all this because I think we are really getting into a bramble bush here of regulations that I do not know how we are going to work through. I think the real answer is to provide a long enough comment period so people can really grasp what you are trying to do here, and have a transparent comment period, then have you folks pay attention to those comments, and then fix the things that you can.

I know you are under a time line, and you told me last time that you thought that it was more important for the consumer to get information as opposed to meet time lines or have an extended comment period.

Well, if they even get the information, I want to tell you one thing, they want to comment because with these two things I've mentioned, I do not know how we implement them; I really don't. I know that you have a difficult task ahead of you. I am not trying to be overly critical. I am just worried about all of this. These two things, probably, what are they, 1-inch however tall that is.

So there, that is my rant, and I apologize for it, but I can tell you that out there the providers—you said in reference to the distinguished Senator from South Carolina that there is a cost that is now being paid.

The problem is that there is not going to be enough doctors and nurses to do this. We do not have enough doctors and nurses to handle this. And right now, there are a lot of doctors that are not serving Medicare patients because of this. I mean, you can have the best health care plan in the world, but if you do not have access to doctors and nurses and health care providers, I do not know what we do.

The CHAIRMAN. Thank you, Senator.

Senator ROBERTS. I would like for him——

The CHAIRMAN. Senator Whitehouse.

Senator ROBERTS [continuing]. To at least have the opportunity to respond to all of my——

The CHAIRMAN. Well, I don't know. Senator, we have to move on. I have another Senator. We have a vote coming up here. You took 1 minute and 50 seconds over the 5 minutes.

Senator ROBERTS. I understand that. I just feel bad that he cannot respond and that I have already picked on him.

The CHAIRMAN. Senator Whitehouse.

Senator Roberts. Sorry.

The CHAIRMAN. I have to try to get through this.

Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Mr. Chairman.

Welcome, Mr. Cohen.

Mr. COHEN. Thank you.

Senator WHITEHOUSE. I represent Rhode Island. Rhode Island, as I am sure you are aware is a real leader State in trying to get the insurance Exchange up. We were the first State through to Level II funding. The Lieutenant Governor, Elizabeth Roberts, is doing a

terrific job of leading this effort and of bringing our entire community along with it through a very open, inclusive, and transparent process.

For those of you who remember Senator Chafee's days in the Senate, his old health care staffer, Christy Ferguson, is now leading the Insurance Exchange effort appointed by John Chafee's son, Lincoln Chafee, who is now our Governor. And it is a very ambitious program.

We don't just want to set up a market. We also want to enable negotiations so that that market power can be brought through to the benefit of the consumers. We also want to set the conditions so that the critical outcomes information, the critical data that is so necessary as we try to squeeze the waste and inefficiency out of our colossally wasteful and inefficient health care system can be accomplished through this.

My worry is that there is an institutional bias, and an understandable one, to put all the attention where the bulk of the States are, and where there are not a lot of States to not pay as much attention to them.

What I would urge to you as a matter of policy is that you should put as much attention and resources as you can into the leadership States, because it is a lot easier to follow when somebody has forged the path.

This is a problem we saw in Rhode Island with our information Exchange. I think we are probably the leading State in the country on a statewide information Exchange that automatically loads data from different providers, from laboratories, from MRI facilities, from specialists, all of that. And the attention is all to the people who are sort of back in the middle, way behind us, slugging through. I think stuff goes viral once it is really made to work.

I would urge you when it comes to your organization—I know you are focusing on the insurance Exchange, so let's focus on that—I would urge you to put disproportionate effort behind the folks who are out front because that will pay huge dividends across the board. Otherwise, you are left fighting a lot of stuff on your own. It is expensive to fight through a lot of the administrative issues that come up, and if you are not really heavily supported, then what you are doing is you are slowing down the lead dogs. When you slow down the lead dogs, you slow down the pack. You can pay a lot of attention to the rest of the pack and they are going to feel good about it, but the whole operation does not move forward as fast.

So I would ask you to comment on that view of the world, and hope that my question has some influence on it.

Mr. COHEN. Thank you, Senator, and I appreciate your comments.

I agree with you completely that it is extremely important that the States that have chosen to move forward and operate their own Marketplaces be successful. And if they are, other States will follow, and they will learn from the experience of the States that have been out in front, as you say, and they will see the benefits of taking on this responsibility at the State level. We have said all along, we believe that is what provides the best opportunity for the Marketplace that will serve a State the best.

We do work very closely with each State ranging from Rhode Island to California and New York who are moving forward to have the State-based Marketplace. We have teams that work very closely with the States that are doing that. Obviously, as you know, we provide the grant funding.

I very much take to heart your advice that we not lose sight of that. While we, obviously, take on the responsibility of making sure that there is a Marketplace in every State, which is our responsibility.

Senator WHITEHOUSE. I am making an even more specific point and that is that within the group of States that have elected to go forward and build their own Exchanges, there is a bulge. There are a few in the lead, there is a bulge in the middle, and there are a few at the tail.

I get the impression that just because there are more of them and they make more noise, the bulge soaks up the bulk of the effort and of the support.

My point to you is: put the support at the front. As I said, let the lead dogs run faster and the whole pack will move faster. If you are spending all your effort in the middle, you are not going to move a lot faster than the lead dog. So please, think of it in those terms if you would.

Mr. COHEN. Thank you. I will.

Senator WHITEHOUSE. Thank you very much.

The CHAIRMAN. I just want to echo that. I think Senator Whitehouse made a very salient, very good point and that is where, I think, the emphasis ought to be put on those few that are really out there in front.

There is a 15-minute vote. We are going to recess for about 20 minutes and we will come back for the second panel.

Again, Mr. Cohen, thank you very much both for your knowledge, for your shepherding this, and for your great leadership on getting these Exchanges up and the navigators going. And I just want you to know that as the chair, I really appreciate what you are doing.

Mr. COHEN. Thank you. I appreciate your support.

The CHAIRMAN. Thank you. And you can stay, if you want, but you don't have to. We will go to the second panel when we come back.

Mr. COHEN. Thank you.

[Recess.]

The CHAIRMAN. The Committee on Health, Education, Labor and Pensions will resume as sitting.

We are now moving to panel two. On the second panel, our first witness will be Kevin Counihan, chief executive officer of Access Health Connecticut, which we just heard about from Senator Whitehouse. No, it was not Senator Whitehouse; Senator Murphy who was supposed to be here but he is in another committee right now.

Mr. Counihan was appointed to his position in July 2012 by Governor Malloy. He comes to the job with a wealth of experience. He previously was president of Choice Administrators in California, and before that, served as the chief marketing officer for the Massachusetts Health Insurance Connector. He has also served as sen-

ior vice president for Tufts Health Plan and VP for Cigna. Thank you very much for being here, Mr. Counihan.

Next is Professor Sabrina Corlette, a research professor and project director at Georgetown's Health Policy Institute. At the Institute, Professor Corlette directs research on health insurance reform issues including regulation of private health insurance and the building of insurance Marketplaces.

Prior to joining Georgetown, she directed health policy programs at the National Partnership for Women and Families, and right before that, I am happy to note, she worked for this committee. Welcome back to the HELP Committee on that side of the table.

Stacy Cook—I want to extend a personal welcome—from Carroll, IA is here to tell her very moving and important personal story. I will not steal her thunder by summarizing it. Stacy is also a volunteer with the American Cancer Society's Cancer Action Network. Thank you very much, Stacy, for taking your time off and being here from Iowa.

Mr. Chris Carlson, a principal in the firm of Oliver Wyman Actuarial Consulting. Mr. Carlson has 18 years of experience in the health care actuarial field providing consulting services to health insurers, health care providers, employer, and State regulators. Before joining Oliver Wyman, Mr. Carlson worked as an actuary at Blue Cross Blue Shield. Thank you very much, Mr. Carlson, for being here today.

All of your statements will be made a part of the record in their entirety. I will start with Mr. Counihan and go down. If you could just sum up in 5 minutes or so, we would certainly appreciate it.

Mr. Counihan, welcome. Please proceed.

STATEMENT OF KEVIN COUNIHAN, CEO OF THE CONNECTICUT HEALTH INSURANCE MARKETPLACE, WEST HARTFORD, CT

Mr. COUNIHAN. Thank you and good morning, Chairman Harkin, Ranking Member Alexander, and members of the committee. Thank you for the opportunity to speak about the issues related to the new market reforms and rating rules under the Affordable Care Act.

As one of 17 States implementing a State-based Exchange, these issues are of particular relevance to us. In Connecticut, our Marketplace is named Access Health CT and we have been particularly fortunate to have had broad-based support for our efforts to implement the ACA.

This support has come from issuers, brokers, the advocacy community, our board of directors, State agencies, the legislature, our congressional delegation, and others. Further, we have received outstanding support from CCIIO and CMS, in particular from Amanda Cowly, Dawn Horner, Sue Sloop, and their teams. We are also very appreciative of the support of Commissioner Rod Bremby, from the Connecticut Department of Social Services and our board chair, Lieutenant Governor Nancy Wyman.

We view these new marketplaces as free market, pro-competition means for individuals and small businesses to access health insurance in a simpler, more transparent way. We believe the market is the best way to assure price competition and high value for con-

sumers. I have seen this work effectively in an earlier role at the Health Connector in Massachusetts.

Access Health CT is committed to serving the needs of individuals and small businesses in Connecticut by facilitating access to qualified private health plans and to assist those eligible with access to premium subsidies and cost sharing reductions.

Access Health CT is guided by the following objectives: first, create a user-friendly shopping and enrollment experience. Two, reduce the level of the uninsured. Three, reduce racial and ethnic disparities in access to health care. Four, promote innovation and competition. And five, facilitate a discussion to create more affordable health insurance coverage. These are longer term objectives of the Connecticut Marketplace and reflect the vision of our Board to improve access to care and to establish more affordable and predictable costs of health care.

Access Health CT continues to make strong progress in implementing our Marketplace. We are one of the leading States in implementation and are in the midst of label and testing with the Federal Data Services Hub, which verifies consumer information with Social Security, Homeland Security, IRS, and other information sources.

Our Board of Directors has made key policy decisions. We have completed our strategy to outsource all key operational functions to private sector firms such as for our call center and for the administration of our Small Business Health Options Program or SHOP.

We are in the process of implementing our broker training and oversight program. We believe brokers represent one of the most effective ways to distribute our products, and educate the marketplace about the benefits and opportunities of health reform.

Our Navigator and in-person assister programs are being built at present, and in conjunction with community-based nonprofit and philanthropic organizations, and which will enhance our direct marketing and outreach strategies.

Finally, we have posted our qualified health plans solicitation for participation by issuers. Our strategy from the outset has been to work collaboratively with issuers and all major stakeholders to make participation in our Exchange as easy and minimally disruptive as possible. While we have much work to do, we are pleased with our results to date.

The ACA introduces a number of significant reforms to the health insurance market. These are meaningful consumer protections to the residents and small businesses in Connecticut and include: No. 1, no underwriting for health status. No. 2, no pre-existing condition limitations. No. 3, title limits for age adjustment. No. 4, no underwriting adjustment for gender. No. 5, guaranteed renewals for individuals and small group markets. No. 6, a minimum 80 to 85 percent Medical Loss Ratios. And finally, inclusion of 10 categories of essential health benefits.

Each of these reforms benefits the residents and employees of small businesses in Connecticut. These reforms also come at a cost. Fortunately, there are a number of protections in the ACA which help to ameliorate the impact of these market adjustments.

These protections include: No. 1, a risk adjustment program which transfers payments from issuers with lower risk enrollment

to those issuers with higher risk enrollees to adjust for risk selection. No. 2, a risk quarter program, which limits issuer underwriting gains or losses. And No. 3, a reinsurance program which reimburses issuers for higher than expected utilization.

As a result, much of the uncertainty over the unknown morbidity of the uninsured and the potential migration of certain employee segments from employer-sponsored insurance to the individual market will be dampened. It is critical that issuers, consumers, small businesses, brokers and others understand the important roles these programs play.

The implementation of the ACA is complex and makes special demands on States, issuers, and others. Like other States, Connecticut has benefited from an exceptionally dedicated staff who work hard to realize the dignity of health insurance coverage for all eligible State residents.

The market reforms of the ACA represent important corrections to enhance access to more affordable coverage. The rate pressure from the removal of prior underwriting controls should be mitigated, in part, by new premium stabilization programs.

The hallmark of health reform has been the concept of shared responsibility, the sense of shared ownership of a common value that our Nation benefits from more citizens realizing the peace of mind of health insurance coverage. Increasingly, shared responsibility must be accompanied by shared patience. We must have the patience to recognize that the implementation of the ACA will take time to be fully realized. The premium rate adjustments will stabilize, that enrollment and health plan choices will be enhanced, and that outreach and communication activities will be more effective.

At Access Health CT, we believe health insurance is a right of citizenship and not just a privilege of employment. The ACA represents the best opportunity we have at present to expand access to health insurance since the introduction of Medicare in 1965.

We are proud to be a leading State in the implementation of the ACA, and to provide a more affordable health insurance to our residents.

Thank you.

[The prepared statement of Mr. Counihan follows:]

PREPARED STATEMENT OF KEVIN COUNIHAN

SUMMARY

We view these new marketplaces as free market, pro-competition means for individuals and small businesses to access health insurance in a simpler, more transparent way. We believe the market is the best way to assure price competition and high value for consumers, and I have seen this work effectively in an earlier role at the Health Connector in Massachusetts. Access Health Connecticut is committed to serving the needs of individuals and small businesses in Connecticut by facilitating access to qualified private health plans and to assist those eligible with access to premium subsidies and cost sharing reductions.

Access Health Connecticut is guided by the following objectives:

- Create a User-Friendly Shopping and Enrollment Experience
- Reduce Level of Uninsured
- Reduce Racial and Ethnic Disparities in Access to Health Care
- Promote Innovation and Competition
- Facilitate Discussion to Create More Affordable Health Insurance Coverage

Our Board of Directors has made almost all core policy decisions; we have completed our strategy to outsource all key operational functions to private sector firms such as our Call Center and the administration of our Small Business Health Options Program (SHOP). We are in the process of implementing our Broker training and oversight program. Our Navigator and In-Person Assistor programs are being built in conjunction with community-based non-profit and philanthropic organizations and which enhance our direct marketing and outreach strategies. Finally, we have posted our Qualified Health Plan solicitation for participation by issuers.

The ACA introduces a number of significant reforms to the health insurance market. These are meaningful consumer protections to the residents and small businesses in Connecticut. The market reforms of the ACA represent important corrections to enhance access to more affordable health insurance and health care. The rate pressure from the removal of prior underwriting controls should be mitigated in part by new premium stabilization programs.

The hallmark of health reform has been the concept of shared responsibility, the sense of shared ownership of a common value that our Nation benefits from more citizens realizing the peace of mind of health insurance coverage. Increasingly, shared responsibility must be accompanied by shared patience. We must have the patience to recognize the implementation of the ACA will take time to be fully realized, that premium rate adjustments will stabilize, that enrollment and health plan choices will be enhanced, and that outreach and communication activities will continue to be more effective.

Good morning, Chairman Harkin, Ranking Member Alexander, and members of the Senate Health, Education, Labor, and Pensions Committee. Thank you for the opportunity to speak about the issues related to the new market reforms and rating rules under the Affordable Care Act. As 1 of 17 States implementing a State-based exchange, this issue is of particular relevance to us.

In Connecticut, our marketplace is named *Access Health CT*, and we have been particularly fortunate to have had broad-based support for our efforts to implement the ACA. This support has come from issuers, brokers, the advocacy community, our board of directors, Connecticut State agencies, the legislature, our congressional delegation, and others. Further, we have received outstanding support from CCIIO and CMS, in particular from Amanda Cowley, Dawn Horner, Sue Sloop, and their teams. We are also very appreciative for the support of Commissioner Rod Bremby of the Connecticut Department of Social Services, and our board chair, Lieutenant Governor, Nancy Wyman.

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GUIDING OBJECTIVES

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- Reduce Level of Uninsured
- Reduce Racial and Ethnic Disparities in Access to Health Care
- Promote Innovation and Competition
- Facilitate Discussion to Create More Affordable Health Insurance Coverage

These are longer term objectives of the Connecticut marketplace and reflect the vision of our board to improve access to care and to establish more affordable and predictable cost of health care.

IMPLEMENTATION—PROGRESS-TO-DATE

Access Health CT continues to make strong progress in implementing our marketplace. We are one of the leading States in implementation and are in the midst of Wave 1 testing with the Federal Data Services Hub, which verifies consumer information through connection to the Social Security Administration, Department of Homeland Security, the IRS and other information sources.

Our board of directors has made almost all core policy decisions; we have completed our strategy to outsource all key operational functions to private sector firms such as our Call Center and the administration of our Small Business Health Op-

tions Program (SHOP). We are in the process of implementing our Broker training and oversight program. We believe brokers represent one of the most effective ways to distribute our products and educate the marketplace about the benefits and opportunities of health reform to individuals and small businesses. Our Navigator and In-Person Assistor programs are being built in conjunction with community-based non-profit and philanthropic organizations and which enhance our direct marketing and outreach strategies.

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MARKET REFORMS AND COST IMPACT

The ACA introduces a number of significant reforms to the health insurance market. These are meaningful consumer protections to the residents and small businesses in Connecticut and include:

- No Underwriting for Health Status
- No Pre-Existing Condition Limitations
- Tighter Limits for Age Adjustment
- No Underwriting Adjustment for Gender
- Guaranteed Renewals for Individual and Small Group Market
- Minimum 80–85 percent Medical Loss Ratios
- Inclusion of 10 categories of essential health benefits

Each of these reforms benefits the residents and employees of small businesses in Connecticut. These reforms also come at a cost. Fortunately, there are a number of protections in the ACA which help to ameliorate the impact of these market adjustments. These protections include:

- Risk Adjustment Program which transfers payments from issuers with lower-risk enrollment to those issuers with higher-risk enrollees to adjust for risk selection.
- Risk Corridor Program which limits issuer underwriting gains or losses.
- Reinsurance Program which reimburses issuers for higher than expected utilization.

As a result, much of the uncertainty over the unknown morbidity of the uninsured and the potential migration of certain employee segments from employer-sponsored insurance to the individual market will be dampened as a result of these programs. It is critical that issuers, consumers, small businesses, brokers, policymakers, and other stakeholders understand the roles these programs play to mitigate excessive rate increases.

CONCLUSION

The implementation of the ACA is complex and makes special demands on States, issuers, and others. Like other States, Connecticut has benefited from an exceptionally dedicated staff who works hard to realize the dignity of health insurance coverage for all eligible State residents.

The market reforms of the ACA represent important corrections to enhance access to more affordable health insurance and health care. The rate pressure from the removal of prior underwriting controls should be mitigated in part by new premium stabilization programs.

The hallmark of health reform has been the concept of shared responsibility, the sense of shared ownership of a common value that our Nation benefits from more citizens realizing the peace of mind of health insurance coverage. Increasingly, shared responsibility must be accompanied by shared patience. We must have the patience to recognize the implementation of the ACA will take time to be fully realized, that premium rate adjustments will stabilize, that enrollment and health plan choices will be enhanced, and that outreach and communication activities will continue to be more effective.

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

I think that last part of your statement, and I underlined it when I read it last evening, is really something that we have to always keep in mind, this shared responsibility especially when talking about young people and these young free riders getting them on these policies.

Professor Corlette, please proceed.

STATEMENT OF SABRINA CORLETTE, RESEARCH PROFESSOR AND PROJECT DIRECTOR, GEORGETOWN HEALTH POLICY INSTITUTE, CENTER ON HEALTH INSURANCE REFORM, WASHINGTON, DC

Ms. CORLETTE. Thank you.

Mr. Chairman, Ranking Member Alexander, and members of the committee, I want to thank you for the leadership of this committee in drafting key provisions of the ACA, and for the ongoing oversight that you are conducting. This hearing today is a timely one as we are now less than 6 months away from enrollment into health plans that will meet sweeping new standards for access, affordability, and adequacy.

In my testimony, I am going to focus on how the individual health insurance market works today for consumers, and how it will change under the ACA's market reforms.

The ACA has a particular focus on the individual market because of its well-documented systemic problems which include a lack of access to coverage, inadequate coverage, unaffordable coverage, and a lack of transparency and accountability.

Today, 48 million Americans are uninsured and 19 million have individual health insurance coverage. Those who buy insurance on their own are self-employed entrepreneurs, farmers, ranchers, early retirees, part-time workers, and young people aging off their parents' plans.

What does the Health Insurance Marketplace look like today for these folks, particularly for someone who might not be in perfect health?

In today's marketplace, one of the ways that health insurers manage costs is to make use of aggressive underwriting to deny coverage to individuals with pre-existing conditions. People with even minor health issues, such as hay fever, may be turned down for coverage. And recent studies have found that these types of underwriting practices are only growing more aggressive.

Under the ACA's guaranteed issue and renewal provisions with limited exceptions, health insurers must accept all applicants regardless of their health condition, health history, or that of a family member. For many individuals, even if they are offered a policy, premium surcharges based on their health can cause them to forgo coverage completely.

Beginning next year, insurers will no longer be able to charge somebody more because of their health status, the work that they do, or their gender. And they will be limited in the amount that they can differentially charge based on age or use of tobacco products. And through the new health Insurance Exchanges, low and moderate income individuals will be eligible for premium tax credits that will help make coverage more affordable.

As for the adequacy of coverage in this market, in many States insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses when they apply for a policy. Under the ACA, these pre-existing condition exclusions were prohibited for children in 2010, and will be for all individuals beginning in January. This means that people will be able to access the care they need from their very first day of coverage.

In addition, in today's marketplace, insurers selling individual insurance often sell stripped down policies that do not cover benefits such as maternity, prescription drugs, or mental health. And individual policies often come with high deductibles, $10,000 or more is not uncommon. In fact, deductibles in these polices can be as much as three times what they are in an employer-based plan, and that these policies have fewer covered services and they cover a smaller share of the cost. It is not surprising, then, that 57 million Americans live in families struggling with medical debt and 75 percent of these families have health insurance.

For the first time, the ACA sets new standards for benefits and out-of-pocket spending to ensure that insurance coverage does what it should: provide real financial protection to individuals and families.

The individual market also suffers from a lack of transparency. Prior to the ACA, individuals attempting to buy coverage faced confusing choices with little information about pricing or what their policy would actually cover and what it would not.

The ACA ushers in a number of critical changes to improve consumers' ability to shop for and compare plans, and purchase one that meets their needs.

Mr. Chairman and members of this committee, the evidence is pretty clear. This current market does not work for the people who need it the most. Anyone with just about any health issue could face difficulty obtaining coverage. What we have today is a system of haves and have-nots. And remember, even if you happen to be a "have," like the young and healthy people who can access this coverage, you still cannot have peace of mind.

It is an unfortunate fact of life that all of us get older, and most of us will have some sort of health problem at some point in our lives, yet today's market cannot even provide people with the most basic obligation of insurance, which is to help people access health care and protect them financially.

Congress, led by this committee, recognized the fundamental injustice in our current Health Insurance Marketplace. It enacted sweeping reforms that will improve access to adequate and affordable coverage. These changes will involve some disruption, undoubtedly, particularly for those in the health insurance industry that have benefited from the inequities of the current system.

The reform is the right thing to do and I thank this committee for taking it on.

Thank you.

[The prepared statement of Ms. Corlette follows:]

PREPARED STATEMENT OF SABRINA CORLETTE

SUMMARY

Access Issues: In today's marketplace, one of the ways health insurers manage costs is to make use of aggressive underwriting practices to deny coverage to individuals with pre-existing conditions. Under the ACA, these denials will no longer be permitted. Under the ACA's guaranteed issue and renewal provisions, with limited exceptions health insurers must accept applicants, and continue to renew their policies, regardless of their health condition, health history, or that of a family member.

Affordability Issues: Health insurance is an expensive product, and it is particularly expensive for people trying to buy it on the individual market. For those in less than perfect health, those premiums can cause them to forego coverage completely. Beginning January 1, 2014, insurers will no longer be able to charge someone more because of their health status, the work they do, or their gender. And they will be limited in the amount they can differentially charge because of someone's age or use of tobacco products. Through the new health insurance exchanges, low- and moderate-income individuals will be eligible for premium tax credits that will help make coverage more affordable.

Adequacy Issues: *Pre-existing condition exclusions or riders*. In many States, insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses on their application for a nongroup policy. Under the ACA, these pre-existing condition exclusions were prohibited for individuals under the age of 19 in 2010, and will be prohibited for all individuals beginning in January 2014. This means people will be able to access the care they need from their first day of coverage.

Lifetime and Annual limits. Prior to enactment of the ACA, it's estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people are in plans with annual limits on their benefits. Thankfully, the ACA brought in a ban on lifetime limits, and put immediate restrictions on annual dollar limits (banning them completely in 2014).

High Out-of-Pocket Costs. Nongroup policies often come with high deductibles and high cost-sharing. In fact, deductibles can be about three times what they are in employer-based plans. One study in California found that nongroup policies pay for just 55 percent of the expenses for covered services, compared to 83 percent for small group health plans. For the first time, the ACA sets new standards to ensure that insurance coverage does what it should: provide real financial protection to individuals and families.

Transparency and Accountability Issues: Prior to the ACA, individuals attempting to buy coverage in the nongroup market-faced confusing choices, with little transparency regarding pricing or what their policy would actually cover—and what it would not.

The ACA ushers in a number of critical changes to improve consumers' ability to shop for and compare plans in a manner that allows them to make informed choices and select a plan that best meets their needs.

Good morning, Mr. Chairman, Ranking Member Alexander, members of the committee. I am Sabrina Corlette, a research professor and project director at Georgetown University's Center on Health Insurance Reforms. I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA).

I thank you for the opportunity to testify before you today, for the leadership of this committee in drafting key provisions of the Patient Protection and Affordable Care Act (ACA), and for the ongoing oversight you have conducted to assess its implementation. This hearing today is a timely one, as we are now slightly less than 6 months away from open enrollment into health plans that will meet sweeping new standards for access, affordability, and adequacy.

In my testimony, I will focus on how the nongroup health insurance market works today for consumers, and how it will change upon implementation of the ACA's market reforms, some of the most significant of which go into effect on January 1, 2014. The ACA has a particular focus on the nongroup market because of its well-documented systemic problems, which include:

1. Lack of access to coverage because of health status discrimination.
2. Inadequate coverage.
3. Unaffordable coverage.

4. Lack of transparency and accountability.

Today, approximately 48 million non-elderly Americans are uninsured, and approximately 19 million non-elderly Americans have insurance coverage in the nongroup market, meaning they do not have coverage through their employer or public programs such as Medicare and Medicaid.[1] Anyone can find themselves at any time in the position of being uninsured, or in the nongroup market. Those who buy insurance on their own can be self-employed entrepreneurs, farmers and ranchers, early retirees, part-time workers, widows, and young people "aging off" their parents' plans. This market tends to be the option people turn to as a last resort when they do not have an employer offer or insurance and are ineligible for public coverage.

What does the health insurance marketplace today look like for these individuals and families, particularly those who might be in less than perfect health?

ACCESS ISSUES

In today's marketplace, one of the ways health insurers manage costs is to make use of aggressive underwriting practices to deny coverage to individuals with pre-existing conditions.[2] A seminal Georgetown study from 2001 found that even people with minor health conditions, such as hay fever, may be turned down for coverage, and more recent studies have found that these practices have only increased over time.[3] [4] Health insurers maintain underwriting guidelines that can list as many as 400 medical conditions as reasons to trigger a permanent denial of coverage.[5] At Georgetown, we hear stories every day of people struggling to access coverage in the nongroup market. For example, we were recently contacted by a young man who was turned down for coverage not because of his own health status—he is a healthy 30-year-old running his own successful consulting business. Rather, he was turned down because his wife is expecting a baby. Even though her prenatal care is covered through her own, student health plan, the insurer turned him down because of the risk that they might have to pay for care for the newborn.

There's also the story of John Craig, a 46-year-old software consultant in Orem, UT, who plays racquetball twice a week, doesn't smoke or drink and isn't overweight. When he tried to buy an individual insurance policy, however, he was denied. The insurance company cited sinus infections and depression, even though he hadn't experienced symptoms of either condition for years.[6]

According to a GAO study, average denial rates in the individual market are 19 percent, but they can vary dramatically market-to-market and insurer-to-insurer.[7] For example, GAO found that across six major health insurers in one State, denial rates ranged from 6 to 40 percent.

Unfortunately, access is probably even more difficult for people with health conditions than these data suggest, because of a common industry practice known as "street" underwriting, in which an insurance company agent asks a consumer questions about their health history and steers them away from the plan before they fill out or submit an application.

Under the ACA, these denials will no longer be permitted. Under the ACA's guaranteed issue and renewal provisions, with limited exceptions health insurers must accept applicants, and continue to renew their policies, regardless of their health condition, health history, or that of a family member.

The ACA also prohibits the practice of rescissions. Prior to the enactment of this provision, which went into effect in September 2010, insurers in many States would investigate individual policyholders who make claims in their first year of coverage. If the company found evidence that their health condition was a pre-existing one, and not fully disclosed during the initial medical underwriting process, the company could deny the relevant claims, and in some cases cancel or rescind the coverage.[8] Thanks in large part to this committee's leadership, this practice is now illegal, ex-

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[1] U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2011," September 2012.

[2] U.S. House of Representatives, Committee on Energy and Commerce, "Memorandum: Coverage Denials for Pre-Existing Conditions in the Individual Market," October 12, 2010.

[3] Karen Pollitz, "How Accessible is Individual Health Insurance for Consumers in Less-than-Perfect Health?" Kaiser Family Foundation, June 2001.

[4] *Supra*, n. 2.

[5] *Id.*

[6] Sarah Lueck, "Seeking Insurance, Individuals Face Many Obstacles," *Wall Street Journal*, May 31, 2005.

[7] General Accounting Office, "Private Health Insurance: Data on Application and Coverage Denials," March 2011.

[8] Girion, L., "Health insurer tied bonuses to dropping sick policyholders," *Los Angeles Times*, November 9, 2007.

cept in a clear case of fraud by the policyholder. And since this provision was made effective in 2010, Georgetown research has found that insurers have generally come into compliance without much incident.[9]

AFFORDABILITY ISSUES

Health insurance is an expensive product, and it is particularly expensive for people trying to buy it on the individual market. Unlike those with employer-sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance must pay their full premium.

For those in less than perfect health, those premiums can cause them to forego coverage completely. One national survey found that 61 percent of people seeking individual coverage but failing to ultimately buy a policy cited the high cost of premiums as the reason.[10] Health insurers manage costs by segmenting their enrollees into different groups and charging them different prices based on their health status or other risk factors.[11] In practice, this means that people can be charged more because of a pre-existing condition (and even if, like John Craig, they've been symptom-free for years), because of their age, gender, family size, geographic location, the work they do, and even their lifestyle. A Georgetown study of rating practices in unregulated markets found rate variation of more than ninefold for the same policy based on age and health status.[12] People in their early sixties can be charged as much as six times the premium of people in their early twenties, based on age alone. I had one gentleman call my office last year, in his early sixties. He told me he couldn't find a policy for less than $1,300 per month. Unfortunately, at the time all that I could tell him was that things would get better in 2014.

They will get better. Beginning January 1, 2014, insurers will no longer be able to charge someone more because of their health status, the work they do, or their gender. And they will be limited in the amount they can differentially charge because of someone's age or use of tobacco products.

Of course, through the new health insurance exchanges, low- and moderate-income individuals will be eligible for premium tax credits that will help make coverage more affordable. An Urban Institute analysis estimates that over 8 million people will take advantage of the tax credit, with an average per-recipient tax credit of $4,553.[13]

ADEQUACY ISSUES

Currently, the insurance coverage available to individuals buying on their own falls considerably short of the comprehensive health coverage that you, as Members of Congress, and I, as a Georgetown professor, have come to expect. In addition to paying more in premiums, people buying individual policies face much higher deductibles and other forms of cost-sharing, limited benefits, and spend a much larger share of their income on health insurance and health care than those of us with employer-sponsored coverage.[14] A recent Commonwealth Fund survey found that 60 percent of people with health problems found it very difficult or impossible to find a plan with the coverage they needed, compared to about ⅓ of respondents without a health problem.[15]

Indeed, the number of "underinsured" individuals has risen dramatically over the last decade, to an estimated 29 million adults in 2010.[16] These are people with

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[9] Katie Keith, Kevin W. Lucia, and Sabrina Corlette, "Implementing the Affordable Care Act: State Action on Early Market Reforms," The Commonwealth Fund, March 2012; Kevin W. Lucia, Sabrina Corlette and Katie Keith, "Monitoring Implementation of the Affordable Care Act in 10 States: Early Market Reforms,"The Urban Institute, September 2012.

[10] Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, "Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families," The Commonwealth Fund, July 2009.

[11] Melinda B. Buntin, M. Susan Marquis, and Jill M. Yegian, "The Role of the Individual Insurance Market and Prospects for Change," *Health Affairs*, November 2004.

[12] *Supra*, n. 3.

[13] Fredric Blavin, Matthew Buettgens, and Jeremy Roth, "State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain," the Urban Institute, January 2012.

[14] Michelle M. Doty, Sara R. Collins, Jennifer L. Nicholson, and Sheila D. Rustgi, "Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most U.S. Families," The Commonwealth Fund, July 2009.

[15] *Supra* n. 10.

[16] Cathy Schoen, Michelle M. Doty, Ruth H. Robertson, and Sara R. Collins, "Affordable Care Act Reforms Could Reduce the Number of Underinsured U.S. Adults by 70 percent," *Health Affairs*, September 2011.

health insurance, but with high out-of-pocket health expenses relative to their income. Underinsurance is particularly prevalent in the nongroup market. In fact, a recent University of Chicago study found that over half of all nongroup plans currently in the market do not meet the minimum standards for coverage set by the ACA.[17] Coverage in the nongroup market today can be woefully inadequate for many reasons, including:

Pre-existing condition exclusions or riders. In many States, insurers are permitted to permanently exclude from coverage any health problems that a consumer discloses on their application for a nongroup policy. This is an amendment to the policy contract called an "elimination rider." In addition, once coverage begins, if a consumer makes claims under the policy, he or she can be investigated to see whether the health problem was pre-existing. In many States, it's not necessary for a health condition to have been diagnosed before the consumer bought the policy for it to be considered "pre-existing." And insurers can look back for up to 5 years into a person's health care history to determine whether the current condition was pre-existing. This is sometimes called "post-claims underwriting." For example, in Alabama, a consumer applying for nongroup coverage might have a known pre-existing condition permanently excluded from his policy. In addition, if he makes a claim for health care services during the first 2 years of his coverage, the health insurer can look back at his medical history dating back 5 years to look for evidence that the current health problem existed before he bought the policy. If such evidence is found, the insurer can refuse to pay for care associated with the condition.

Under the ACA, these pre-existing condition exclusions were prohibited for individuals under the age of 19 in 2010, and will be prohibited for all individuals beginning in January 2014. This means people will be able to access the care they need from their first day of coverage.

Limited Benefits. Insurers selling health insurance in the nongroup market often sell "stripped down" policies that do not cover benefits such as maternity care, prescription drugs, mental health, and substance abuse treatment services. For example, 20 percent of adults with individually purchased insurance lack coverage for prescription medicines, but only 5 percent of those with employer coverage do.[18]

To improve the value of coverage, the ACA sets minimum standards that insurers must cover. This "essential health benefits" package requirement is designed to ensure that consumers have comprehensive coverage that meets their health needs and protects them from financial hardship. The essential health benefits are expected to be included in the coverage of up to 68 million Americans by 2016 and will include—at a minimum—10 categories of benefits: ambulatory patient services; emergency services, hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[19]

Lifetime and Annual limits. Prior to enactment of the ACA, it's estimated that about 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. And 18 million people are in plans with annual limits on their benefits. These limits can be a matter of life and death. For example, Georgetown faculty recently documented the story of Martin Addie, a gentleman with severe hemophilia.[20] His body produces less than 1 percent of the clotting factor he needs, so he must administer clotting factor every other day to prevent bleeding. This costs approximately $60,000 per month. Prior to the ACA, he had blown through lifetime limits with three different health plans, causing incredible stress and worry—and putting his health at significant risk. Thankfully, the ACA brought in a ban on lifetime limits, and put immediate restrictions on annual dollar limits (banning them completely in 2014).

High Out-of-Pocket Costs. Nongroup policies often come with high deductibles—$10,000 or more is not uncommon—and high cost-sharing. In fact, deductibles can be about three times what they are in employer-based plans.[21] As a result, many

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[17] Jon R. Gabel, Ryan Lore, Roland D. McDevitt, Jeremy D. Pickreign, Heidi Whitmore, Michael Slover, and Ethan Levy-Forsythe, "More than Half of Individual Health Plans Offer Coverage that Falls Short of What Can Be Sold Through Exchanges as of 2014," *Health Affairs*, June 2012.

[18] *Supra*, n. 10.

[19] Sabrina Corlette, Kevin W. Lucia, and Max Levin, "Implementing the Affordable Care Act: Choosing an Essential Health Benefits Plan," The Commonwealth Fund, March 2013.

[20] JoAnn Volk, "Martin Addie: ACA Ban on Lifetime Limits has Ended his Coverage Circus," CHIRblog, November 14, 2012.

[21] Roland McDevitt, Jon Gabel, Ryan Lore, et al., "Group Insurance: A Better Deal for Most People than Individual Plans," *Health Affairs*, January 2010.

have very low actuarial values, below the minimum standard in the ACA of 60 percent for a "Bronze" level plan.[22] One study in California found that nongroup policies pay for just 55 percent of the expenses for covered services, compared to 83 percent for small group health plans.[23] Thus, these policies have fewer covered services AND cover a smaller share of the costs associated with the services they do cover. It is not surprising that approximately 57 million Americans live in families struggling with medical debt and 75 percent of those families had health insurance.[24]

For the first time, the ACA sets new standards to ensure that insurance coverage does what it should: provide real financial protection to individuals and families. The law sets coverage tiers, with Platinum plans being the most generous (enrollees will pay, on average, 10 percent of the out-of-pocket costs) and Bronze plans being the least generous, with enrollees paying, on average, 40 percent of the out-of-pocket costs. In addition, the ACA sets new limits on the total amount of out-of-pocket spending consumers must incur, based on their income.

And, for individuals earning up to 250 percent of the Federal poverty level, the ACA provides cost-sharing subsidies that will reduce the cost-sharing amounts and annual out-of-pocket limits. These subsidies have the effect of increasing the overall actuarial value of coverage, on a sliding scale basis, so that people between 100–150 percent of poverty will be responsible for only 6 percent of their out-of-pocket costs, rising to 22 percent for people at 250 percent of poverty.

TRANSPARENCY AND ACCOUNTABILITY ISSUES

Last, transparency and accountability are critical to a well-functioning insurance marketplace. Shopping for health insurance is a complex and confusing task for consumers, most of whom do not understand important components of the products being sold to them or how it works. As one study noted, most consumers rate reading their health insurance policy as a less appealing activity than preparing their income taxes or going to the gym.[25]

Prior to the ACA, individuals attempting to buy coverage in the nongroup market faced confusing choices, with little transparency regarding pricing or what their policy would actually cover—and what it would not. For example, one woman contacted a colleague of mine when she was attempting to switch to a higher deductible plan last December. The insurer told her that they could not quote her a monthly premium until she actually enrolled in the plan. And when questions arise about these confusing choices and the lack of transparency, consumers have few places to go to get unbiased, impartial advice on the plan that would best suit them and their family.

The ACA ushers in a number of critical changes to improve consumers' ability to shop for and compare plans in a manner that allows them to make informed choices and select a plan that best meets their needs.

One of the most talked about are the State-based health insurance exchanges (now called "marketplaces") that will help consumers make apples-to-apples comparisons among health plan options, and allow them to shop with confidence, knowing that all of the participating plans have met minimum quality standards.

Less talked about, but in polling one of the most popular provisions of the ACA, are the new "Summaries of Benefits and Coverage," (SBC) which insurers are now required to provide to individuals and employees seeking coverage. These standardized, easy to read summaries of the benefits, cost-sharing, limitations and exclusions in a plan can help consumers understand their coverage and make better choices. Recent consumer testing by Consumer Reports has found that consumers rated the SBC as more helpful than other sources of plan information, such as employer guides and health insurers' brochures.[26]

The ACA also includes new expectations for accountability for insurers. The law improves State rate review practices, and authorizes the Federal Government to review unreasonable rate increases if a State is unwilling or unable to do so. Insurers proposing new premium rate increases must provide detailed and public justification

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[22] *Supra*, n. 17.

[23] Jon Gabel, Jeremy Pickreign, Roland McDevitt, et al., "Trends in the Golden State: Small-group Premiums Rise Sharply While Actuarial Values for Individual Coverage Plummet," *Health Affairs Web Exclusive*, July/August 2007.

[24] Peter J. Cunningham, "Tradeoffs Getting Tougher: Problems Paying Medical Bills Increase for U.S. Families, 2003–2007," Center for Studying Health System Change, Tracking Report No. 21, September 2008.

[25] ehealth, Inc., "New Survey Shows Americans Lack Understanding of Their Health Coverage and Basic Health Insurance Terminology," January 3, 2008.

[26] Lynn Quincy, "Early Experience With a New Consumer Benefit: The Summary of Benefits and Coverage," Consumers Union, February 27, 2013.

for those increases. Insurers must also comply with new medical loss ratio (MLR) standards, meaning they must spend at least 80 percent of nongroup premiums on health care and improving heath care quality. If insurers' MLRs go below 80 percent, they must issue rebate checks to enrollees. The MLR was in effect for 2011, and in 2012 nearly 12.8 million Americans received rebates totaling more than $1.1 billion.[27]

CONCLUSION

The evidence is clear and unequivocal: the current nongroup market does not work for the people who need it most. Anyone with just about any health condition could face difficulty obtaining coverage in the individual market. What we have today is a system of "haves" and "have nots." And remember—even if you happen to be a "have," such as those young and healthy individuals who can access this market—you cannot have peace of mind. Just because you are young and healthy today does not mean you will remain so. It is an unfortunate fact of life that all of us will get older and most of us will have some health problems at some point in our lives. Yet today's nongroup market can't even provide people with the most basic obligation of insurance, which is to protect people from bad, unexpected events. And remember those of us who are happy with our employer-based coverage cannot be guaranteed it will last forever. A bad economy—a bad election—and any one of us could be subject to the nongroup market and all of the risks that come with that.

Congress, led by this committee, recognized the fundamental injustice of the current health insurance marketplace. In the ACA it enacted sweeping reforms that will improve Americans' access to adequate, more affordable health insurance coverage that allows them to get the care they need and protect them financially. This kind of change will be transformative and disruptive, particularly for those who have benefited from the inequities of the current system. But it is the right thing to do.

Thank you, Mr. Chairman, Ranking Member Alexander, and members of the committee, for the opportunity to speak before you today. I look forward to your questions.

The CHAIRMAN. Thank you very much, Professor Corlette and welcome back, as I said.

And now, we will turn to Stacy Cook from Carroll, IA. Stacy, welcome. Please proceed.

STATEMENT OF STACY COOK, CARROLL, IA

Ms. COOK. Chairman Harkin, Ranking Member Alexander, and members of the committee.

Thank you for inviting me to share my story about the positive impact, I believe, that health insurance reforms that were included in the Affordable Care Act will have on me.

I am a volunteer for the American Cancer Society Cancer Action Network, which advocates on behalf of millions of cancer patients nationwide. It is both an honor and a privilege to have the opportunity to address the Health, Education, Labor, and Pensions Committee and have my voice heard.

My name is Stacy Cook and I live in Carroll, IA. I am 36 years old and in December 2004, I was 28 and diagnosed with breast cancer in my right breast. I was fortunate. At that time, I had adequate health insurance through my job, so I was able to receive the care that I needed.

In November 2009, I moved from Iowa to Arizona and in March 2012, I found another lump in my breast. I immediately made an appointment to get it looked at. I got the call about a week later

[27] Healthcare.gov, "The 80/20 Rule: Providing Value and Rebates to Millions of Consumers," June 21, 2012.

that confirmed it was cancer again, except this time, it was in my other breast.

The CHAIRMAN. That's all right. Take your time. It's no problem. These are not easy.

[Pause.]

Ms. COOK. And I was scheduled to see an oncologist on April 3d, and I went to see the oncologist and he confirmed that I would need to have chemotherapy. He also told me that I would need to see a surgeon.

As I was checking out of the oncologist's office, my oncologist came and told me that the surgeon wanted to see me right away. I thought to myself, "Wow, this is happening fast." My aunt was with me, so we went straight over to the surgeon's office and within a few minutes of examining me, he told me he was going to do a mastectomy the next morning.

I was overwhelmed. Everything was happening so fast. And I had my mastectomy the next day. In the midst of all of this, I was informed that my insurance would not cover any procedures such as the mastectomies and hysterectomy I would need, would not cover the chemotherapy treatment I would need, and would only pay for five doctor visits a year. So not only did I have all these emotions from being diagnosed and having a mastectomy, now I had to worry about how I was going to get the treatment that I needed.

I applied for the Arizona State Health Insurance and was denied. I searched and searched for any other insurance that would help me, and I tried the pre-existing condition insurance plans, but found out that I would have to be without health insurance coverage for 6 months to be able to qualify, which would have been after my treatment had been completed.

I was told that in order to be able to have my chemotherapy treatments, I would need to pay for them up front before they would administer them. Because of the kindness of friends and family, I was able to pay for three out of six chemotherapy treatments that were recommended by my oncologist.

I was only working 28 hours a week and was not able to take any more hours on because of the effects of my treatment. I got to where I could not afford my rent or pretty much anything else, so I made the decision to move back to Iowa.

At 36, I was moving back in with my parents and I felt like a failure, but I had no other option. After I had moved back to Iowa, I continued my search to try and identify health insurance coverage that would allow me access to lifesaving cancer treatments I needed.

I looked into the Iowa State Health Insurance Plan and found that because of my breast cancer, I would have qualified for the program if I had been diagnosed in Iowa. Since I was diagnosed in Arizona, I was denied health insurance coverage again. But thanks to the hospital and the town where I live, I was able to get the rest of the chemotherapy treatments I needed without having to worry about paying for them up front. The hospital has a policy of treating patients first and then worrying about how they will get paid after.

Currently, I am seeing my oncologist every 3 months for followup visits, and I am also paying out-of-pocket for my prescription cancer drug Tamoxifen. However, I am now so far in debt because of my medical bills that I feel I will likely need to file bankruptcy in 2013. My medical debt is most likely near $40,000. I now have the peace of mind knowing that in 2014, I will no longer be denied coverage because of my pre-existing condition, cancer, and having access to affordable insurance coverage and quality medical care will give me a better peace of mind for the future.

My future is much brighter today than before the enactment of the Affordable Care Act, and for that I am very grateful.

Thank you very much for your time. I will be happy to answer any questions.

[The prepared statement of Ms. Cook follows:]

PREPARED STATEMENT OF STACY COOK

SUMMARY

In December 2004, I was 28 and was diagnosed with breast cancer in my right breast. I was fortunate that, at the time, I had adequate health insurance through my job, so I was able to receive the care that I needed.

In November 2009, I moved from Iowa to Arizona. In March 2012, I found another lump in my breast. I immediately made an appointment to get it looked at. I got the call about a week later that confirmed it was cancer again; I had my mastectomy the next day.

In the midst of all of this, I was informed that my insurance wouldn't cover any procedures such as the mastectomies and hysterectomy I would need, would not cover the chemotherapy treatment I would need, and would only pay for five doctor visits a year.

I applied for the Arizona State Health Insurance Program and was denied. I looked into the Preexisting Condition Insurance Plan but, by the time I would have been eligible for the program, I would have completed my treatment.

I was told by the hospital where I was receiving my care that in order to be able to have my chemotherapy treatments, I would need to pay for them up front before they would administer them. Because of the kindness of friends and family, I was able to pay for three of the six chemotherapy treatments that were recommended by my oncologist.

After I moved back to Iowa, I continued my search to try and identify health insurance coverage. I looked into the Iowa State Health Insurance Plan but, since I was diagnosed in Arizona, I was denied health insurance coverage again.

I am seeing my oncologist every 3 months for followup visits. I am also paying out-of-pocket for my prescription cancer drug. Unfortunately, I am now $40,000 in debt because of my medical bills, and I feel that I will likely need to file bankruptcy 2013.

I now have peace of mind knowing that, in 2014, I will no longer be denied coverage because of my pre-existing condition—cancer. Having access to affordable insurance coverage and quality medical care will give me a better peace of mind for the future. My future is much brighter today than before the enactment of the Affordable Care Act, and for that I am very grateful.

Chairman Harkin, Ranking Member Alexander, and members of the committee, thank you for inviting me to share my story about the positive impact I believe the health insurance reforms that were included in the Affordable Care Act will have on me. I am a volunteer with the American Cancer Society Cancer Action Network (ACS CAN) which advocates on behalf of millions of cancer patients nationwide. It is both an honor and a privilege to have the opportunity to address the Health, Education, Labor, and Pensions Committee, and have my voice heard.

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the call about a week later that confirmed it was cancer again; except this time, it was in my other breast. I was scheduled to see an oncologist on April 3d. I went to see the oncologist and he confirmed that I would need to have chemotherapy. He also told me that I would need to see a surgeon. As I was checking out of the oncologist's office, my oncologist came and told me that the surgeon wanted to see me right away. I thought to myself, wow this is happening fast! My aunt was with me so we went straight over to the surgeon's office. Within a few minutes of examining me, he told me that he recommended that I have a mastectomy the next morning. I was overwhelmed—everything was happening so fast. I had my mastectomy the next day.

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Unfortunately, I am now so far in debt because of my medical bills, I feel that I will likely need to file bankruptcy in 2013. My medical debt to date is near $40,000.

I now have peace of mind knowing that, in 2014, I will no longer be denied coverage because of my pre-existing condition—cancer. Having access to affordable insurance coverage and quality medical care will give me a better peace of mind for the future. My future is much brighter today than before the enactment of the Affordable Care Act, and for that I am very grateful.

Thank you very much for your time. I will be happy to answer any questions.

The CHAIRMAN. Thank you very much, Miss Cook for your very poignant, moving statement. I think that just pretty much sums it all up.

Mr. Carlson, welcome. Please, please proceed.

STATEMENT OF CHRIS CARLSON, PRINCIPAL AND CONSULTING ACTUARY, OLIVER WYMAN CONSULTING, MILWAUKEE, WI

Mr. CARLSON. Thank you. Mr. Chairman and members of the committee, thank you for this opportunity to testify on the impact of guarantee issue and new rating rules.

My testimony will focus on the studies that I and other actuaries have prepared to assess the impact of changes in non-group pre-

mium rates resulting from the ACA. There are three issues I will address specifically.

First, the analysis that we and others performed to measure the impact of the 3 to 1 age rating limitation on non-group policies. Second, the estimates we have developed on the increase in premiums that will be required to fund the health insurer taxes beginning in 2014. Third, the report sponsored by the Society of Actuaries that measures the impact of newly insured on claim costs in the non-group market. In addition, I will touch on other issues that will both increase and decrease premiums.

First, Kurt Geisa and I co-authored an article published in the American Academy of Actuaries magazine. The purpose of the article was to assess the impact of age-rated limitations required by the ACA. Currently in most States, health insurance premium rates are allowed to vary by a ratio of at least 5 to 1 based on age, however, actual costs may vary by as much as 6 or 7 to 1. Thus, insurers must compress the rates at the high and low ends to maintain the required ratio of premium rates by age.

Our work was intended to measure the impact of age rating compression, but also includes an assumption for the impact of all other provisions of the ACA. For this, we relied upon the CBO's letter to Senator Bayh in 2009 where the CBO estimated that non-group premiums would increase by 10 to 13 percent relative to current law. This amount represents changes due to factors such as the increase in benefits, competitive factors, and guaranteed issue.

In our analysis, we assumed that the overall change due to these other factors would be at the low end of this range or a 10 percent increase. Importantly, I note that our article illustrates the impact on premiums for those individuals that are not eligible for the subsidies.

We showed that for individuals in the lowest age bracket, ages 21 to 29, premiums would increase by 42 percent in total, of which 29 percent is due to the age rating compression. Further, individuals at ages 30 to 39 would see an increase of 31 percent in total or 19 percent due to the age rating compression.

The Urban Institute recently published a report that also researched the impact of age rating. They concluded that the premiums for individuals between the ages of 21 to 27 would increase by 21 percent due to age rating, consistent with our results. We also agree with their conclusion that this would not affect most young adults due to premium subsidies available through the Exchanges. However, there will be certain individuals who are not eligible for subsidies whose premiums will increase substantially due to the age rating limitations.

Regarding the second topic, Oliver Wyman researched the impact of health insurer taxes. We, and others, including the CBO, believe that these fees will be passed through directly to policyholders in the form of higher premiums. Overall, we anticipate that these increases will affect premiums by roughly 2 percent in 2014, and as much as 3.7 percent by 2018.

Third, the Society of Actuaries sponsored a report prepared by Optum that estimated the change in claim cost due to newly insured individuals in the non-group market. It is expected that in most States which currently do not require a guaranteed issue,

new entrants to the non-group market will have higher morbidity than those currently insured. Therefore, it is expected that the premiums in the non-group market will need to be increased in 2014 due to the inclusion of a less-healthy population.

On average, Optum estimated that the non-group claim costs would increase by 32 percent after inclusion of the new entrants into the market. The results, however, vary widely by State from a reduction of 13.9 percent in New York, which currently has guaranteed issue and community rating, to an increase of 80.9 percent in Ohio. Generally, the States that have more restrictive market rules prior to the ACA will see lower claim costs relative to current costs.

Finally, I will briefly discuss other components expected to affect premiums in the non-group market.

First, premiums will increase due to requirements to provide essential benefits and minimum actual values. For example, the CBO estimated that increases in premiums due to the amount of insurance coverage would be 27 to 30 percent.

Second, the open marketplace created as a result of the Insurance Exchanges will put pressure on health plans to keep premium rates down in order to be one of the lowest cost options and to attract those that are eligible for subsidies.

If a health insurers' premium rate is greater than the second lowest Silver Plan, enrollees would have to pay more out-of-pocket in premium, which would not be reimbursed by the premium subsidies.

Third, additional fees and taxes, including the exchange fees of 3.5 percent for the Federally Facilitated Exchanges and the medical device tax, will also likely pass through to premiums.

Fourth, and finally, the Temporary Reinsurance Program will reduce non-group premium rates by reimbursing health insurers for individual claims that exceed a threshold. The State of Vermont recently published post-ACA rate filings, one of which estimated that the reduction in costs for the non-group market, due to the Temporary Reinsurance Program, would be 9.6 percent in 2014.

Mr. Chairman, again, I thank you for the opportunity to speak, and look forward to answering any questions.

[The prepared statement of Mr. Carlson follows:]

PREPARED STATEMENT OF CHRIS CARLSON

I. INTRODUCTION

Chairman Harkin, Ranking Member Alexander, and members of the committee, I am Chris Carlson, principal and consulting actuary at Oliver Wyman. I have nearly 20 years of experience as a health care actuary and have been actively involved the last few years in helping stakeholders, including clients, regulators and actuarial colleagues understand and implement the changes required by the Affordable Care Act (ACA). I am delighted to have this opportunity to testify on the effect of guarantee issue and the new ratings rules on the nongroup health insurance marketplace.

My testimony will focus on topics that I and my firm of Oliver Wyman and other health actuaries have studied in preparation of implementing the new marketplace rules required by the ACA. These topics include:

- The analysis that we and others performed to measure the impact of the 3 to 1 age rating limitation of the ACA on nongroup policies.
- The estimates we have developed on the increase in premiums that will be required to fund the health insurer taxes beginning in 2014.

• The report sponsored by the Society of Actuaries that describes the cost of newly insured individuals in the marketplace relative to the current nongroup marketplace participants.
• Other factors that will impact the level of health insurance premiums in the nongroup marketplace after implementation of the ACA.

Overall, we note that the age-rating limitations by themselves result in no change in the average premium. However, since current age-rating laws in most States allow for a 5 to 1 ratio or more in the highest to lowest rate, the change in the premium required for certain policyholders to compress to a 3 to 1 ratio is significant. Our study indicates that the impact of the age rating compression will increase the average premium for policyholders between ages 21 and 29 by 29 percent. The Urban Institute published a report [1] that assessed the impact of age rating compression but using a different methodology. Although the magnitude of their results is different, the results are consistent as they estimated that premiums for single adults between ages 21 to 27 would increase 21.3 percent due to the age rating compression. In both cases, this increase would only apply to individuals that are not eligible for any premium subsidies and have incomes above 400 percent of the Federal Poverty Level.

Beginning in 2014, health insurers will be assessed additional premium taxes required by the ACA. The amount to be collected in 2014 is $8 billion, increasing to $14.3 billion in 2018 and with trend thereafter. We estimate that the impact of these taxes will be to increase premium rates by 1.9 percent to 2.3 percent in 2014, and by 2.8 percent and 3.7 percent in years 2018 and later.

The Society of Actuaries sponsored a study [2] of the newly insured individuals that will be enrolled in the nongroup market as a result of the ACA's provisions related to guarantee issue. This report estimated that the nongroup cost per member per month across all ages would increase by 32 percent after the ACA compared to pre-ACA. This would be in addition to the increases for the younger individuals aged 21 to 29, described above.

There are other factors that will drive changes, both increases and decreases, in the nongroup premium rates after implementation of the ACA. These include:

- Increases:
  - Benefits required for essential benefits and actuarial value.
  - Additional fees and taxes including the Exchange fees of 3.5 percent and the medical device tax which will likely be passed through to premiums.
- Decreases:
  - Competition created by the Exchange marketplace.
  - The temporary reinsurance program will reduce nongroup premium rates in the first 3 years post-ACA.

II. AGE-RATING UNDER THE ACA

The ACA reforms the market rules that all health insurance providers must follow in the pricing of health premiums beginning on January 1, 2014. In general, premium rates are only allowed to vary by four criteria: geography, age, tobacco usage and actuarial value. Of these, there is a further restriction that the premiums may not vary by age by more than 3 to 1 from the highest age tier to the lowest age tier. In fact, the regulations that were promulgated by the Department of Health and Human Services mandated specific factors by age to be used, unless otherwise developed by an individual State.

Kurt Giesa and I, actuaries at Oliver Wyman, co-wrote an article for *Contingencies* magazine, which is published by the American Academy of Actuaries, which estimated the impact of the age rating compression on different age cohorts in States that currently allow age rating beyond 3 to 1. The importance of this work is to help move beyond looking at premium changes based on broad averages, especially in a case where an average would mask substantial differences. We believe it is especially important to look at the age cohort from 21 to 29, since even after accounting for ACA's provision requiring that adult children be allowed to remain on their parents' coverage until age 26 this age group has an uninsured rate that is roughly twice the uninsured rate for the nonelderly population.

To create our study, we used three primary data sources. The first was the 2011 Current Population Survey (CPS) conducted by the U.S. Census Bureau (use of the

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[1] Blumberg, Linda J. and Buettgens, Matthew, "Why the ACA's Limits On Age-Rating Will Not Cause 'Rate Shock': Distributional Implications of Limited Age Bands in Nongroup Health Insurance", The Urban Institute, March 2013.

[2] "Cost of the Future Newly Insured Under the Affordable Care Act (ACA)", Society of Actuaries, March 2013.

2011 CPS data takes into account the impact of the ACA's adult child coverage provision, which became effective for plan years beginning on or after Sept. 23, 2010). For premium-level assumptions, we relied on Congressional Budget Office (CBO) estimates regarding selection and impact of increased benefit levels tied to actuarial values. We excluded the effects of medical cost trend because it's assumed to occur regardless of the ACA. (CBO estimates of premium increases include growth in the underlying cost of coverage related to an increase in benefits over what is purchased today, positive selection due to an assumed improvement in risk pool mix, and lower prices due to greater market efficiencies.) Our estimates of the level of premium assistance are generous, as we based them on average premiums. Had we based them on estimates of premiums for the second lowest-cost silver plan (as will be the case under the ACA), the assumed levels of premium assistance would have been lower and consumer out-of-pocket costs for health insurance and the premium rate changes in 2014 would have been higher.

To construct premiums by age in 2013, we relied on a set of proprietary rating factors maintained by Oliver Wyman. These rating factors are based on costs and are consistent with factors used in the industry. For 2014, we used the standard age curve that CMS put forward in its proposed Health Insurance Market Rules. We also collected data from two large health insurance issuers to verify our estimates derived from CPS data on demographic distributions and found similar results when looking at these carriers' actual market data.

While a range of ACA provisions will be implemented in 2014, perhaps the most important for young adult insurance premiums are the provisions for age band compression and the provisions related to advanced premium assistance tax credits and cost-sharing reduction assistance. The essence of age band compression is that younger people pay more for their coverage so that older people can pay less. As with many other issues that affect pricing, this is effectively a matter of the amount of cross-subsidization that will flow among different enrollees with respect to their health insurance premiums. We need to distinguish the cross-subsidies that are the result of age band compression from the general pooling of risk that underlies all insurance. While insurance generally provides a retroactive cross-subsidy among insured individuals to protect against unknown risks, age band compression is a prospective cross-subsidy from the young to the old.

Our analysis shows that under the ACA, premiums for people aged 21 to 29 with single coverage who are not eligible for premium assistance would increase by 42 percent over premiums absent the ACA. People aged 30 to 39 with single coverage who are not eligible for premium assistance would see an average increase in premiums of 31 percent. Those with single coverage aged 60 to 64 who are not eligible for premium assistance would see about a 1 percent average increase in premiums. Our estimates of these effects are shown in Chart 1 and reflect the assumptions described above. These estimates assume a starting age band of about 5 to 1, reflecting States where coverage currently is underwritten.

Our core finding is that young, single adults aged 21 to 29 and with incomes beginning at about 225 percent of the FPL, or roughly $25,000, can expect to see higher premiums than would be the case absent the ACA, even after accounting for the presence of the premium assistance. Similarly, single adults up to age 44 with incomes beginning above approximately 300 percent of FPL can expect to see higher premiums, even after accounting for premium assistance. This is because in today's market, younger enrollees can buy coverage that more closely reflects their expected actuarial costs based on their age, and this coverage is pooled with other similar risk classes in accordance with standard actuarial principles. In addition, the ACA requires that all nongroup coverage meet essential health benefit requirements, both with respect to the type of services covered and with respect to the actuarial value of the coverage.

Consider, for example, a 25-year-old person with income at 300 percent of FPL, or $33,510. This person currently could purchase coverage for about $2,400 per year, or 7.2 percent of his or her income. Age band compression and the other changes to the ACA would result in premiums (before premium assistance) increasing by 42 percent to $3,408. As shown in Chart 2, this person at 300 percent FPL will be required to pay 9.5 percent of his or her income, or $3,183, toward the cost of coverage. The cost of his or her actual premium would increase by $783, even with the $225 in premium assistance. (The impact of cost-sharing reduction assistance at these income levels is not relevant because the assistance completely phases out at household incomes above 250 percent of FPL.)

While our analysis focused primarily on the impact of age band compression, the interaction of age band compression and the elimination of premium variation related to health status also deserves attention. Analysis of representative carrier data suggests that eliminating health status as a rating factor itself may increase

premiums by roughly 17 percent to 20 percent for those who have preferred rates because of lower-than-average health risks. Young adults often qualify for these preferred rates. These increases would be in addition to any premium rate change due to age compression, required increases to benefits, or other factors discussed above. On the flip side, older individuals often cannot get coverage in the nongroup market or afford coverage if it is offered. The ACA addresses many of these concerns for older persons separate from the issue of age band compression. It mandates that nongroup coverage be offered on a guaranteed-issue basis. The ACA's prohibition on varying premiums based on health status will lower rates for older people. And the same arguments that apply with respect to premium assistance for younger individuals apply to those who are older—for anyone with household income up to 400 percent of FPL, the ACA makes premium assistance available that caps spending on coverage at 9.5 percent of income, or a lower amount for incomes less than 300 percent of FPL. The difference between young and old at similar income levels is that younger individuals at a given income level are much less likely to find it economically rational to purchase coverage if it takes up 9.5 percent of their income, while older individuals have a greater expectation of health care cost spending as a percentage of income.

In light of these tradeoffs, it is important to consider ways of mitigating the effect on rates for younger people while leaving benefits of the ACA in place for older people in the pre-65 age cohort.

Breadth of Impact

Looking at the uninsured by FPL and age in 2011 shows that 11.2 million people (or almost 25 percent of the uninsured in 2011) were between the ages of 21 and 29, and roughly 1.4 million of these individuals will not be eligible for premium subsidies because their household income exceeds 400 percent of FPL. At the same time, close to another 2.6 million uninsured individuals are estimated to have incomes above 225 percent of FPL, the crossover point above which those purchasing single coverage can expect to pay more out-of-pocket for coverage than they otherwise would, even after accounting for premium assistance. In total, this means that close to 4 million uninsured individuals aged 21 to 29—or roughly 36 percent of those currently uninsured within this age cohort (4 million/11.2 million)—can expect to pay more out-of-pocket for single coverage than they otherwise would, even given the availability of premium assistance.

Roughly 7.6 million people, or 40 percent of those covered in the nongroup market in 2011, had incomes above 400 percent of the FPL and would be ineligible for premium assistance. Taking into account both the 400 percent FPL phase-out level and the 225 percent FPL crossover point, we estimate that almost 80 percent of those ages 21 to 29 with incomes greater than 138 percent of FPL who are enrolled in nongroup single coverage can expect to pay more out-of-pocket for coverage than they pay today—even after accounting for premium assistance. With a crossover point of about 300 percent of FPL for those aged 30 to 44, we estimate that about one-third of those older than age 29 with incomes greater than 138 percent FPL who currently are insured with individual contracts will see higher premiums even after accounting for premium assistance.

Also of potential importance to the cost of coverage for young adults are two ACA provisions: the creation of a catastrophic plan option and coverage of adult children to age 26 through their parents' group coverage. The ACA provides that beginning in 2014 issuers can offer a catastrophic plan option to those under age 30 and to others for whom the cost of coverage is deemed unaffordable. The ACA's provisions on cost-sharing applicable to "metallic level" coverage and the actuarial value requirements do not apply to these plans. If they are substantially more affordable than other coverage, catastrophic plans may prove an important option for young adults to keep premiums affordable (though premium assistance will not be available to those purchasing the catastrophic coverage, regardless of income). The ACA also includes provisions allowing parents to keep adult children on their employer-sponsored group coverage up to age 26. This provision is already in effect, and early indications are that it has helped to cover more young adults. Because this coverage is by definition group coverage, however, increasing dependent coverage for young adults in this way does not improve the quality of the risk pools in the nongroup market. In fact, comparing the 2011 CPS data against earlier periods suggests that one effect of the adult child coverage provision on the nongroup market has been to increase the proportion of older enrollees in relation to younger enrollees.

From a policy perspective, the issue of age band compression and whether its effect on the cost of coverage for young people is outweighed by the value of premium assistance matters for at least two reasons:

• Equity—While judging fairness and the tradeoffs implicit in age band compression raises subjective questions, technical analysis can help objectively unmask distributional differences relevant to this question.
• Market Efficiency—If people aged 21 to 29 are asked to pay substantially more for their coverage than they otherwise would, will they choose to obtain or maintain coverage at all?

This question has clear implications for insurance markets, which rely on the presence of balanced risk pools in order to provide affordable coverage. Younger people tend to be healthier and have expected health care costs that are lower than those of older people. An adult near retirement age, for example, is generally expected to have health care costs that are roughly six to seven times or more than those of the average male aged 21 to 29. If healthy young people choose to leave the risk pool or join in proportionately fewer numbers relative to those with immediate health care needs, the effect would be to create an unbalanced risk pool and higher prices for those seeking coverage.

Our analysis raises questions as to whether younger individuals will perceive coverage as cost effective. In our analysis, we blended young males with young females to look at age 21 to 29 cohorts as a whole. Had we broken the analysis out by gender, it would show a greater impact on young males (meaning premium increases would be higher and the crossover point would occur at a lower FPL level) and less of an impact on young females. The CBO's 2009 analysis of premiums under the ACA suggests that more young people would obtain coverage under the ACA than under current market conditions, leading presumably to the conclusion that risk pools for nongroup coverage in 2016 would be younger and healthier than today's markets. More recent estimates at the State level by various parties have reached different results. These analyses have focused on factors such as the impact of guaranteed issue and the elimination of underwriting. Important to all these analyses are assumptions regarding the effectiveness of the individual coverage mandate, which could encourage young people to obtain and retain coverage even if it is not otherwise in their perceived economic interest to do so. In this regard, the ACA requires that every individual maintain coverage or pay a tax penalty that is equal in 2014 to the greater of $95 or 1 percent of modified adjusted gross income, with the penalties for not maintaining coverage gradually increasing over time—phasing up to the greater of $325 or 2 percent for 2015 and ultimately the greater of $695 or 2.5 percent of income after 2016. The relatively low penalties associated with the individual mandate make the effectiveness of the mandate uncertain, particularly in the first few years of reform when stability is essential and the penalty can be expected to fall well below the annual cost of the minimum standard of coverage required under the ACA. This situation was given clarity in the June 2012 ruling from the U.S. Supreme Court—the law does not require maintenance of coverage, only maintenance of coverage or payment of the tax penalty.

Given the significance of these issues, policymakers should assess how various ACA provisions affect the underlying affordability and cost of coverage for younger individuals, in order to better understand issues that may affect their decisions to obtain and/or maintain coverage. Understanding these issues requires analyses that go beyond consideration of broadly stated averages, which can mask the effects on important subpopulations. There are several options for mitigating the potential impact of age band compression. One approach, provided the ACA allows for this, would be to phase in the age band requirements over a period of years, thus allowing the market to stabilize with respect to other changes before full implementation of age band compression requirements. This might also bring about higher enrollment levels among young adults, which could lead to a healthier risk pool overall and help hold down premium rates for everyone—young and old.

Another complementary possibility would be to ensure that the pricing rules for catastrophic coverage provide adequate flexibility to increase the likelihood that these policies will be affordable. This appears to be the approach that CMS had taken in its recently released "Notice of Benefit and Payment Parameters for 2014." Affordability is especially important for young adults who have incomes that make them ineligible for premium assistance or are above the 225 percent FPL crossover point. For these individuals, an affordable catastrophic coverage plan could mean the difference between obtaining and going without coverage. Because these plans are not eligible for premium assistance and are limited to those age 30 and younger (and those for whom coverage is "unaffordable"), there would be a natural limiting point with respect to the number of people who would be expected to enroll. As a result, the potential impact on coverage costs for older people because of the reduced level of cross-subsidy from those enrolled in catastrophic coverage would be limited.

The Urban Institute prepared a similar study using their simulation model to assess the impact of the age rating compression. In general, the results of their model

are consistent with our results for the youngest ages. The Urban Institute estimated that the increase in premium rates due to the age rating compression would be 21.3 percent for the ages 21 to 27, compared to our estimate of 29 percent. Further, we agree with the Urban Institute's conclusion that "most young adults currently covered by nongroup insurance will be shielded from the full effects of the narrower age-rating bands." However, we believe that some young individuals will be affected by the age-rating and will see substantial increases beginning in 2014.

III. INSURER TAXES

The ACA, establishes an annual fee on the health insurance sector—effective in 2014. The new fee applies with some exceptions to any covered entity engaged in the business of providing health insurance (including private plans that participate in public programs), but does not include self-insured employer-provided health plans. The amount of the fee will be $8 billion in 2014, increasing to $14.3 billion in 2018, and increased based on premium trend thereafter. The fees are non-deductible for Federal tax purposes. As we explain later, this feature implies that for each dollar assessed and paid in fees, more than a dollar in additional premium amounts must be collected (e.g., $1.54 for every $1.00 in fees, assuming a 35 percent Federal corporate income tax rate). In total, on a statutory basis, between 2014 when the fees are first imposed and 2019, the total amount assessed (and actually collected from health insurers) will be at least $73 billion. Net revenues to the Federal Government, however, will increase by a lesser amount as reflected in revenue effect estimates by the Joint Committee on Taxation ("JCT") which show Federal revenues increasing by $60.1 billion over 10 years (2010–19). As highlighted below, both the JCT and CBO conclude that the new fee on health insurance plans would increase premiums.

The CBO prepared an estimate of the impact of the market reforms required by the ACA in a letter to Senator Evan Bayh on November 30, 2009. However, in this document, the CBO made no explicit calculation of the impact of the insurer fees on average premiums in the market. Instead, they stated "these fees would largely be passed through to consumers in the form of higher premiums for private coverage."

In a June 2011 letter to Senator Jon Kyl, the JCT explained that the fee on health insurance providers is similar to an excise tax based on the sales price of health insurance contracts. They estimated that repealing the health insurance industry fee would reduce the premium prices of plans by 2.0 to 2.5 percent, and that eliminating this fee could decrease the average family premium in 2016 by $350 to $400.

Our analysis quantified the impact of the fees imposed on health insurers under the ACA on the cost of health insurance coverage in both the commercial and public sectors. Our analysis estimates that the insurer fees will increase the costs of fully insured coverage by an average of 1.9 percent to 2.3 percent in 2014, further increasing over time such that by 2023, the fees will ultimately increase costs on average by 2.8 percent to 3.7 percent. This implies a material increase the average dollar cost of fully insured coverage, raising the average cost of such coverage by several thousand dollars over a 10-year period beginning in 2014.

IV. COST OF NEWLY INSURED

The Society of Actuaries (SOA) sponsored a report that was prepared by Optum that estimated the impact on claim costs due to the expansion of the nongroup market. It is expected that in most States, which currently do not require guarantee issue, new entrants to the nongroup market will have higher morbidity than those currently insured. Therefore, it is expected that the premiums in the nongroup market will need to be increased in 2014 due to the inclusion of a less healthy population. On average, Optum estimated that the nongroup claim costs per member per month would increase by 32 percent after inclusion of new entrants in the market. The results vary widely by State from a reduction of 13.9 percent in New York (which currently has guarantee issue and community rating) to an increase of 80.9 percent in Ohio. Generally, the States that have more restrictive market rules prior to the ACA will see lower claim costs relative to current costs. The full report can be found at *http://cdn-files.soa.org/web/research-cost-aca-report.pdf*.

V. OTHER FACTORS

I briefly discuss other components expected to affect premiums in the nongroup market:

• Increase in benefits required for essential benefits and actuarial value: The CBO estimated that the increase in premiums due to the amount of insurance coverage would be 27 percent to 30 percent.[3]
• Competition created by the Exchange marketplace: It is expected that the open marketplace created as a result of the insurance exchanges will put pressure on health plans to keep premium rates down in order to be one of the lowest cost options and to attract those that are eligible for subsidies. If a health insurer's premium rate is greater than the second lowest silver plan, enrollees would have to pay more out-of-pocket in premium that would not be reimbursed by the premium subsidies.
• Additional fees and taxes including the Exchange fees of 3.5 percent in federally facilitated exchanges and the medical device tax which will likely be passed through to premiums.
• The temporary reinsurance program will reduce nongroup premium rates in the first 3 years after January 1, 2014: Health insurers will receive reimbursement for individual claims that exceed a threshold. These reimbursements will decrease the insurers' claims costs during 2014 to 2016, when this program in operational. The State of Vermont recently published post-ACA rate filings, one of which estimated that the reduction in cost for the nongroup market due to the temporary reinsurance program would be 9.6 percent in 2014.[4]

The CHAIRMAN. Thank you very much, Mr. Carlson, and thank you all for your testimony.

I knew that Senator Murphy was delayed in getting here because of prior commitments, and I want to recognize Senator Murphy, who wanted to make some statements.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you very much, Mr. Chairman. I merely wanted to welcome Mr. Counihan to the panel; so glad that the committee selected him to join us.

I am going to have to leave again, but we are very lucky to have him in Connecticut overseeing our Exchange. Despite the tough timelines, we are doing very well and he brings to this panel a wonderful combination of experience in the public sector having worked a similar job in the Massachusetts Connector, as well as in the private sector. He has been very articulate talking about the provisions of the health care bill that will help to ease some of the rate shock concerns that have been expressed by these panels today.

And I wanted to thank the Chairman for having him be part of this panel and thank him for being here and for his great work in Connecticut.

The CHAIRMAN. Thank you, Senator Murphy.

We will now begin a round of 5-minute questions. Ms. Cook, Stacy, when you said you are now $40,000 in debt and may have to file bankruptcy this year.

I think I saw someplace, and maybe staff or someone down there can help me, that one of the single largest causes of personal bankruptcies in America was health care debt. Am I saying it correctly? Professor Corlette.

Ms. CORLETTE. I believe that is correct, Senator.

The CHAIRMAN. I also saw that one of the reasons, the highest reason for bankruptcy and also for losing homes, not being able to pay mortgages, is because of high medical debt.

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[3] *http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11–30-premiums.pdf.*
[4] *http://www.dfr.vermont.gov/sites/default/files/MVPH–128956063.pdf.*

I think your story really does illustrate so much of what is going on in America. Unfortunately, there are hundreds of thousands of people in your same situation. It may not be cancer, but it may be something else.

Ms. COOK. I agree.

The CHAIRMAN. They just simply cannot get insurance coverage. I mean, I was struck by the fact that you moved back to Iowa and the Iowa State Health Insurance Plan would not help because you were diagnosed in Arizona. I just find that alarming: that because of moving from one State to the next, I mean, you were diagnosed in one State, but you cannot get the coverage in another State. That just is mindboggling.

So now, you are doing your followup. But again, now you are pre-existing, this won't happen until, what, October 1st of this year, is that right? When the no pre-existing condition clauses start, is that right?

Ms. CORLETTE. Miss Cook will be able to enroll in a plan starting October 1st, but the coverage does not actually start until January 1st.

The CHAIRMAN. She can enroll, but the coverage starts in January.

Ms. CORLETTE. The open enrollment period begins in October.

The CHAIRMAN. Oh, that is right. There is an open enrollment period. So, at least you have the peace of mind of knowing that——

Ms. COOK. Yes.

The CHAIRMAN [continuing]. You will be able to get coverage that you can afford beginning next January. And you can seek the health care that you need.

Ms. COOK. Yes.

The CHAIRMAN. I just wish you didn't have to go through that. I wish hundreds of thousands of Americans did not have to go through that.

And then when I hear about young people now, free riders as we have called them in the past, that now they are going to have to sign up. They are going to have to pay more. Mr. Carlson pointed that out. It has been pointed out before. These young people have got to pay more. But I bet you when you were in your early 20's, you were diagnosed at what age, 28?

Ms. COOK. Yes.

The CHAIRMAN. I bet before that, you probably thought you were just going to sail right through.

Ms. COOK. I actually turned down cancer insurance not 2 months before I was diagnosed. I never thought that I——

The CHAIRMAN. Because you are young and you are healthy.

Ms. COOK. Yes.

The CHAIRMAN. Yes, you are invulnerable. I remember. I was like that once. Young, you're invulnerable.

I think what Mr. Counihan said, really brings it home that, how did you say that, again? I am going to remember that, Mr. Counihan. I just thought it was very profound. You said that,

> "The hallmark of health reform has been the concept of shared responsibility, the sense of shared ownership, of a common value that our Nation benefits more from more citizens realizing the peace of mind of health insurance coverage."

I think that is really it. I think that's really it, that this is a shared sense of responsibility.

As I said to the earlier panel that we all know, any of us who have been involved in insurance know that the best insurance coverage, the cheapest is when you have more people in the pool. Get more people in the pool. When you start dividing it up, there are going to be some winners, and there are going to be some losers. And therefore, then you put the responsibility, then you shift, you shift to those who are the least able to maintain health, or those who have been hit with a double whammy like Miss Cook. So I just see it in those terms of a shared value in this country.

And as others have pointed out that we are paying for it one way or the other. We pay for it through uncompensated care. Sadly enough, we also pay for it through the suffering of people who cannot get insurance coverage. Is that not also something we care about, too, in our society? People should not have to. I mean, it is enough to be hit with a chronic illness or disease, cancer, other things, it is enough. But then to be double hit with the fact that you cannot even get health care. You cannot pay for it. You have to go into debt up to your eyeballs, have to file for bankruptcy. Is that what we are about as Americans? Is this the right system? Is that the right kind of system?

I think, as I said, Miss Cook, I think you just brought it all home with your story about what this is all about. I will have some more questions maybe, but I just wanted to get that out.

Senator Alexander.

Senator ALEXANDER. Thanks, Mr. Chairman.

I want to thank the witnesses for coming. Sorry, I was a little late getting back because of the vote. Miss Cook, thank you especially for coming. That cannot be easy to do.

Mr. Carlson, I would like to ask you a couple questions. You mentioned the Congressional Budget Office report in 2009. It estimated, I think you said, that the President's proposed health care plan would increase individual premiums by 10 to 13 percent. Is that what you said?

Mr. CARLSON. That is correct.

Senator ALEXANDER. Some of those people would then have subsidies, right, which would reduce the cost?

Mr. CARLSON. Yes.

Senator ALEXANDER. But not all of them, right?

Mr. CARLSON. Not all.

Senator ALEXANDER. Do you know what the percent was?

Mr. CARLSON. I do not know those numbers offhand.

Senator ALEXANDER. I think it was about half.

Mr. CARLSON. But it was in our article, we do show the numbers there.

Senator ALEXANDER. Right. That was a discussion that I happened to have with the President. I know that in 2008, he went around the country, and we have it in "The *New York Times*" saying that he would lower the country's health care cost of premiums by $2,500 for a typical family.

I was asked to speak at the Health Care Summit the President invited me to in 2010, which I did, and we had a difference of opinion when he said that individual premiums would go down 14 to

20 percent. I cited that CBO report saying they would go up, net, 10 to 13 percent. He said I was wrong. I think I was right. The CBO was talking about an actual increase in premiums. Is that correct?

Mr. CARLSON. That is correct, yes.

Senator ALEXANDER. And in your study, the Society of Actuaries, one of the Obama administration officials said that was an insurance company report. Is that correct?

Mr. CARLSON. The Society of Actuaries is an independent organization and they sponsored the report. It was written by Optum which may be owned by an insurance company, but from my perspective it is an independent report.

Senator ALEXANDER. Your conclusion was that individual premiums would rise, how much?

Mr. CARLSON. The SOA report expected that they would go up 32 percent due to the new——

Senator ALEXANDER. This would be when the law takes effect, is that right, in 2014 through——

Mr. CARLSON. That is correct.

Senator ALEXANDER [continuing]. 2017?

Mr. CARLSON. Well, I think it is——

Senator ALEXANDER. Over what period of time?

Mr. CARLSON. I do not know that they quantified the timing of that increase.

Senator ALEXANDER. Yes. And do you recall what the reasons for the increase in the prices, the expected jump in rates were? What the principle, driving forces were?

Mr. CARLSON. That was principally going to be driven by the individuals who are going to be entering the market who had preexisting conditions and needed the insurance for getting medical care.

Senator ALEXANDER. Would another one be that the requirement that somebody my age would pay less and somebody my son's age would pay more?

Mr. CARLSON. That is actually not included in that 32 percent.

Senator ALEXANDER. That is a cost in addition.

Mr. CARLSON. For a young individual, that would be a cost in addition.

Senator ALEXANDER. Do you have any idea how much individual premiums for young men may go up over the next several years. Have you done any estimate of that?

Mr. CARLSON. We have not necessarily put the pieces together, but it is possible you can do that and kind of look at all the different components, and see how they add up, and it would be quite——

Senator ALEXANDER. But wouldn't common sense say that unless coverage was reduced, which it has not been so far as I know, that if you reduce prices, costs for someone my age, they go up for someone my son's age. That is the whole point of the rating, is it not?

Mr. CARLSON. That is correct, yes.

Senator ALEXANDER. Equalize that. In the equalization, it tends to keep this one down and raise this one up. Would another reason that the individual rates might be going up be that the require-

ments that the policies have more benefits to them, that they are richer policies?

Mr. CARLSON. That is correct.

Senator ALEXANDER. What did the report say about that?

Mr. CARLSON. The CBO report said it was 27 to 30 percent. I think it depends greatly on what State you are in. Some of the States have already significant mandates for providing benefits, so their increases may be significantly less than that.

Senator ALEXANDER. Have you done any work to determine whether people who are self-employed, the policies they typically have, would be consistent with the requirements of the new law?

Mr. CARLSON. I am sorry. I do not think I understand the question.

Senator ALEXANDER. The people who are self-employed and have their own individual insurance plan, will then have to have a new plan that meets the requirements of the law.

Mr. CARLSON. Absolutely. Yes.

Senator ALEXANDER. Have you done any work to determine whether the new requirements are consistent with what most people already have?

Mr. CARLSON. No, I mean, I think all of these, the factors that we are discussing will affect those individuals as well.

Senator ALEXANDER. Mr. Chairman, there is no doubt that the law expanded coverage, but I think the point we are finding is that someone is going to be paying the cost. Individual rates are going up.

The President said they would not. He said that at a meeting with Members of Congress, he was talking about actual increases in rates. He was, unfortunately, incorrect about that based upon all of the projections that I have seen from the Society of Actuaries, from BlueCross BlueShield in Tennessee, and others. But we will know for sure when the implementation of the law takes place fully beginning next year.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Franken.

Senator FRANKEN. As I said in the first panel, the record is that, for over the last 3 years, we know that part of ACA has gone into effect. And now, if you have pre-existing conditions as a child, you have to be offered coverage. And we know that the growth in the cost of care has actually slowed down relative to what it has been in the last 50 years.

The President never said it would go down as an absolute. It was——

Senator ALEXANDER. I have it here. I was at the meeting, Senator Franken. He was speaking to me and I have the text here if you would like to read it afterwards.

Senator FRANKEN. I never heard him say it publicly. What he said publicly was that relative to what they would otherwise be, costs would go down. That is what I heard publicly.

Senator ALEXANDER. I do not mean to interrupt your time.

Senator FRANKEN. That is quite all right. That is in response to a private conversation you had with the President or a conversation you had with the President. What I heard publicly is that the

price, we were bending the cost curve. I do not know how often we heard that. I would like to take that time, though.

The CHAIRMAN. I do not see a statement.

Senator FRANKEN. I would like to take that time.

Professor Corlette, as you discuss in your written testimony, the health care law includes new requirements for insurance companies that will help prevent premium increases, and I think they already have.

For example, my Medical Loss Ratio provision—a provision that I based on a Minnesota State law that has been on the books since 1993—requires insurance companies to spend 80 to 85 percent of your premium dollars on actual health care. And only 15 percent for large group policy, 20 percent for a small group policy, for an individual policy, on administrative costs, on profit, on marketing, CEO salaries, et cetera. If your insurance company goes over this ratio, you get a check back or your employer gets a check back. Over 13 million Americans benefited from that.

In your analysis, how will these features of the health care law pressure insurance companies to keep premiums from going up? Do you think the Federal Government is doing a good job implementing this provision and is there room for improvement?

Ms. CORLETTE. Thank you, Senator, for that question.

As you know, last year, about 12.8 million Americans got over $1 billion in rebates because of your MLR provision. So we thank you for that.

I do think the Federal Government is implementing it well. I am sure there may be some tweaks that people might be advocating for, but in general, I believe it is being implemented well.

I also think this provision of the law coupled with the rate review provisions will take on added importance as we go into 2014 and the insurance market changes. Because it will be really important to have State insurance departments and the Feds examining the proposed rate increases that are coming in from the insurance companies, and looking at the assumptions they are making and the projections they are making to ensure that they truly are justified. And if they are not justified, thanks to the MLR provision, consumers will get that money back at the end of the year.

So both of those provisions combined are critical. Thank you.

Senator FRANKEN. Thank you. Miss Cook, thank you for your testimony.

Ms. COOK. You're welcome.

Senator FRANKEN. This is why I ran. There is a woman in Fergus Falls, MN who has diabetes. When I was running in 2007–8, her son, 24 years old, had diabetes, pre-existing condition. He could not get insurance. So she shared her insulin with him. This is why we are doing this.

What does it mean to you that you know that with a pre-existing condition, you will now be able to get coverage?

Ms. COOK. It means a lot to me, because after having it twice, there is a good chance that possibly I could get cancer again. So at least I will be able to have insurance if it does happen again.

Senator FRANKEN. I know I am out of time. I would love to have a second round.

The CHAIRMAN. Senator.

Senator FRANKEN. I said I am out of time, but I would love to have a second round.

The CHAIRMAN. I will try. We will have a second round.

Senator FRANKEN. Thank you.

The CHAIRMAN. Professor Corlette, I want to get to the essence of this. Mr. Carlson's analysis, and I read it last evening—I looked at it again here—compares premiums for coverage now with projections for premiums for coverage after 2014. But again as Senator Alexander and I were just having a little conference here privately, that is not really comparing apples to apples, is it, because the benefits that are going to be provided will be a lot different than what they have right now.

You described in your testimony some of the gaps and holes in the benefits in the current market. Could you elaborate on that, the kind of "Swiss cheese" coverage—that is my own term—that we have now that they would have to pay for out-of-pocket. But now, that is going to be a covered benefit.

Could you elaborate on that?

Ms. CORLETTE. Sure. Thank you, Senator.

I think your analysis is dead-on and that premiums actually only tell you one part of the picture. People in today's market frequently have to pay out-of-pocket when care is not covered under their plan. And it is the reason why 57 million Americans live in families struggling with medical debt and 75 percent of those Americans have health insurance.

We are moving to a system that doesn't just address the premiums that people pay, but the actual overall out-of-pockets that they pay. So when you look at the financial picture for an individual or a family, you have to be looking at both.

The CHAIRMAN. OK. A followup then, this analysis Mr. Carlson compares premiums that would have been paid by uninsured adults before versus after ACA reforms are in effect. But doesn't that miss the fact that many uninsured people in the market now have been turned down for coverage altogether, and then that they have to pay for medical costs out-of-pocket, Miss Cook being a primary example of that? I mean, isn't that a fact that many of them have already been turned down?

Ms. CORLETTE. Yes, Senator. And I think that those kinds of out-of-pocket spending should——

The CHAIRMAN. So I asked Mr. Carlson, how can you compare, have an analysis that compares premiums that would have been paid by uninsured adults before versus after in-effect? Since a lot of the people that you are looking at there—I don't know, maybe you can correct me—you did not separate out those that had been turned down for insurance. Did you?

Are they not lumped in that same group?

Mr. CARLSON. They are, yes, and I don't disagree with what you are saying. I think as an actuary, our responsibility is simply to educate people on what the cost of this is going to be. That really is the purpose of the reports.

The CHAIRMAN. There is no cost to Ms. Cook. She cannot pay anything. She gets turned down. So it is not a cost before versus a cost after. It is the cost after for full coverage because she has already been turned down.

We are not talking about someone who is paying in for insurance now and what they are going to pay afterward. We are talking about someone now who cannot even get insurance, who has medical bills, racking up debt compared to what is going to be afterwards.

But your analysis does not take, the actuarial analysis, does not take that into account.

Mr. CARLSON. Right. And you are correct. We are looking at people who are currently insured and what their expectations are going to be.

The CHAIRMAN. Perfect. Thank you for your honesty. I appreciate that very much. We are not really looking at apples versus apples on this thing.

Now, I must, of course I will be able to with my friend on this here, but we were looking at the statements by President Obama—he used to be a Senator—in regards to this going back and forth. And in my reading of it, I thought it was very clear that he pointed out this difference in his statement there.

Do you mind if I read that?

Senator ALEXANDER. No, but you have to read the whole thing.

The CHAIRMAN. I can't read the whole thing.

Senator ALEXANDER. I don't mind at all if you read it.

Senator FRANKEN. I would love to hear the context.

The CHAIRMAN. Well, no. That is not it. That was another one.

Senator ALEXANDER. Well, here is the part.

The CHAIRMAN. Of course, look, we are all—in this business sometimes we do say things that maybe we did not give full thought to or something like that, so I always excuse those.

If someone in our position has said something that is not quite square, you have got to go back and say, "Is that what they really meant or did they mean something else?" People do get a lot—and this is a confusing topic sometimes, even for those of us that have been in it for years and years. Sometimes, I know I have said things I have to go back and say, "Did I say that? If I did, that is not what I really meant. I was thinking of something else, but it came out wrong."

Senator ALEXANDER. That is what he said to me.

The CHAIRMAN. Yes, well, this just struck me that, I guess this is a transcript.

Senator ALEXANDER. Right.

The CHAIRMAN. He said, this is the President,

> "So Lamar, when you mentioned earlier that you said premiums go up, that's just not the case according to the Congressional Budget Office."

Senator Alexander came back and said, "CBO report says the premiums will rise in the individual market as a result of the senate bill." The President says, "No, no, no, no. Let me, and this is an example of where we have got to get our facts straight." Senator Alexander, "That's my point." This is a good reading.

[Laughter.]

And the President says,

> "Well, exactly. So let me respond to what you just said, Lamar, because it's not factually accurate. Here's what the

> Congressional Budget Office says, 'The cost for families for the same type of coverage as they're currently receiving would go down 14 to 20 percent.' What the Congressional Budget Office says is that because now they've got a better deal because policies are cheaper, they may choose to buy better coverage than they have right now, and that might be 10 to 13 percent more expensive than the bad insurance that they had previously,"—what I call the 'Swiss cheese' coverage—"But they didn't say that the actual premiums would be going up. What they said was that they'd be going down by 14 to 20 percent."—That is that apples-to-apples—"I promise you, I've gone through this carefully with the Congressional Budget Office. I'd be happy to present this to the press, whoever is listening, because this is an important issue."

Well, anyway, it goes on and on, and on and on, and on and on. But I thought what the President was trying to do was to make the case that I was trying to just make is that, yes, premiums are going to go up because you've got better coverage. You've got more complete coverage. Before, if you were lucky enough to be able to buy it, you had "Swiss cheese" coverage or you are like Miss Cook, you don't even have "Swiss cheese" coverage; you don't have any coverage at all. I guess that is just the point I was trying to make, and I have used up way too much of my time.

Senator Alexander.

Senator ALEXANDER. So thanks, Mr. Chairman. And I won't use up much of my time. And on one point, I do not disagree with you, on one of the main reasons that premiums are going to go up is because of expanded coverage. I don't disagree with that. In fact, that is what the Society of Actuaries found.

Is that right, Mr. Carlson?

Mr. CARLSON. Yes, that is correct.

Senator ALEXANDER. And you have found that the medical claims will go up by about one-third.

Is that correct?

Mr. CARLSON. Yes.

Senator ALEXANDER. And as a result, the cost of the premiums would go up significantly.

Mr. CARLSON. You can make that assumption, yes.

Senator ALEXANDER. And then there were two other reasons that costs were going up. One is the costs are allocated differently.

Is that correct?

Mr. CARLSON. Well, the cost allocation would impact the younger individuals, but obviously——

Senator ALEXANDER. So for a younger individual it might go up more.

Mr. CARLSON. Yes.

Senator ALEXANDER. And then the third reason was what Senator Harkin said was that the policies are richer. I mean, if you've got more of a Buick or even a Cadillac, than a Chevrolet or a Ford, and so you are paying more for it.

Mr. CARLSON. Right.

Senator ALEXANDER. So those are all correct reasons, but the point is the costs are going up.

The discussion the President and I had, and without plowing it too much, I had said that the congressional—just what Mr. Carlson said. That under the President's plan, the CBO said in 2009 that the premiums would actually go up 10 to 13 percent in the individual market. That is what it said. It did not say it would go up relative to anything other than what they were today, they would be that much higher. They also said that some people would get subsidies; that was about half the people, I think.

And then the President interrupted me and said that I was wrong about that, and he pointed out that for a comparable policy, costs would go down. Correct. But we are not talking about a comparable policy. We are talking about policies that are richer, that cover more people, and that have different rating systems.

The fact of the matter is, according to the Society of Actuaries, when this law is fully implemented—and most of it happens next year—costs are going up in the individual market. And BlueCross BlueShield of Tennessee says they are going to go up at the rate of about 32 or 33 percent. And for younger people, it may be 2 or 3 times that. For them, that is rate shock.

Now, that does not mean it is a bad idea to expand coverage, that a better policy is not better than a worse policy. It may mean that giving me more benefit than my son is something that we ought to talk about.

We just need to be honest about the fact that when this hits, it is going to be a shock to a lot of people. It is going to be a rate shock, and we can take credit for the expanded coverage and the better policy. But somebody has got to pay the bill. That is what I am saying and that was the difference of opinion that the President and I had.

Having said that, the President served a nice meal last night at the White House to a group of Senators, and I was privileged to be one of them, and I appreciated that very much. But I thought that was an instructive discussion.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Alexander.

Senator Franken.

Senator FRANKEN. My point is the President kept saying, and said over and over again, he is going to bend the health care cost curve. Any discussion of whether—you said that discussion wasn't relative to what it would otherwise be. Well, of course.

So then it is meaningless because if the insurance premiums were going to go up anyway by more than that, then relative to what they were going to go up to, it was going to bend the cost curve and go down relative. And that is important because we know that in the past 3 years, relative to what insurance premiums were going to go up to, they have bent the cost curve.

In Connecticut, Aetna, because of the Medical Loss Ratio cut premiums, did it not? Mr. Counihan.

Mr. COUNIHAN. I do not know the details of that, Senator, but I know what you are saying.

Senator FRANKEN. It is because the Medical Loss Ratio includes administrative costs. You have to hit 80 or 85 percent, depending on whether you are an individual policy or a large group policy.

Let me ask you this: in your actuarial study, the 3.5 percent, you said, is going to get passed to the consumer?

Mr. CARLSON. Correct.

Senator FRANKEN. Does that count as administrative cost? How is that used?

Mr. CARLSON. I do not know the exact——

Senator FRANKEN. Well, you are the expert on the study, how was that 3.5 percent figured in, in the Medical Loss Ratio?

Mr. CARLSON. It may not be a part of what is considered administrative costs.

Senator FRANKEN. May not? What is it? I want to know.

Mr. CARLSON. There are certain fees and taxes that are excluded from the calculation of the administrative expenses and they may qualify as one of them.

Senator FRANKEN. I would like to know the context. Do you know, Professor?

Ms. CORLETTE. I am afraid I do not offhand.

Senator FRANKEN. OK. I think that is important.

Here is the other point. Yes, Ms. Cook's policy is cheaper than a policy that she might have now, but the policy did her no good. Doesn't that mean something? Does it mean something to you, Ms. Cook?

Ms. COOK. Yes.

Senator FRANKEN. It means everything to you, doesn't it? So yes, policies might increase. The cost of an average policy might go up because it includes basic coverage.

I think that is the whole point. Half of the bankruptcies in this country have been because of medical costs; half. Do you know what the bankruptcies are in Germany and they don't have a single payer? They have insurance. The bankruptcies because of medical costs are zero.

That is the whole point of this thing is so that Ms. Cook can get treated for cancer when she is 28 years old. I cannot believe we are losing sight of that. So that the mother in Fergus Falls does not have to share her insulin with her 24-year-old son. That is the whole point of this. And yet, we have put things in place, like the Medical Loss Ratio that have actually bent the cost curve on the cost of insurance thus far.

Isn't that right, Professor Corlette?

Ms. CORLETTE. It certainly has given insurers an incentive to price their products more accurately.

Senator FRANKEN. OK. So this study was done by, you said they are owned by an insurance company? What insurance company are they owned by?

Mr. CARLSON. I believe their parent company is United.

Senator FRANKEN. OK. And most actuaries in this country, what percentage are employed by insurance companies?

Mr. CARLSON. I don't know that number offhand.

Senator FRANKEN. OK. What you are talking about is mainly about what it costs for people. What age group did you mainly focus on?

Mr. CARLSON. We looked at all age groups, but obviously the main bullet point is to look at the ages 21 to 39, basically, to see what the impact on their premiums would be.

Senator FRANKEN. And what percentage of those, say, 21 to 29 would be eligible for subsidies?

Mr. CARLSON. I don't have the number offhand, but it is a majority.

Senator FRANKEN. Professor?

Ms. CORLETTE. I do not have that number offhand either, but I would also point out that they may be eligible for Medicaid. And they can also buy Bronze level or catastrophic plans, which would be cheaper than the Silver level plans.

Senator FRANKEN. OK. My time is up. I would like to thank all the witnesses, and I would like to thank the Chairman and the Ranking Member for this hearing.

I just want to say one more time, the President, when he talked about this time, and time, and time, and time, and time again talked about bending the curve, bending the cost curve. That is what he was talking about.

Senator ALEXANDER. Mr. Chairman, if I am going to be contradicted, in "The *New York Times*," July 23, 2008, Barack Obama said, "I will lower the health care costs of this country enough to "bring down premiums by $2,500 for the typical family."

Senator FRANKEN. Yes, and may I say that you can quote someone, and then the next sentence could be, of course, that means relative to——

Senator ALEXANDER. Let me read the whole speech by him, Mr. Chairman. "In speech after speech, Senator Barack Obama has vowed that he will lower the country's health care costs enough to, "Bring down premiums by $2,500 for the typical family." Moreover, Mr. Obama, the presumptive democratic nominee has promised his health care plan will be, "In place by the end of my first term."

I would not bring this up except for the fact that I was in the President's Health Care Summit. I said, I repeated what the Congressional Budget Office said, which was that individual premiums would go up as a result of this law. The President said I was wrong. I was right about that. Now, there are reasons for that.

Senator FRANKEN. No, he explained, though, that what they said was for if it was the same policy, it would go down.

The CHAIRMAN. He did say that.

Senator FRANKEN. We are both acknowledging that——

Senator ALEXANDER. Senator Franken, I was there and you were not, and I have the transcript and you don't.

Senator FRANKEN. I know, but you read the transcript.

Senator ALEXANDER. I read the transcript and what I said was, "Mr. President, the CBO says that the new health care law will raise individual premiums 10 to 13 percent," and that is precisely what it said.

He then explained that if there were comparable costs, well, we weren't talking about comparable costs. We were talking about a new health care law that we were considering, and which is now the law, and which will have the effect of raising individual premiums by more than 10 to 13 percent.

Now, I do not think we need to argue about that. That is just a fact. And there are reasons for it. We have discussed the reasons. The reasons are that expanded coverage, richer benefits, those two

are the principle reasons; more medical claims according to the Society of Actuaries.

But he did say that and it is nothing to be ashamed of, he just said it.

Senator FRANKEN. Well, look, I would note that he said this at a time when he also said it would be in place before the end of his first term. So it sounds like pretty early in the process.

And what I have heard him say is, so many times, is that we would bend the cost curve, and that means relative to what health care costs would have gone up anyway. And I am saying that in the last 3 years since we have passed the Affordable Care Act, we have had the lowest increase in insurance premiums than we have had in about 50 years.

So that tells me that we are bending the cost curve, and I am very proud of the Medical Loss Ratio provision I put in because that has helped bend the cost curve.

Senator ALEXANDER. The only last word I would say, Mr. Chairman, is that the President's Health Care Summit was in February 2010. He was the President. This is when we were passing the law, and bending the cost curve is all of our objectives.

But the fact was CBO said individual premiums will go up as a result of this law 10 to 13 percent. The law has not yet gone into effect in most parts, and when it does, it looks like it will cost, the premiums will cost more.

The CHAIRMAN. Thank you, I guess, as chair, I do get the last word.

The record will remain open for 10 days for other statements to be submitted to the record.

I am listening to this and I am thinking we can go back and say, he said-she said, they were right-they were wrong. We can go back and look at all that stuff.

I think where we are now, we just have to ask the question: will the general public, will the American citizens, writ large, be better off under this system than they were under the other system?

Will we close some of these tragic, tragic cases like Miss Cook and others around that have been so tragically portrayed today and in other forums? Will we move beyond that?

Will we recognize—I keep coming back to what Mr. Counihan said—will we recognize that what we are talking about is a sense of shared ownership of a common value? Shared ownership of a common value, that value is that our Nation benefits if we have more citizens covered by some form of health insurance that have that peace of mind,

I think we are a better country for it. I don't know, everybody keeps talking about bending this cost curve and stuff like that. I have said many times, the best way to bend that cost curve is keep people healthy in the first place.

We keep forgetting about that, prevention, getting to people early, preventative health care services, wellness programs that we know work demonstrably. We have data on this from the Trust for America's Health and other independent groups.

It seems to be going forward since this is the law. As I stated in my opening statement, we have had a lot of political back and

forth on this in campaigns all over the country. I won't be engaging in that any longer.

But it seems that we have settled this. We have a law. The question is: how do we make it work best? Yes, how do we make it cost-effective? What is the best cost-effective way of having this shared value of having everyone covered? Not having people that have pre-existing conditions, of having that peace of mind that you won't go bankrupt.

What is the best way? We have the law. If there are suggestions on how to improve it, make it more cost effective without damaging Miss Cook, or damaging somebody else, or separating out this group from another group and saying,

> "Well, you are young and healthy. You don't need to pay anything. You can grab that parachute when you jump out of the plane," so to speak. "When you get sick, you can run down and get coverage, but you don't have to pay for anything now. You're not part of our society." I don't think that is the way we want to go.

From the very beginning of this, the priority in my mind is to put everybody in this pool, this insurance pool. Put everybody in this pool. Give everybody at least some basic coverage which they can rely on, cannot be excluded from no matter their age, or condition of health, their sex, their gender. I don't care.

We can go back and say, "Well, you said this." I bet I have, over the last several years of working on this bill both as chairman and working on the health care bill, I bet there are a lot of things I have said that have been wrong.

Maybe I just did not understand it at the time, or I was thinking of something else. Yes, we make mistakes and say things. OK, fine. We can go back.

Right now, going forward, how do we make this work? What is the best way? If you have some ideas on making it more cost effective, I would like to know it.

That is what I hope these hearings are going to show is that we are trying to move ahead to change the health care system and make it work for more people in this country. And to bring us all into this pool of shared values, of keeping everyone covered by health insurance.

So I thank all the witnesses for being here. I thank my good friend, Senator Alexander, and he is a good friend. He knows that and I respect him highly.

And I will say this publicly. Senator Alexander is always looking to see just what is the best way forward. What is the best way? Not going backward, he is going forward and I appreciate that. It is right to raise these questions. If there are things that need to be fixed and adjusted, OK, let's figure out how we do that.

I hope that moving forward, that is the spirit in which we can go forward, both on this committee and other committees, too, that have a part of this, like the Finance Committee and others.

But it is going to happen. I mean, it is set in law. Nothing is changing it, but fine tuning it. I said before, if fine tuning needs to be done, then let's figure out how to fine tune it and make it even better than what it is. I do not think that what we have is

the end-all and be-all of health care coverage in America. I think it is a heck of a lot better than what we have had.

But I hope we go forward in that kind of spirit.

With that, thank you all very much. The committee will stand adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

RESPONSE BY GARY COHEN TO QUESTIONS OF SENATOR HARKIN, SENATOR ALEXANDER, SENATOR SANDERS, SENATOR WHITEHOUSE, SENATOR BALDWIN, AND SENATOR ENZI

SENATOR HARKIN

Question. One of the most important of the set of consumer protections that will become effective in 2014 is the requirement that private insurance plans cover a comprehensive set of essential health benefits. Congress required pediatric dental services to be covered as part of this package, recognizing how important oral health is for children—as the Medicaid program has for years. I'm interested in your Office's work on this issue. For children and families who currently have coverage, what is being done to ensure a smooth transition to 2014, without disruption of coverage? Could you describe the Federal Exchange's outreach and enrollment efforts directed at families with children without dental coverage?

Answer. CMS has been following a multi-step plan for outreach to individuals, families, and small businesses in preparation for open enrollment. This plan is aimed at identifying both individuals who are without coverage and individuals who have coverage who may transition to the Marketplace. Children and families who currently have pediatric dental coverage will be able to keep the coverage they have if they choose to do so. CMS is in contact with State Medicaid and CHIP programs to coordinate outreach and eligibility activities, and will incorporate information into our call center and consumer materials to direct individuals to this information.

SENATOR ALEXANDER

Question 1a. Under the health care law, Medicaid eligibility will be based, as it is now, on monthly income at the time of application, while eligibility for premium tax credits in the exchanges will be based on yearly income.

How is your office coordinating with Federally Facilitated and State-based Exchanges to ensure that taxpayer-funded subsidies are not over or under paid to enrollees?

Answer 1a. The Affordable Care Act set up a system of coordinated, streamlined processes to determine eligibility for enrollment in a qualified health plan, advance payments of the premium tax credit, Medicaid, or CHIP. This system is designed to ensure that individuals and families are enrolled in the right coverage the first time. Marketplaces will be able to check authoritative data sources such as IRS income data for tax credit eligibility. On the application, individuals will be asked to attest to projected annual household income, as well as current income. If the attestation to projected annual household income is inconsistent with information that the Marketplace receives from the IRS and SSA, the Marketplace will take additional steps to verify the attestation, including requesting additional documentation from individuals in certain circumstances. This process is detailed in 45 CFR 155.315(f) and 155.320(c). In addition, when presenting individuals with an eligibility determination for tax credits, Marketplaces will make individuals aware of the potential for reconciliation of advance payments of the premium tax credit, should their circumstances change. Marketplaces have flexibility to establish reasonable thresholds for the requirement to report changes in income. Finally, if an individual, receiving advance payments of the premium tax credit experiences a reduction in income over the year, they may be able to claim the difference on their tax return.

Question 1b. Governor Haslam of Tennessee recently proposed expanding access to the new exchange in our State to individuals who would otherwise be eligible for Medicaid. His proposal would affect 175,000 Tennesseans and is similar to the plan put forward by Governor Beebe of Arkansas. Please provide a status report on how well Governor Haslam's proposal is being received by the Department.

Answer 1b. HHS remains committed to working with States as they consider the expansion of Medicaid. As we have outlined, we are interested in providing States with the flexibility within the law that they identify as helpful to the coverage of the new adult group made eligible by the Affordable Care Act. We are pleased that States have come to us with innovative ideas and we continue to work with each of them. Like other States, we are working directly with Tennessee on the ideas they have outlined and look forward to continuing those discussions.

Question 1c. Have you considered that if CMS does not work with Tennessee to approve this request, lower-income Tennesseans could be denied access to health insurance?

Answer 1c. We believe the Affordable Care Act provides the opportunity and avenues to ensure health insurance for millions of Americans who currently lack it. Both through the availability of Medicaid coverage and coverage through the new Marketplaces, we want to make sure that currently uninsured Americans have an avenue to achieve coverage. As you are aware, the Supreme Court's ruling left the decision to provide Medicaid coverage to the new adult group made eligible by the Affordable Care Act to the States. With that in mind, we are working hard with each interested State to identify how these coverage opportunities will work best in their State, to provide opportunities for coverage for currently uninsured Americans.

Question 2. Have you done any analysis to determine the cumulative impact upon premiums of all the new mandates, taxes, and fees being imposed upon health plans operating in the new health insurance exchanges? If so, please provide the total cost. If not, please explain why.

Answer 2. We do not have an aggregate estimate of the impact on premiums at this time because we do not know the rates or the numbers of enrollees. It will be up to the issuers to determine how to set their premiums. We expect that the Marketplace will be a competitive one, and we will evaluate premium information once we receive the qualified health plan certification packages from issuers.

Question 3. Please detail your agency's legal authority to use Prevention and Public Health funds to pay for implementation of the new health law, including the new navigator grant program and implementation of the health insurance exchanges.

Answer 3. The purpose of the Prevention and Public Health Fund is to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs. In fiscal year 2013, CMS will invest Prevention Fund resources to assist Americans in gaining affordable health care coverage which aligns with the purposes of Prevention Fund to be used for prevention, wellness, and public health activities. The Affordable Care Act-related activities funded with the Prevention Fund will include consumer engagement and education, eligibility support including support for appeals, assistance with enrollment, and the Navigator program to help individuals understand options available and enroll in health insurance. Implementing the Health Insurance Marketplace is the Administration's top public health activity and will likely significantly improve prevention in the next year by enabling individuals to enroll in coverage through private health insurance. Increasing access to care, in particular to preventive services, is a component of our national efforts to restrain the cost of health care and ensure more Americans can lead healthy lives, which is also a key goal of the Prevention Fund.

Question 4. In your agency's recent budget, the outlays for the Federal Pre-existing Condition Insurance Program are projected to be greater than the amount of money left in the fund. Please detail how your agency will fill this shortfall so that those enrolled do not lose access to insurance before 2014.

Answer 4. CMS is working to ensure that the limited amount of funding appropriated to the program is available to continue providing covered services to enrollees until 2014, when people will no longer be denied health coverage because of their health status. The fiscal year 2014 congressional Justification does not project that outlays in fiscal year 2014 will exceed the $5 billion provided in the Affordable Care Act for this program. CMS is aggressively managing costs in the Federal PCIP program to ensure that the remaining funds are sufficient to cover current enrollees, and will use all available cost-containment strategies to ensure that coverage continues through 2013 for current enrollees.

For example, CMS has been monitoring PCIP enrollment and spending regularly and has made necessary adjustments to the program to ensure responsible management of the one-time $5 billion appropriation. We maintain low administrative costs and work to maximize the appropriation for patient medical care.

Starting in 2014, health insurance issuers will no longer be able to discriminate against Americans with pre-existing conditions. All Americans—regardless of their health status or pre-existing conditions—will finally have access to quality, affordable coverage. On October 1, 2013, Americans with pre-existing conditions will be able to apply for affordable health insurance coverage through the new Health Insurance Marketplace.

Question 5. We understand that insurers are in the middle of the submission process for plan submissions to the Federally Facilitated Exchange (FFE). Many are stating that the applications are quite complex. What are you doing to ensure a data-submission process that has no bumps in the road?

Answer 5. The submission process for the Federally Facilitated Marketplace began on April 1, 2013. The early response has been very encouraging and we expect to see robust competition for the business of millions of Americans who will be shopping for health insurance in the Marketplace. States that are operating their own Marketplaces have also begun accepting submissions from issuers as well.

We have been committed to supporting the submission process for insurers. We've gotten feedback from States and issuers as they've accessed the system and we've addressed whatever issues have come up. CMS made available a draft letter to issuers about offering Qualified Health Plans in the Federally Facilitated Marketplace for comment. CMS made changes to the draft letter based on the comments received from a variety of stakeholders, including issuers, health and patient advocacy organizations, agents and brokers, and consumer groups. We have a Help Desk that responds by e-mail to anyone with questions about how to submit information to us, we hold regular phone calls and we regularly publish answers to frequently asked questions. I am extremely proud of the work the team is doing to make sure that we will have products on the shelves on October 1.

Question 6. You've said time and time again that States will continue to regulate insurance markets. If that is the case, why are you requesting so much data be submitted to HHS, including data that duplicates what insurers have to submit already to the States? For example, any rate increase. Won't this increase administrative costs? And what do you plan to do with all this data?

Answer 6. Title XXVII of the Public Health Service Act (PHSA) assumes that States will exercise primary enforcement authority over health insurance issuers in the group and individual markets to ensure compliance with health insurance market reforms. CMS has confirmed that almost all States—including States where a Federally Facilitated Marketplace is operating—will enforce the market reforms of the Affordable Care Act. Where a State is enforcing these market reforms, CMS will not duplicate the State's work, and will instead rely upon the State to ensure that issuers are in compliance. This includes the State's review of whether individual and small group market health plans, and potential qualified health plans, cover essential health benefits and comply with actuarial value standards.

To address your specific question about rate increases, section 2794(b)(2)(A) of the PHSA requires the Secretary of Health and Human Services to monitor premium increases of health insurance coverage offered both inside and outside the Marketplace beginning in plan year 2014. On February 27, 2013, CMS finalized a rule (78 FR 13406) requiring that issuers offering health insurance coverage in the small group or individual markets report information about all rate increases. We have worked to minimize the administrative burden on issuers by simplifying the reporting template and coordinating with State processes.

Standardizing the reporting process will reduce administrative burden and duplication over time, and enable both States and CMS to evaluate information about the single risk pool, actuarial value, essential health benefits, and other market reforms beginning in 2014. This reporting will also assist States and CMS in monitoring the health insurance market inside and outside the Marketplace for adverse selection.

SENATOR SANDERS

Question. I would also like to ask about the guidance recently issued by CCIIO establishing criteria for Qualified Health Plans to contract with Essential Community Providers. When we are talking about safety net providers, and especially primary care safety-net providers, we need to consider access to care in addition to access to insurance. An insurance card is not worth very much if you cannot see your doctor. I am concerned that the guidance reduces the strength of congressional intent and that insurers in Vermont and across the country will not contract with all Essential Community Providers. If a Qualified Health Plan does not contract with an Essential Community Provider, such as a community health center, I want to be sure that low-income patients are not charged higher cost-sharing out of network for visiting their health center. Can you please explain how you plan to update this guidance and implement stronger standards in the future to protect low-income beneficiaries who are seeking the cost-effective, high quality care they deserve? If you do not currently have any such plans, could you please tell me about actions you will be taking to address this concern?

Answer. The Exchange Establishment final rule at 45 CFR 155.1050 and 45 CFR 156.230 sets forth network adequacy requirements for all Marketplaces. A QHP issuer must maintain a network that is sufficient in number and types of providers, to assure that all services will be accessible without unreasonable delay. Provider directories must be made available online (and in hard copy by request) and list pro-

viders who are not accepting new patients. The State or CMS will use the QHP certification process to ensure network adequacy. Ongoing monitoring is typically handled by State insurance departments. In general, States enforce network adequacy as all issuers, both inside and outside the Marketplace, must meet the standards set forth in State law. Nothing prohibits States from applying more stringent standards or protections across their markets.

In addition, 45 CFR 156.235 requires that a QHP issuer have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of ECP providers for low-income and medically underserved individuals in the QHP's service area. Because the number and types of ECPs available varies significantly by location, CMS will evaluate QHP applications for sufficient inclusion of ECPs for the 2014 coverage year based on the Safe Harbor Standard articulated in the annual letter to issuers, released on April 5, 2013. Issuers that meet or exceed the standard will be presumed to meet the standard without additional documentation. Nothing prohibits States from applying more stringent standards or protections across their markets. Issuers that fail to meet the Safe Harbor Standard will be required to submit a narrative justification detailing how the issuer will provide access for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network(s).

This policy balances the need to include ECPs in issuer networks and affordability of coverage. CMS will continue to assess QHP provider networks, including ECPs, and may revise its approach to reviewing for compliance with network adequacy and ECPs in later years.

SENATOR WHITEHOUSE

Question 1. I would like to ask about the guidance recently issued by CCIIO on March 1 and finalized on April 5 that establishes criteria for Qualified Health Plans (QHPs) to contract with Essential Community Providers (ECPs). I have heard from advocates in my State who are concerned that, under the guidance released by CCIIO, there may not be a sufficient number of ECPs included in QHP provider networks to ensure access to care for underserved populations. Please discuss how CCIIO arrived at the safe harbor requirement that a QHP that demonstrates that at least 20 percent of ECPs in the plan's service area are included in the plan's provider network will meet the regulatory standard in 45 CFR §156.235(a). Does CCIIO anticipate raising the safe harbor and minimum expectation thresholds in future guidance?

Answer 1. The Exchange Establishment final rule at 45 CFR 155.1050 and 45 CFR 156.230 sets forth network adequacy requirements for all Marketplaces. A QHP issuer must maintain a network that is sufficient in number and types of providers, to assure that all services will be accessible without unreasonable delay. The State or CMS will use the QHP certification process to ensure network adequacy. Ongoing monitoring is typically handled by State insurance departments. In general, States enforce network adequacy, as all issuers, market wide (inside and outside Marketplaces), must meet the standards set forth in State law. Nothing prohibits States from applying more stringent standards or protections across their markets.

In addition, 45 CFR 156.235 requires that a QHP issuer have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of ECP providers for low-income and medically underserved individuals in the QHP's service area. Because the number and types of ECPs available varies significantly by location, CMS will evaluate QHP applications for sufficient inclusion of ECPs for the 2014 coverage year based on the Safe Harbor Standard articulated in the Letter to Issuers, released on April 5, 2013. Issuers that meet or exceed the standard will be presumed to meet the standard without additional documentation; however, nothing prohibits States from applying more stringent standards or protections across their markets. Issuers that fail to meet the Safe Harbor Standard will be required to submit a narrative justification detailing how the issuer will provide access for low-income and medically underserved enrollees and how the issuer plans to increase ECP participation in the issuer's provider network(s).

We believe that this policy balances the need to include ECPs in issuer networks and affordability of coverage. CMS will continue to assess QHP provider networks, including ECPs, and may revise its approach to reviewing for compliance with network adequacy and ECPs in later years.

Question 2. I'm proud that Rhode Island has been proactive in planning and implementing its exchange. Rhode Island was the first State in the Nation to receive

a Level II Exchange Establishment Grant to help with implementation. I'm also pleased to report that I've heard from folks in my State that CCIIO has been a great partner in working with Rhode Island to set up its exchange. However, I'm concerned that there hasn't been sufficient focus on how to best set-up the exchanges so that they will be able to help drive delivery system reform and improve health and productivity outcomes. Rhode Island is committed to implementing an active purchaser exchange that will help drive delivery system reforms. But if we do not build the exchanges from the start in a way that gives them the tools to contribute to better delivery and outcomes, I think there are going to be very legitimate questions about the value of the investments we are making. What specifically is CCIIO doing to support and encourage States like Rhode Island that want to ensure they effectively use Federal support to build exchanges capable of supporting more systemic reforms in the future?

Answer 2. CMS encourages States, such as Rhode Island, to develop and implement Marketplaces in a manner that best suits the needs of their residents. Through rulemaking, guidance and grant funding authorized by section 1311 of the Affordable Care Act, CMS has defined minimum Marketplace requirements that provide States with the maximum flexibility possible. Within the design of their Marketplaces, States have the flexibility and funding to design systematic health reforms. For example, State-based Marketplaces have the option to design QHP certification as an active purchaser or a passive facilitator of plan choices. We anticipate that States will continue to be on the vanguard in using the Marketplace to drive delivery system reform in the private insurance market.

CMS has also worked to foster collaborative efforts that enable States to share knowledge and efficiencies that can contribute to improved delivery systems. Rhode Island is a member of the multi-State consortia led by the University of Massachusetts Medical School that received Early Innovator Grant funds. This grant benefited individuals and small businesses in Connecticut, Maine, Massachusetts, Rhode Island, and Vermont by creating and building a flexible Marketplace information technology framework in Massachusetts and sharing those products with other New England States.

Question 3. What support has CCIIO offered States to help measure carrier and provider health and outcomes as well as the effects of coverage on the population?

Answer 3. The Affordable Care Act includes a wide variety of provisions designed to expand coverage, provide more health care choices, enhance the quality of health care for all Americans, hold insurance companies more accountable, and lower health care costs. CMS is working across all programs and with States to improve population health outcomes.

Section 1311 of the Affordable Care Act authorizes grant to States to implement Marketplaces. These Marketplaces will help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. CMS has supported States to design, test, and implement innovative designs to measure and improve enrollee health, compare quality of plans, and leverage the new marketplaces to improve the health care delivery system. Furthermore, as a requirement of their Applications and Blueprints, State Marketplaces are expected to have in place programs for monitoring the impact they are having in their markets.

One of the first steps to improve health outcomes is to assure that all Americans get the care they need. Nearly 71 million Americans now have expanded access to preventive services with no additional cost sharing through their private insurance plans, and 27 million women now have guaranteed access to additional preventive services without cost sharing.[1] In 2014, insurance companies will no longer be able to discriminate against those with pre-existing conditions. For the first time, all Americans will have access to high-quality, affordable coverage in the new marketplaces and if eligible, get financial assistance to help pay for the coverage. Coverage in 2014 will be comparable by different actuarial values, must cover the 10 categories of essential health benefits, and must not discriminate against those with high medical needs.

Based on current estimates of the size of the individual market and the percent of enrollees in currently marketed plans without coverage for certain services, coverage of benefits in the individual market may expand as follows:

- 8.7 million Americans will gain maternity coverage.
- 4.8 million Americans will gain substance abuse coverage subject to requirements regarding parity with medical and surgical benefits.

[1] *http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib__prevention.cfm.*

• 2.3 million Americans will gain mental health coverage subject to requirements regarding parity with medical and surgical benefits.
• 1.3 million Americans will gain prescription drug coverage.

CMS will continue to work with our State partners to improve the health care system by combining support for State innovation, guaranteed access to insurance, financial assistance, and improved benefit designs that facilitate improved comparison on quality and price.

SENATOR BALDWIN

Question 1. Some Wisconsin insurance companies have experienced trouble receiving timely answers to questions submitted on the CMS Enterprise portal. These companies would like assurances that the data they submit to the portal will be accepted as timely and accurate. What is CMS doing to address technical difficulties being faced by issuers in a way that will ensure robust plan participation in Wisconsin's Health Insurance Marketplace?

Answer 1. We have had a very encouraging response from issuers in the QHP application process so far, and we expect to see robust competition between issuers within the Marketplace. We have continued to improve our process since the portal opened on April 1. We have gotten feedback from States and issuers as they have accessed the system and we have addressed whatever issues have come up. We have a Help Desk that responds by e-mail to anyone with questions about how to submit information to us, and we hold regular phone calls and publish documents to answer frequently asked questions or address technical difficulties.

Question 2. What protections are CMS enacting to prevent adverse selection within the Marketplace?

Answer 2. The Affordable Care Act created and CMS recently finalized the rules establishing risk adjustment, reinsurance and risk corridors programs (referred to as the premium stabilization programs), the cost-sharing reductions program, and Marketplace affordability programs such as advance payments of the premium tax credit. These programs are designed to provide consumers with affordable health insurance coverage, to reduce incentives for health insurance issuers to avoid enrolling sicker people, and to stabilize premiums in the individual and small group health insurance markets inside and outside the Marketplaces.

The permanent risk adjustment program makes it possible for issuers to price competitively without worrying that they will end up with more costly enrollees. Therefore, issuers will be able to provide coverage to individuals with higher health care costs and will help ensure that those who are sick have access to the coverage they need. The transitional reinsurance program is a 3-year program designed to reduce premiums and ensure market stability for issuers and for enrollees in the individual market with the implementation of new consumer protections in 2014. The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 by having the Federal Government share risk in losses and gains. Finally, the tax credits and cost-sharing reductions available to consumers will encourage young, healthy individuals to purchase insurance and, in doing so, balance risk in the market.

Question 3. In States with Federally Facilitated Marketplaces, what more can be done to create collaborative structures to disseminate information, and to collect constructive feedback? Can formal or informal advisory committees be set up that include providers, medical professionals, health advocates, and other key opinion leaders?

Answer 3. CMS has conducted robust outreach with stakeholders across the Nation regardless of whether their State is operating its own Marketplace, is partnering with CMS to operate its Marketplace, or whether they have the Federally Facilitated Marketplace. CMS recently held and I participated in a meeting of State Insurance Department officials from the States that will have the Federally Facilitated marketplace. We will continue to meet and work very closely with insurance departments and the departments of health around the country to help get this law implemented.

We've also begun a significant stakeholder outreach effort, including a national call in March with over 3,000 participants, including State officials, issuers, and consumers. We also plan to hold regional and State-by-State calls, leveraging our presence with 10 CMS regional offices around the country.

We are happy to work with your office to ensure that we are getting as broad participation in these outreach efforts in Wisconsin as possible as we move closer to the opening of the Marketplace there.

Question 4. Many individuals seem to misunderstand the decision about consumer choice, and believe small employers will not have access to exchanges. Is there a plan for enhanced public education for small businesses? In Wisconsin, the percentage of small employers offering coverage has dropped from 58 percent to 32 percent since 2000.

Answer 4. CMS is conducting extensive outreach and education to raise awareness among consumers and small businesses about new options to access quality, affordable health care later this year when open enrollment in the Health Insurance Marketplace and its Small Business Health Options Program begins. This includes conducting consumer and small employer research and building infrastructure for customer service channels like the call center and Web site.

We have begun offering educational sessions to staff and stakeholders to understand the SHOP program in particular and will have additional resources and materials available over the summer. A call center for employers will be available in August, specifically aimed at helping small employers take advantage of the new program.

To specifically help educate small businesses, we are working with our regional offices to provide updates on recent rollouts and to conduct business outreach. We held meetings in March—in Dallas, TX and Atlanta, GA—and look forward to working with other regional offices to provide more specific information on the impact of the Affordable Care Act on businesses. Additionally, we are working with the Small Business Administration (SBA) to make resources available that provide key information about how the Affordable Care Act affects businesses so each can make the right decisions for its own particular circumstances. For example, the SBA recently launched a weekly webinar series for the small business community in collaboration with Small Business Majority, and CMS is serving as a partner on those webinars as well. Through these "Affordable Care Act 101" webinars, small business owners can learn the basics of the law and what it means for their company and employees, including insurance reforms, the small business health care tax credit, the Health Insurance Marketplace, and Employer Shared Responsibility. These webinars are held every Thursday from now through the opening of the Marketplace in October and are open to all small business owners.

Question 5. For Essential Health Benefits benchmark plans in the exchange that do not include coverage for habilitative services, HHS has issued a rule that allows insurance companies to define the coverage it will provide for habilitative services and report that to HHS. For these types of plans, will HHS review the individual insurers' submissions to make sure they do not discriminate on the basis of disability?

Answer 5. As articulated in the Essential Health Benefits final rule at 45 CFR 156.125, an issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Subsequent to the release of that rule, CMS released a letter to issuers in Federally Facilitated and State Partnership Marketplaces on April 5, 2013 that provided additional guidance and operational guidance to issuers to help them participate in Marketplaces.

In that guidance, CMS stated that to ensure non-discrimination in benefit design it will identify outliers with respect to QHP cost sharing (e.g., co-payments and coinsurance) as part of its QHP certification reviews. Identification as an outlier does not necessarily indicate that a QHP benefit design is discriminatory; rather, CMS will use the outlier identification to target QHPs for more in-depth reviews. In addition, pursuant to 45 CFR 156.200(e) issuers will be required to attest that their QHPs will not discriminate against individuals on the basis of health status, race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Question 6. Will there be a process where individuals with disabilities or groups that represent individuals with disabilities can file a complaint with HHS if they believe an insurer's plan discriminates on the basis of disability?

Answer 6. Because States are primarily responsible for enforcement of EHB requirements for issuers in the individual and small group markets, individuals or groups who have complaints or concerns about a plan's compliance with EHB requirements should contact their State Department of Insurance.

Question 7. What advantages do you foresee for rural communities and providers within the new Marketplaces?

Answer 7. Marketplaces will make purchasing private health insurance easier for all Americans, including those living in rural communities, by providing eligible individuals and small businesses with one-stop shopping where they can choose quali-

fied health plans that best fit their needs. New premium tax credits and cost-sharing reductions will help ensure that eligible individuals and families can afford to pay for the cost of a private qualified health plan purchased through the Marketplaces.

As more individuals and families get access to quality health insurance through the new Marketplaces, rural providers will have a broader and consistent pool of insured patients to care for, connecting them with more patients and helping to reduce the burden of uncompensated care on providers.

Question 8. Are there any barriers to farmers giving up their expensive high deductible plans and entering into the Marketplaces?

Answer 8. No, and we encourage farmers self-employed individuals and other small businesses to take advantage of the qualified health plans that will be available in the Marketplaces. Today, small employers and self-employed individuals like farmers have a tough time finding and affording coverage that meets their needs, and, because of the rising cost of health care, are forced to enter into plans that don't meet their needs. Additionally, research has shown that the occupational hazards of farming make them an at-risk group so that farmers may face higher premiums and lower coverage than other individuals.

Starting in 2014, farmers and other small businesses will have more consumer protections. Non-grandfathered health insurance issuers in the individual and small-group markets will be prohibited from charging higher premiums to enrollees because of their current or past health problems, gender, occupation, and small employer size or industry. All non-grandfathered health plans in the individual and small group markets must cover essential health benefits, which include 10 statutory benefit categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. Non-grandfathered health plans in the individual and small group markets also must meet certain actuarial values. The required actuarial value levels are 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage paid by a health plan on average of the total allowed costs of benefits. For example, if a plan has an actuarial value of 70 percent, the average consumer generally would be responsible for about 30 percent of the costs of the essential health benefits the plan covers. These tiers will allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums and other factors, will help consumers make more informed health insurance coverage decisions.

Small businesses will also have more choice and control over their health insurance through the Small Business Health Options Program (SHOP), a new program designed to simplify the process of finding health insurance for a small business. Because of the lack of competition and transparency in the current small group market, some small businesses have been locked into insurance plans that continually provide worse benefits at higher premiums. With the availability of the SHOP Marketplaces, small businesses will be able to choose among plans and make side-by-side comparisons of important features, such as benefits, premiums, and quality. Thus SHOPs will expand options, increase competition, and reduce administrative hassle for small businesses across the country. Currently, if farmers provide insurance for themselves and their workers, they could have access to the Small Business Healthcare Tax Credit, worth up to 35 percent of their premium costs for eligible employers that have low- to moderate-wage workers. Beginning in 2014, for those farmers who choose to provide insurance through the SHOP, this tax credit is worth as much as 50 percent of an employer's contribution toward employee premium costs for eligible employers who have low- to moderate-wage workers. Businesses with up to 100 employees will be eligible for SHOP, although States can limit participation to businesses with up to 50 employees until 2016. About 4 million small businesses across the country may be eligible for these tax credits.

Additionally, the Affordable Care Act creates a new type of non-profit health insurer, called a Consumer Operated and Oriented Plan (CO-OP). CO-OPs are run by their customers. CO-OPs are meant to offer consumer-friendly, affordable health insurance options to individuals and small businesses. Ten CO-OPs, including the Common Ground Healthcare Cooperative in Wisconsin, have received approval from their State insurance regulators to operate in 11 different State markets. These CO-OPs will be able to offer coverage both inside and outside the Marketplaces, starting October 1. We are confident that these CO-OPs will be able to offer consumers in their areas an additional choice in affordable high quality insurance option.

SENATOR ENZI

Question 1. 1. States are expected to have fully operational Health Exchanges for consumers by January 1, 2014. Many States are expected to struggle with developing entirely new and comprehensive health information technology infrastructures. Many of the consumers that may need to navigate these Exchanges will be new and old Medicaid patients. However, a 2011 Health Affairs study estimates that 50 percent of all adults with family incomes below 200 percent of the Federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse, in just the first year of the Exchanges. What is being done to address potential coverage issues for the most poor and vulnerable populations that cross eligibility thresholds during all of these major health system changes?

Answer 1. The Affordable Care Act and its implementing regulations set up a system of coordinated, streamlined processes to determine eligibility for enrollment in a qualified health plan, advance payments of the premium tax credit and cost-sharing reductions, Medicaid, or CHIP. This system is designed to ensure that individuals and families are enrolled in the right coverage the first time. We have established the beginnings of a streamlined system of coverage that will be supported by modernized eligibility and enrollment systems and a new, data-based eligibility verification system that relies on existing data sources to confirm eligibility rather than requiring applicants to produce paper documentation. All of these changes are fundamentally designed to minimize disruptions in coverage and to ensure smooth transitions between insurance affordability programs where appropriate. As you note, however, sometimes individuals experience changes in circumstances that will affect their eligibility. The Exchange Establishment final rule at 45 CFR 155.330(b)(1) states that Marketplaces must require individuals to report changes in circumstances that would affect their eligibility within 30 days. Marketplaces have flexibility to establish reasonable thresholds for the requirement to report changes in income. Individuals enrolling in qualified health plans with advance payments of the premium tax credit will be advised at the time of enrollment about the requirements to report changes in factors that affect eligibility. Marketplaces must also periodically check the records of Medicaid and CHIP, if applicable, to see if individuals have been determined eligible for those programs. And States can take a variety of approaches across the Marketplace, Medicaid, and CHIP to smooth transitions, including working together to coordinate the availability of plans across all programs and providing information to consumers regarding plans that serve the Marketplace, Medicaid, and CHIP.

Eligibility rules published on March 27, 2012 (77 FR 18310) create a strong alignment between Medicaid, CHIP, and the Marketplace. States and the Federal Government have already made great strides in identifying and enrolling eligible children in Medicaid and CHIP coverage and many of those successful strategies are being carried forward to apply to the other insurance affordability programs. For example, 12 months of continuous eligibility is a strategy that many States have already adopted for children and pregnant women in Medicaid and CHIP that could easily be carried over to the new expansion population of low-income adults in Medicaid through waiver authority. We are also entertaining States' proposals and strategies for allowing individuals to remain in the same source of coverage, regardless of changes in circumstances. This approach is intended to promote continuity of coverage between Medicaid or CHIP and the Marketplace. More information about this policy is available in the December 20, 2012 frequently asked questions (#14) *http://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs–12–10–2012.pdf.*

Additionally, CMS issued a letter to State health officials and State Medicaid directors on May 17, 2013 (*http://www.Medicaid.gov/Federal-Policy-Guidance/downloads/SHO–13–003.pdf*) describing five strategies to increase enrollment. Those five strategies are:

1. Implementing the early adoption of Modified Adjusted Gross Income (MAGI)-based rules;
2. Extending the Medicaid renewal period so that renewals that would otherwise occur during the first quarter of calendar year (CY) 2014 (January 1, 2014–March 31, 2014) occur later;
3. Enrolling individuals into Medicaid based on Supplemental Nutrition Assistance Program (SNAP) eligibility;
4. Enrolling parents into Medicaid based on children's income eligibility; and
5. Adopting 12-month continuous eligibility for parents and other adults.

Question 2. Mr. Cohen, States like Wyoming that have opted to have the Federal Government run their Exchange need to know that coverage won't be disrupted for

thousands of their citizens on January 1st. When will the Administration issue a proposed rule on the federally funded Exchange? How much does the Administration estimate the Federal Exchange will cost? What type of outreach has CMS or HHS done to date with the Federal Exchange States to ensure that there won't be disruptions in coverage?

Answer 2. The Exchange Establishment final rule published on March 27, 2012 (FR 182309) fully details the standards for a Marketplace, whether it is run by the Federal Government, a State, or through a partnership between the two. We have also provided technical information and specific details about the Marketplaces through various guidance such as the General Guidance of Federally Facilitated Exchanges published on May 16, 2012, Exchanges, Market Reforms and Medicaid Frequently Asked Questions released on December 10, 2012, and the Guidance on State Partnership Exchanges published on January 3, 2013. As implementation continues, we have worked closely with States and other stakeholders to ensure all questions are answered and guidance is available when needed.

We will continue the close contact with States to ensure that everyone has the information they need so that they can be ready for enrollment to begin on October 1, and to ensure that there are no disruptions in coverage. Keep in mind, if a person receives their insurance through their large employer, like most people, their insurance will not be affected. If a person works for a small business, then that small business may be able to choose from plans in a side-by-side comparison through the SHOP Marketplace. This expanded Marketplace will increase competition and lower individual costs. Small businesses may also be eligible for tax credits to make offering insurance more affordable, so people whose employers do not offer insurance now could possibly enroll in employer-sponsored insurance in the future. If a person does not currently have insurance, then the Affordable Care Act and the Marketplaces make it easier than ever before to find and afford insurance. Starting October 1, people are going to be able to buy comprehensive insurance without discrimination based on gender or pre-existing conditions.

Many of these people will qualify for premium tax credits to help lower their monthly insurance premiums, and will benefit from increased transparency and competition in the Marketplace. The Marketplaces will not disrupt coverage, instead they will make insurance coverage more available and affordable for everyone.

As for the cost of the Federally Facilitated Marketplace, the President's fiscal year 2014 budget requests $1.5 billion for costs related to Marketplaces, including operations of a Federally Facilitated Marketplace in each State that will not have its own Marketplace by January 1, 2014, oversight of State-based and Partnership Marketplaces, and to carry out the Secretary's duties on behalf of all Marketplaces, such as operation of a data services hub. These functions will be operational in fiscal year 2014 beginning with open enrollment in October 2013. In addition, CMS will collect user fees from all issuers offering qualified health plans in the Federally Facilitated Marketplaces starting in January 2014. CMS anticipates collecting $450 million in user fees in 2014. The cost of implementation of Wyoming's Federally Facilitated Marketplace for fiscal year 2014 is included in this budget request. For Wyoming, the Federally Facilitated Marketplace will be completely funded out of Federal funds and user fees, at no cost to the State for fiscal year 2014.

RESPONSE BY KEVIN COUNIHAN TO QUESTIONS OF SENATOR ALEXANDER AND SENATOR FRANKEN

SENATOR ALEXANDER

Question 1. I recognize that many of the rating rules imposed by the new health care law were already in existence in your State, but one we discussed during the hearing—age rating bands—could have a significant impact for younger individuals. Are you concerned at all about adverse selection leading to an unbalanced risk pool in your State? Have you done any actuarial analysis about how premiums will be affected in your State, particularly for young people?

Answer 1. At present, CT has an age rating band of essentially 6:1. We are cognizant of the impact on both younger and older individuals of reducing the age rating band to 3:1. We have developed a comprehensive marketing and outreach plan to raise awareness of the ACA and of Access Health CT among individuals and small businesses in our State, and we have elements of this plan which focus in particular on the 18–35 age band segment.

Question 2. The media has quoted you as saying you need more time to implement the law. Why? And if Congress were to grant you another year to get Connecticut's exchange up and running, what benefits do you believe that would provide consumers?

Answer 2. Implementation of a State-based marketplace is complex and largely unprecedented. Like all States, we are focused on providing the best customer experience possible for CT consumers. Our implementation plan includes contingencies in case we have service interruptions at either the State or Federal service levels. Obviously, the more time any State has to implement and communicate the benefits and obligations of the ACA would be helpful, but we are prepared to begin open enrollment on October 1.

Question 3. Even with open enrollment periods, there is concern that young, healthy individuals will wait until they have a serious medical need to purchase insurance. To mitigate this issue, have you given thought to limiting individuals to bronze level plans if they wait to buy insurance?

Answer 3. We have not given consideration to that option as CT wishes to give consumers as much choice in plan design and carrier options as possible. Further, the risk of adverse selection is ameliorated largely through the limits of an annual enrollment period.

SENATOR FRANKEN

Question. The medical loss ratio provision, which I authored and which was included in the health care law, requires that insurers spend 80 to 85 percent of the premium dollars they receive on actual health care services, and only 15 to 20 percent on administrative costs. In your role as the CEO of Access Health CT, can you tell us how the medical loss ratio has changed the insurance market? How has the provision benefited consumers?

Answer. The medical loss ratio provision provides significant benefits to consumers through the dedication of a specific percentage of premium to the payment of medical services. While most carriers in CT are consistently pricing their plans to meet these rations, we have examples of consumers receiving rebates from carriers who did not meet the MLR requirements.

RESPONSE BY SABRINA CORLETTE TO QUESTIONS OF SENATOR ALEXANDER AND SENATOR WHITEHOUSE

SENATOR ALEXANDER

Question 1. In Medicare Parts B and D, CMS pairs an open enrollment period with a late enrollment fee to incentivize seniors to enroll when they are first eligible. This encourages younger, healthier people to enroll earlier and makes the overall risk pool stronger. For States that are worried about their risk pools in 2014, would a similar system be beneficial for exchange-based plans?

Answer 1. The Affordable Care Act includes several mechanisms to ensure a balanced risk pool and mitigate market disruptions. These include:

- Premium tax credits and cost-sharing reductions to make coverage more affordable for individuals between 100–400 percent of the Federal poverty level.
- A requirement that individuals maintain a minimum standard of coverage or face a penalty (often called the "individual mandate").
- A reinsurance program.
- A risk corridor program.
- A risk adjustment program.

The Affordable Care Act also requires exchanges to create a navigator program. Navigators are charged with conducting outreach and enrollment activities, and providing consumers with assistance enrolling in Marketplace coverage. Many of these outreach and education activities are targeting young adults and encouraging them to enroll.

Question 2. On page 7 of your written testimony, you state,

> "And, for individuals earning up to 250 percent of the Federal poverty level, the ACA provides cost-sharing subsidies that will reduce the cost-sharing amounts and annual out-of-pocket limits."

Is it your belief that individuals with incomes between 250 and 400 percent of the Federal poverty level will end up paying *more* out-of-pocket than they would have without the law?

Answer 2. Under the Affordable Care Act, individuals between 250–400 percent of the Federal poverty level are eligible for premium tax credits but are not eligible for cost-sharing reductions. However, the law requires insurers to limit annual out-of-pocket costs for consumers, including copayments, coinsurance, and deductibles, to the level established for high-deductible health plans that qualify for health savings accounts ($6,350 for an individual, $12,700 for a family in 2014). For individ-

uals with high health care needs, this provision provides critically important financial protections that were not widely available in the individual market, prior to enactment of the law.

SENATOR WHITEHOUSE

Question 1. Experts have said that, over the long-term, the exchanges could play an important role in coordinating payment incentives with other State payers to encourage more comprehensive delivery system reforms. What are some specific examples of steps exchanges could take to help encourage system-wide reforms and what lessons can they learn from States that have gone forward with multi-payer delivery system reform initiatives?

Answer 1. Currently, only a small number of States have decided to authorize their exchanges to selectively contract with insurers in order to provide greater value to consumers. But those that have chosen a selective contracting or "active purchaser" approach have been working to encourage insurers to work with their provider networks to improve health care quality and efficiency in the delivery of care. For example, Massachusetts is requiring insurers to transition from traditional fee-for-service payments to providers to alternative payment models such as global or bundled payments. California is requiring participating insurers to participate in the eValu8 survey, a data collection tool used by large employers to assess health plans' efforts to drive quality and efficiency improvements. Plans are also judged based on their use of mid-level providers and physician extenders to drive cost efficiency and expand access to care, their use of delivery system models of care such as Accountable Care Organizations (ACOs) and Patient-Centered Medical Homes (PCMH), and their support of shared decisionmaking. In Vermont, insurers, including qualified health plans, are required to participate in the State's existing "Blueprint for Health" as condition of doing business in VT. Specifically, they must provide reimbursement to all recognized Blueprint Medical Homes and designated Community Health Teams.

Question 2. As States work toward finalizing their exchanges, what lessons can they learn from the Medicare Part D program, including how to apply Part D best practices to the exchanges and how to avoid some of Part D's early mistakes?

Answer 2. In implementing the ACA, State and Federal officials and other stakeholders can draw on the Federal Government's successful launch of Medicare Part D, a major national health coverage program that became law in December 2003 and started enrollment just 2 years later. The program, which now includes 35 million beneficiaries, represented the first Medicare coverage of outpatient prescription drugs to be implemented and the first Medicare benefit delivered exclusively through private plans.

Like the exchanges, Part D required extensive outreach and education in a short timeframe. And, like the exchanges, Part D also required ongoing coordination among Federal and State agencies and private plan sponsors.

Although the officials implementing Part D encountered significant technical, educational, and coordination difficulties at first, 8 years later, many of the initial difficulties have been forgotten. The public generally views the program as a success.

There are numerous areas in which current policymakers can learn from the Part D experience. One key area is eligibility and enrollment. Beneficiaries had two initial decisions before acquiring drug coverage in Medicare Part D: whether to enroll and which plan to select. Many had a third choice as well: whether to apply for the LIS. Individuals and families eyeing exchanges must make a more complicated set of assessments about their financial and health situations and the benefits and costs of making a change, due in part to new tax implications of certain decisions under the ACA.

It was initially hard for potential Part D enrollees to understand the value of the new benefit. Many factors, including an unpopular late-enrollment penalty, provided a reason for beneficiaries to enroll. As a result, many initially uncertain about enrollment, including those taking few drugs, did sign up. The ACA also includes incentives for people to enroll in coverage, such as significant premium tax credits and cost-sharing subsidies for those with low and moderate incomes. More controversially, the law requires that individuals who do not maintain coverage pay a tax penalty. It remains unclear whether these incentives will be sufficient to encourage people, particularly healthy people, to enroll.

Another issue Medicare beneficiaries faced was confusion about plan choices. For many, selecting a plan among a set of alternatives was a new experience. The considerable array of choices made it challenging to compare plans effectively, and many chose plans that were not optimal for their personal circumstances. There is early evidence in the new Marketplaces that, at least in some markets, consumers

are facing challenges comparing plan premiums, benefits, networks, and cost-sharing arrangements.

RESPONSE BY CHRIS CARLSON TO QUESTIONS OF SENATOR ALEXANDER AND SENATOR ENZI

SENATOR ALEXANDER

Question 1. In your testimony, you provide evidence that many individuals participating in the exchange will pay more out-of-pocket to purchase health insurance than they otherwise would if the law had not passed. Is it your belief that this problem will only grow larger as more employers shift employees to the exchanges?

Answer 1. At this time, the impact of employers shifting their employees to the exchanges is unclear. On one hand, if the individuals that are shifted to the exchanges are from groups that have a higher concentration of younger employees, those employees may find themselves purchasing policies that are more costly than they otherwise would have paid in the group plan. However, individuals that are fully employed tend to have lower morbidity and thus could actually provide improvement in the individual risk pool.

Question 2. An Obama administration spokesperson recently dismissed the Society of Actuaries study, claiming it was done by an insurance company. Would you comment on that assertion?

Answer 2. The Society of Actuaries is an independent organization that maintains high professional standards for its members. As credentialed actuaries, we are required to comply with the Code of Professional Conduct in all areas of our work. Specifically, Precept 7 addresses conflicts of interest and states that, "An Actuary shall not knowingly perform Actuarial Services involving an actual or potential conflict of interest unless the Actuary's ability to act fairly is unimpaired."

Question 3. You note in your testimony that the age 21–29 group has an uninsured rate that is roughly twice the uninsured rate for the nonelderly population. Would giving States some flexibility to establish age bands in a way that wouldn't negatively impact risk pools help alleviate some of the pressure facing young adults? Are there other viable options? Why is it so important to get this right?

Answer 3. Giving flexibility to the States to establish age bands would certainly help to alleviate potential rate shocks to young adults. However, it is important to recognize that any flexibility that still requires States to maintain the 3 to 1 ratio on age bands will have a very limited effect. One potential option would be to allow States to phase in the age rating over several years. While this would not change the ultimate outcome, that young adults will subsidize older adults, the impact of the rate shock would not be evident immediately and it could produce greater participation in the non-group market. As Senator Harkin discussed in the hearing, this issue is important because the non-group market needs to have the risk spread to as many consumers as possible. Any limitation in the participation in the market, especially by those at younger ages that are likely to be of better health, will spread the cost across a smaller population thus increasing the rates for everyone.

Question 4. Your testimony touches on another important subject—an excise tax on health insurers. Can you tell me what benefit the consumer gains from these taxes on health plans?

Answer 4. It is my understanding that the tax's purpose is to offset the costs of the Affordable Care Act, which mostly is represented by the premium subsidies that will be available to individuals below 400 percent of the Federal poverty limit who purchase non-group coverage on the health insurance exchanges. Otherwise, there is no discernible benefit to the consumer for paying the taxes.

SENATOR ENZI

Question. Mr. Carlson, you have talked about a number of actuarial studies related to the impact of the health care law. For example, the Society of Actuaries estimates that health insurance premiums in the individual market will increase by 32 percent on average nationally and in Wyoming specifically. The National Association of Insurance Commissioners, in a paper released last week, concluded that States "should begin evaluating these and other strategies **immediately** in order to mitigate rate increases when the major market reforms take effect in 2014." What should the Administration be doing to better address the risks identified by these and other reports? What can Congress do to better monitor this risk?

Answer. Although there are provisions of the ACA that will reduce premiums, since the focus of this question is rate increases, I will limit my response to that

side of the equation. Specifically the issues that I will discuss that may increase premiums are guaranteed-issue, expansion of benefits, and limits on rating.

Guaranteed-issue will increase rates because individuals that can currently not obtain insurance because of underwriting restrictions will now be able to obtain coverage with no restrictions. These individuals will be more expensive than those currently insured. The ACA's reinsurance provision attempts to mitigate the increase in cost for these individuals, and carriers' rate filings indicate that rates in the non-group market may be as much as 10 percent lower as a result of the temporary reinsurance program. An extension and expansion of the reinsurance program could potentially limit the rate increases as a result of guaranteed-issue.

The other concern with guaranteed-issue is that individuals will forgo health insurance until they become sick, at which point they will purchase coverage. The individual mandate and the premium subsidies attempt to lessen this risk as individuals will be compelled to purchase insurance because of the mandate, and the premium subsidies will make the actual premiums paid by individuals below 400 percent of poverty more affordable. However, the premium subsidies are not available to everyone, and further, the individual mandate may not be sufficient to compel healthy and younger individuals to enroll in coverage.

In response to these issues, the American Academy of Actuaries suggested in their May 2013 issue brief[1] on premium changes under the ACA:

> *Strengthening the individual mandate would help mitigate premium increases due to a less healthy enrollee population. Approaches could include less frequent open enrollment periods, penalties for late enrollment, more generous premium subsidies, and enhanced public outreach and consumer education.*

I would concur with these suggestions.

The expansion of benefits has a significant impact on premiums because many non-group policies have high deductibles and cost-sharing and also limit or exclude the coverage of certain benefits, such as prescription drugs and maternity. From an out-of-pocket perspective, the addition of these benefits generally does not increase total costs (premiums plus cost-sharing) since individuals will not pay less when they do require services. However, the premium rates that individuals will see in the market will be higher as a result, and consumers may not be knowledgeable enough to understand the tradeoff. Instead consumers may be turned off by higher premiums. Without the obvious solution of relaxing the essential benefits requirements, consumers will need to be better educated about the premium increases due to essential benefits will be offset by higher levels of benefits.

Finally, limits on rating, such as requiring age-rating to be 3 to 1, increases the premiums for one group while decreasing the premiums for another group. Assuming that the limitations on rating do not affect the composite premiums, the only way to mitigate the rate increases for certain policyholders would be to remove or relax the limitations on the rating. For example, moving from a 3 to 1 age-rating limits to 4 to 1 limits would negate almost all of the impact of the age-rating compression and resulting rate shock.

[Whereupon, at 12:41 p.m., the hearing was adjourned.]

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[1] *http://www.actuary.org/files/Premium__Change__ACA__IB__FINAL__050813.pdf.*