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OBAMACARE EMERGENCY: STABILIZING THE INDIVIDUAL HEALTH INSURANCE MARKET

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING THE AFFORDABLE CARE ACT, FOCUSING ON STABILIZING THE INDIVIDUAL HEALTH INSURANCE

FEBRUARY 1, 2017

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C O N T E N T S

STATEMENTS

WEDNESDAY, FEBRUARY 1, 2017

OBAMACARE EMERGENCY: STABILIZING THE INDIVIDUAL HEALTH INSURANCE MARKET

WEDNESDAY, FEBRUARY 1, 2017

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

The committee met, pursuant to notice, at 10:03 a.m. in room SD–430, Dirksen Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Burr, Collins, Cassidy, Young, Roberts, Murkowski, Scott, Murray, Casey, Franken, Bennet, Whitehouse, Baldwin, Murphy, Warren, Kaine, and Hassan.

OPENING STATEMENT OF SENATOR ALEXANDER

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

Today, we are holding a hearing on what we can do to stabilize the individual health insurance market which, in some States, is in an emergency condition.

Senator Murray and I will each have an opening statement, and then we will introduce our witnesses. We thank you very much for coming. Afterwards, we will go to a 5-minute round of questions.

I have a prepared statement, but let me try a little different approach today.

For 6 years, Republicans and Democrats have been fighting like the Hatfield's and McCoy's over the Affordable Care Act, which we call Obamacare. We are very good at this. We can make our speeches in our sleep and cast many votes on either side of the aisle.

I received a letter from Senator Kaine and, I think, a dozen other Democratic Members of the Senate saying, "We would like to work with you as you Republicans begin to take a look at the Affordable Care Act and make changes in it."

I responded to him to say I would like to do that.

Now, I am not a naive person and I know that it is not easy to move from the Hatfield's and McCoy's to working together on this issue. But if there is one area where we ought to be able to do that, it is with the individual market and the problems that we have with it because it is a relatively small part of our healthcare system.

Just while I have this up, and I gave it to Republican Senators and I am glad to give it to Democrats too, so we will have an idea of what we are talking about.

Medicare is 18 percent and in the discussions that we are having, at least I am having and most of the people I talk to, is about changing our healthcare system, or repealing, or replacing Obamacare. We are not talking about Medicare. So that leaves three.

Go down here to the Medicaid area. Most of the conversation we are having about Medicaid is about more flexibility for States. That can be discussed separately.

The employer market, most of that is not in crisis, although the small group market, which is this relatively small part of that, could stand a lot of work.

But where the trouble is—and what I would like and what this hearing is about—is the individual market, the people who buy insurance themselves in the individual market. They are too young for Medicare. They are not covered by Medicaid. They do not have insurance through their employer, which is where most people get their insurance. So they are in the individual market. That is about 6 percent of everybody in the country who has insurance. So, 4 percent of the 6 percent, or two-thirds of the 6 percent, and 4 percent of everybody insured are in the Obamacare exchanges.

That is the focus for today. And as far as I am concerned, I am focusing on the individual market especially exchanges because I understand that what happens in the exchanges affects the rest of the individual market. So that gets us up to about 18 million people. It is a small, small percentage of everybody who has insurance, but these are all real people and they are in trouble if we do not, at least in our State of Tennessee, if we do not take some steps.

I would just say to my colleagues that I am certainly willing to try to do as we have often done here on big issues about which we have had historic agreements, and that is look for areas of willingness to work together.

Again speaking for myself, I think we are going to have to take some action pretty quickly. It is going to have to be consensus action, which means it is going to have to get more than 60 votes. It is going to be the kind of thing that I hope was mentioned in the letter that Senator Kaine and others wrote to me.

It can be done just affecting the individual market without arguing about the whole rest of the American healthcare system. It can be done temporarily. It can be done, in effect, to stabilize that market for 2 or 3 years while we discuss everything else.

I think it means that Republicans are going to have to approve some things we normally might not support and Democrats are going to have to do some things they normally might not do during this transition. But that might be a good step toward the kind of legislating that we were accustomed to doing in this committee.

The only other things I would say are these. In my home State of Tennessee in September 2016—and we are going to hear more about this from Julie McPeak, the State Insurance Commissioner—we woke up one morning and Blue Cross Blue Shield announced that it was pulling out of Nashville, Memphis, and Knoxville. That is 131,000 people who had Blue Cross insurance, and in the individual market, and they would not be able to buy it in 2017. So they do not have that option this year.

That is an alarm bell in every one of those homes. I mean, it is a lot of trouble when you lose your insurance option. And in two-thirds of our counties in Tennessee, people who buy their insurance through the exchanges only have one option now. And that is true in one-third of the counties across the country.

What we are told is that unless we take action fairly quickly—and that is what I want to hear from our witnesses today—that we may reach a situation in 2018 where many Americans have a subsidy through the Affordable Care Act to buy insurance in the individual market, but they do not have any insurance to buy. It would be like having a bus ticket in a town where no buses run. Right now, in two-thirds of our counties, we have only one bus running through town and in 2018, we might have zero. That is the problem to solve.

It does not make as much difference to me whose fault that is. I can make a pretty good speech about that and you could make a pretty good speech saying why it is not your fault or it is our fault.

The question the American people want to know, particularly if they are of the 11 million people in the exchanges or the 18 million in the whole individual market is, "Well, what are you going to do about that?"

Some of the things can be done by the Secretary of Health and Human Services. I would like to include in the record a list of Health Insurance Reform Regulatory Changes from the National Association of Insurance Commissioners which has specific recommendations on how to stabilize markets including providing more State flexibility and improving the regulatory environment.

[The information referred to was not available at press time.]

Some of it will have to be done by us. We will have to agree on it.

That is a subject I hope we can discuss today. While there is a lot to say about Medicaid, there is a lot to say about the employer market. There are fine speeches to be made defending Obamacare and attacking Obamacare. And Senators have a right to make those speeches, and witnesses have a right to say what they want to say.

But for me, the most helpful thing that could happen today is for you to answer these questions.

No. 1, is there really trouble in the individual market in our country, and in what States, and in how many States? No. 2, specifically, what should we do about it? And No. 3, by when do we have to do it?

One insurance commissioner told me that if we did not act by April of this year, there would not be insurance sold in his State next year, which is 2018. In other words, people would be sitting there in that State with their bus ticket and no bus to get on.

That is what I hope the hearing is about. I hope and say, I thank Senator Kaine and others for their letter. It is in the spirit of the way Senator Murray and I have worked on a lot of issues over the last couple of years. I realize this is a contentious issue and I realize this is a contentious time, but things change. And when people need help, we are supposed to provide it.

I thank the witnesses for coming and so many Senators for being here.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you very much, Chairman Alexander for holding this hearing. I appreciate your opening remarks.

I like what you said. I think the individual market is a challenge. It always has been.

Before the ACA, no one could get insurance, and if they would buy insurance, it did not cover what they thought it covered when they had been paying for it for years. It is a challenge and the ACA actually provided a way for millions of people to purchase insurance. It did lower the rising costs of insurance to people and it is an important discussion. I wish that was what was happening, but I think that is not what Republicans have actually been doing right out of the box.

We saw in the budget the first week of the session, a move to go to reconciliation, repeal Obamacare. That is where this Congress is headed, it is what the President is talking about, and it is the path we are on. If we take that conversation away and Republicans stop going down the path of repealing Obamacare, then I think all of us are interested in a conversation. But just to repeal Obamacare and then have this discussion, leaves a lot of people in jeopardy.

I just want to open with that and I want to thank all of our witnesses who are here. Governor Beshear, I especially appreciate you taking time to share your invaluable personal experience in your State. I want to thank all of our colleagues and I want to thank our colleagues who joined us for the pre-hearing press conference. I thought it was important to hear this morning from real families and doctors about the devastating impact that ripping apart our healthcare system would have on them and millions across the country.

Since the election, I have heard from so many families in my State who come up to me with tears in their eyes about a wide range of issues facing our Nation. And one sentiment I have heard over and over again is worry and fear about what is going to happen to their healthcare.

I am going to share just one of my constituents' stories. I think it bears repeating because it truly speaks to the angst so many families are feeling right now.

Two years ago, Brice, who is a constituent of mine who lives in Seattle, was kayaking in West Virginia and he injured his back. Several months later, that pain in his back had not gone away. After a visit to the hospital, what doctors first suspected was only a stubborn muscle sprain ended up being a very rare type of bone cancer called Ewing's sarcoma.

As we can all imagine, to him, that was pretty terrible hearing that news. Thankfully, he said his family had insurance because of the Affordable Care Act. And today, Brice is getting excellent treatment at Seattle Children's Hospital where doctors have been able to ease some of his pain, and he is beginning to respond to chemotherapy.

Brice is almost 18. He is going to need care, very expensive care, for the rest of his life. Brice and his family are gravely concerned that if Republicans continue down the path of dismantling our healthcare system with no plan with what to do instead, the pre-existing conditions that we fought so hard for in the Affordable Care Act will be undermined as well. And if that were to happen, Brice's dad said he does not know how they will be able to afford healthcare or get the benefits and treatments that Brice is going to need for a long time.

Mr. Chairman, they and the nearly 32 million people who stand to lose their healthcare deserve security. They deserve certainty and not empty promises.

It is my hope that we will be able to have an open, honest discussion today about what is at stake for millions of families and their healthcare. That all of us, Democrats and Republicans, prioritize what is best for them, not what is best for politics.

Repealing the affordable healthcare plan with no plan to replace it will create chaos throughout our healthcare system. That is not just my view. It is not just Senate Democrats' view. It is a view shard by the majority of independent policy experts, hospitals, insurers, including State leaders from both parties across the country.

Republican Governors from Alabama, Arizona, Idaho, Nevada, Ohio and many others agree that an abrupt repeal of the law would be devastating. That is why Democrats on this committee thought we should hear a Governor's perspective today, the former Governor of Kentucky, Steve Beshear, who will speak to the damage repeal of the Affordable Care Act will do to his State and many others.

Here is what we already know. Premiums will skyrocket by as much as 25 percent in the first year of repeal and 50 percent over the next 10 years according to the recent report by the CBO. Out-of-pocket prescription drug costs will rise as will healthcare costs overall. Patients with pre-existing conditions, like Brice who I just talked about, will be denied care. Those are facts. No serious experts deny that.

Yet President Trump, and some of my Republican colleagues here, continues to double-down on repeal even after it is clear they cannot agree with what to replace that with. And let us not forget that Republican policies that are on the table will also cut Medicaid and defund Planned Parenthood, not to mention ending the guarantee of full coverage under Medicare leaving women, and seniors, and families further exposed.

This just is not my view and I know my Republican colleagues held a retreat last week to strategize on repeal; we all saw the news coverage. I think it did not go quite as planned and it seems like they were left with a lot of questions more than answers. And as one member put it, in a moment of remarkable candor, he said,

> "We are telling people that we are not going to pull the rug out from under them, and if we do this too fast, we are, in fact, going to pull the rug out from under them."

And I could not agree more.

In spite of all this and in spite of what the Chairman said about working together on a small piece of this, President Trump and

some Republicans are still rushing ahead to rip apart the healthcare system without a plan for the aftermath.

I want to be very clear. While my colleagues on the other side of the aisle do not have a plan, they are now creating Trumpcare by sabotage. It is a broken system of chaos and uncertainty that will hurt, not help, families and it is increasingly a broken promise from the President who said he would deliver better healthcare at lower costs and vowed to ensure, "Insurance for everybody."

On his first day in office, President Trump signed an Executive order which overturned vital consumer protections threatening the health and financial security of millions of families. Before President Trump's Executive order, families could count on their health insurance plan covering a broad range of benefits, maternity care, preventive care, prescription drugs, mental healthcare. And now, that guarantee is gone.

Last week, President Trump created even more confusion by preventing families from finding out about their coverage options when he canceled advertising and consumer outreach efforts. These outreach activities had already been paid for, but President Trump still took those ads off the air at the very end of open enrollment when the largest number of people are looking for coverage and need help. Open enrollment, by the way, ended yesterday. Who knows how many more Americans would have found affordable coverage if President Trump had not pulled the plug?

These actions do nothing to clarify the confusion and disarray among Republicans about their plans to actually replace the Affordable Care Act. Instead, what they do is heighten uncertainty for millions of working families whose access to healthcare hangs in the balance.

I hope President Trump, and my Republican colleagues, reverse course and stop pursuing the repeal of the affordable healthcare system. And if they do not, if they continue rushing to take away families' healthcare with no alternative plan, they will be fully responsible for the chaos and the uncertainty that Trumpcare is already causing and will continue to cause.

I have no doubt that millions of people who are speaking out louder than ever against harmful partisan policies will hold them accountable and Democrats here in Congress will as well. But, of course, it is families like Brice's nationwide who will feel the real impact and the hurt.

I am glad that some of my Republican colleagues here in this committee are hearing loud and clear from the overwhelming majority of Americans who do not want to have their lives upended. Because as I have said many times, if they are truly serious about helping women, and families, and seniors get quality affordable care, we are ready to work together as we always have been on real improvements that need to be made.

The families we serve are making clear they do not want their healthcare or their lives to be at risk, and they want to see us work together to get this done right instead. I hope our Republican colleagues will stop what they have started, listen, and urge them to make the right choice.

With that, Mr. Chairman, I have left a packet on each member's desk so that everyone has a better understanding of what repeal

will mean, including some patient testimonies from States, and data on what repeal will mean for each State. I would like that submitted for the record.

[The information referred to was not available.]

The CHAIRMAN. It will be. Thank you, Senator Murray.

I am pleased to welcome our four witnesses today. I will give them brief introductions so we can have more time for their testimony and for the questions the Senators have.

Julie McPeak is the Tennessee Department of Commerce and Insurance leader. She has been there since 2011. Before that, she practiced law as counsel to the insurance practice group in a law firm, and served as executive director of the Kentucky Office of Insurance. She is president-elect of the National Association of Insurance Commissioners.

Marilyn Tavenner is well-known to this committee. Well today, she leads America's Health Insurance Plans, a national association for the health insurance industry. She served as Administrator of the Centers for Medicare and Medicaid Services in the Obama administration. Before that, she was Secretary of Health and Human Services in the cabinet of Virginia Governor Tim Kaine, who is a member of this committee.

Janet Trautwein is the chief executive officer of the National Association of Health Underwriters representing 100,000 employee benefit professionals involved in the design, implementation, and management of health plans all over the United States.

We welcome Governor Steve Beshear, Governor of the Commonwealth of Kentucky from 2007 to 2015. He launched the Kentucky Health Benefit Exchange to provide access to insurance under the Affordable Care Act. He was formerly in the House of Representatives and Lieutenant Governor. He currently practices law in Lexington.

Ms. McPeak, let us begin with you. And if you could each summarize your remarks in about 5 minutes, we will go to a 5-minute round of questions for each Senator afterwards.

Miss McPeak.

STATEMENT OF JULIE MIX McPEAK, COMMISSIONER, TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE, NASHVILLE, TN

Ms. MCPEAK. Thank you. Good morning, Chairman Alexander, Ranking Member Murray, and members of the committee. Thank you for inviting me to testify this morning.

I am Julie McPeak, commissioner of the Tennessee Department of Commerce and Insurance. In addition to my responsibilities at home, I also serve as president-elect of the National Association of Insurance Commissioners. I participate at the International Association of Insurance Supervisors, and the Federal Advisory Committee on Insurance. I have spent most of my career in insurance regulation and I have a strong affinity for our country's State-based system of insurance oversight.

My testimony today will briefly highlight Tennessee's history with the Affordable Care Act before discussing some practical reforms that Congress and the Administration may consider to help stabilize the individual insurance market in Tennessee.

First, I would like to share with you the most important message that I will have for you today, insurance markets do not respond well to uncertainty. To the extent possible, as you consider ACA reforms, it is critical to remain transparent and to minimize surprises in our regulatory system.

Tennessee's insurance market is struggling. Today we have three insurance carriers offering policies on our Federally Facilitated Marketplace. However, in 73 of 95 counties, Tennesseans only have one FFM option.

Tennesseans have seen rates steadily increase since 2014 culminating in increases ranging from 44 percent to 62 percent for 2017. These rates have been fully justified. According to the Department of Health and Human Services, Tennessee had the highest risk score in the Nation in 2014 and the second highest in 2015. Further in 2014, Tennessee's premium rates were the second lowest in the country.

In addition, Tennessee had a co-op that provided coverage from 2014 through the end of 2015 when the Department placed the company in supervision.

In short, Tennessee's ACA individual market experience has meant fewer marketplace carriers and higher priced premiums for Tennessee consumers.

Tennessee's experience, which is not unique, suggests a need for policy change, but the challenge is implementing reforms without disrupting an already distressed marketplace. If carriers are uncertain of the regulatory landscape for 2018, they may withdraw from the current rating areas, further restricting consumer choice. This is not to suggest that Congress and the Administration need to delay any repeal, replacement, or other modifications to the ACA.

You should return as much flexibility as possible to the States to address our respective marketplace needs and stabilize the individual insurance markets.

A few key areas that could provide immediate assistance to our marketplace are rating factors, essential health benefits, special enrollment periods, and grace periods.

As you know, all ACA-compliant plans must offer the same package of benefits called EHB. You should consider granting to States the flexibility to redefine EHB so that we may consider a base set of benefits that would need to be included in a few standard plans, while also allowing more flexible designs in other available plans. This approach would allow consumers an option to select a limited benefit plan that covers basic needs, but not all of the ACA required benefits.

Congress, and the Administration, should also relax restrictive age bands that limit premiums based on age to no more than a 3 to 1 ratio; a ratio closer to 5 to 1 or 6 to 1 would provide more rate flexibility in the market. When coupled with EHB flexibility, may have the ultimate impact of growing the individual insurance pool in Tennessee by attracting younger and healthier populations.

Two other issue areas that you could address quickly are special enrollment periods and grace periods. We all agree that special enrollment periods are an absolute necessity for individuals experiencing a change in life circumstances. Unfortunately, special enrollment periods have been so broadly interpreted at a Federal level

that they are almost akin to a permanent open enrollment period, which allows an individual to access health insurance benefits only when healthcare is an immediate necessity. Obviously, this has a negative impact on the overall health of the risk pool.

Extended grace periods have added administrative costs to the market as well. The 90-day grace period potentially allows a policyholder to incur claims well past the time that premium payments have been discontinued. You should consider shortening the grace period to around 30 days to provide certainty to the insurance market.

In conclusion, the ACA introduced new policies, new concepts, and at times, new rigidity to our insurance marketplace. Rates have gone up. Consumer choice and marketplace competition have gone down.

As this committee continues to work to stabilize individual insurance markets, I would again stress two points. First, States should be empowered to tailor insurance regulation to our unique market and medical and insurance community.

Second, please continue to be as open and transparent in this process as possible. Markets need clarity so we do not see carriers exiting markets in bulk when they do not know what to expect in terms of regulation over the next several years.

Thank you for the opportunity to discuss the Tennessee experience with the committee. I will be happy to answer any questions that you might have.

[The prepared Statement of Ms. McPeak follows:]

PREPARED STATEMENT OF JULIE MIX MCPEAK

SUMMARY

HIGHLIGHT

Insurance markets do not respond well to uncertainty. To the extent possible as you consider ACA reforms, it will be important to remain transparent, as today's hearing suggests, to engage stakeholders, and to minimize surprises in our regulatory system.

TENNESSEE EXPERIENCE

Tennessee's individual insurance market is struggling. Today we have three insurance carriers offering policies on our Federally Facilitated Marketplace ("FFM"). However, in 73 of 95 counties, Tennesseans only have one FFM option. Competition in the FFM only exists in three rating areas of the State. This is down from 2016 when we had two carriers offering policies in all of our counties. Tennesseans have seen rates steadily increase since 2014. Approved rate increases ranged from seven (7) to 19 percent for 2015; increased up to 36 percent for 2016, and ranged between 44 and 62 percent for 2017. Tennessee's premium rates have gone from the second lowest in the country in 2014, to the fifth lowest in 2015, to the 15th lowest in 2016, and have increased substantially for 2017. Tennessee's ACA individual market experience since 2014 has meant fewer marketplace carriers, less competition, and higher priced premiums for available products. In addition, we have seen existing FFM carriers move toward narrower networks, further limiting consumers' access to providers of their choosing.

ACA TIMELINE

The Congress and/or Administration need to be keenly aware of the filing dates that insurance carriers currently expect. Insurance carriers are beginning to make decisions on their 2018 footprints. Forms and rates must be approved no later than August 21, 2017. Insurance companies facing significant uncertainty are likely to pull back their business operations. If carriers are not aware of what the regulatory landscape may look like for 2018 before the date that they need to decide what to

offer to consumers in 2018, we may see carriers pull back from the current rating areas in which they offer services.

MARKET REFORMS

The Congress and/or Administration should return as much flexibility as possible to the States to address our respective marketplace needs. A few key areas that can provide immediate assistance to our marketplace include: rating factors, essential health benefits (EHB), special enrollment periods (SEPs), and grace periods. To help stabilize insurance premiums, we need young and healthy risks to enter the insurance marketplace. Providing States the flexibility to redefine EHB to bring more innovative products to market and then allowing rates to vary more substantially based on member age could go a long way toward bringing products to market that will appeal to younger and healthier populations. Addressing SEPs and grace periods will help provide additional market stability.

INTRODUCTION

Good morning Chairman Alexander, Ranking Member Murray, and members of the committee. Thank you for inviting me to testify this morning.

I am Julie Mix McPeak. I am commissioner of the Tennessee Department of Commerce and Insurance (TDCI). TDCI is comprised of several divisions that regulate professions ranging from the insurance companies to hair salons, and in my capacity as commissioner, I also serve as the State's Fire Marshal. In addition to my responsibilities at home, I also serve as president-elect of the National Association of Insurance Commissioners (NAIC), as an executive committee member of the International Association of Insurance Supervisors (IAIS), and as a member of the Federal Advisory Committee on Insurance (FACI). I have spent most of my career in insurance regulation, previously serving as the executive director of the Kentucky Office of Insurance, and have a strong affinity for the country's State-based system of insurance oversight.

My testimony today will briefly highlight Tennessee's history with the Affordable Care Act (ACA) before discussing some practical reforms that Congress and/or the Administration can consider to help stabilize the individual insurance market in Tennessee. First, I would like to share with you the most important message that I will have for you today: Insurance markets do not respond well to uncertainty. To the extent possible as you consider ACA reforms, it will be very important to remain transparent, as today's hearing suggests, to engage stakeholders, and to minimize surprises in our regulatory system.

TENNESSEE'S INDIVIDUAL MARKET

Tennessee's individual insurance market is struggling. Today we have three insurance carriers (BlueCross BlueShield of Tennessee, Cigna, and Humana) offering policies on our Federally Facilitated Marketplace ("FFM"). However, in 73 of 95 counties, particularly the more rural areas of the State, Tennesseans only have one FFM option. Competition in the FFM only exists in three rating areas of the State. This is down from 2016 when we had two carriers offering policies in all of our counties.

Tennesseans have seen rates steadily increase since 2014. Approved rate increases ranged from seven (7) to 19 percent for 2015; increased up to 36 percent for 2016, and ranged between 44 and 62 percent for 2017. These rates have been fully justified, and according to the Department of Health and Human Services (HHS), Tennessee had the highest risk score in the Nation in 2014 and the second highest in 2015. The HHS risk score essentially measures the health and health care utilization of insured populations. Tennessee's premium rates have gone from the second-lowest in the country in 2014, to the fifth-lowest in 2015, to the 15th lowest in 2016, and have increased substantially for 2017.

In addition, Tennessee had a co-op that provided coverage from 2014 through the end of 2015. A multitude of factors led the Department to place that company under Supervision and I'm proud to say that as a result of our efforts, while our co-op has failed, the company should be able to repay the Federal Government a portion of the moneys allocated for its startup and solvency purposes.

In short, Tennessee's ACA individual market experience since 2014 has meant fewer marketplace carriers for Tennessee consumers, less competition across the State, and higher priced premiums for available products. In addition, we have seen existing FFM carriers move toward narrower networks, further limiting consumers' access to providers of their choosing.

ACA TIMELINE

Tennessee's experience, which is likely not unique, suggests a need for policy changes from the Congress and/or Administration. The challenge you will face is in implementing reforms without disrupting an already distressed marketplace. As I mentioned previously, insurance companies facing significant uncertainty are likely to pull back their business operations to the extent possible.

For instance, and again using my home State as an example, if carriers are not aware of what the regulatory landscape may look like for 2018 before the date that they need to decide what to offer to consumers in 2018, we may see carriers pull back from the current rating areas in which they offer services. Such an industry reaction would result in Tennessee consumers potentially being left with zero FFM options in certain areas of the State for 2018.

The Congress and Administration need to be keenly aware of the filing dates that insurance carriers currently expect, absent any changes that may come out of the Federal Government. Insurance carriers are already beginning to make decisions on their 2018 footprints. Under existing Federal guidance, carriers must submit "policy forms," i.e., the benefit plans that they would like to offer, for review by the State before May 3, 2017. Rates, again under existing Federal guidance, are currently due between May 3 and July 17, 2017, as determined by the State. Forms and rates must be approved no later than August 21, 2017.

This is not to suggest that Congress and the Administration need to delay any repeal, replacement or other modifications to the ACA. While it would be a significant challenge to implement policy changes for the already underway 2017 plan year as consumers have selected plans, made payments, and started to receive medical services, there are changes that I will discuss next that the Congress and Administration should consider.

INDIVIDUAL MARKET REFORMS

The Congress and/or Administration should return as much flexibility as possible to the States to address our respective marketplace needs as you consider revisions to the ACA. As that concept is more broadly considered, there are certain areas that Congress and the Administration could address in the short- and long-term future that would help stabilize Tennessee's individual insurance market. I would like to focus on a few key areas that I believe can provide immediate assistance to our marketplace: rating factors, essential health benefits (EHB), special enrollment periods (SEPs), and grace periods.

As you know, all ACA-compliant plans must offer the same package of benefits, called EHB. Insurance carriers largely do not compete anymore on innovative benefit packages, but rather they compete on networks, price, and name recognition. The Congress and/or Administration should consider granting States the flexibility to redefine EHB. Should the State be provided a blank slate to define EHB, we may consider a base set of benefits that would need to be included in a few standard plans while also allowing more flexible designs in other available plans. This approach would allow consumers to select from broader benefit plans, while also potentially providing an option to select a limited benefit plan that will still cover the basics such as hospitalizations, physician visits, and mental health care, but may not provide all of the benefits that are currently required of all ACA-compliant plans.

Congress and the Administration should relax restrictive age bands that have created a situation where premiums can only differ based on age by no more than a 3:1 ratio. Providing more flexibility to insurance regulators and carriers in how individuals are rated, even while keeping prohibitions against discrimination based on pre-existing conditions, may help stabilize insurance markets. Ratios closer to 5:1 or 6:1 would provide more rate flexibility in the market and when coupled with EHB flexibility may have the ultimate impact of growing the individual insurance pool in Tennessee. Today 51 percent of Tennessee's individual market is 45 years of age or older. To help stabilize insurance premiums, we need young and healthy risks to enter the insurance marketplace. Providing States the flexibility to redefine EHB to bring more innovative products to market and then allowing rates to vary more substantially based on member age could go a long way toward bringing products to market that will appeal to younger and healthier populations.

Two other issue areas that the Congress and/or Administration could address quickly to the benefit of individual insurance markets are SEPs and grace periods. We all agree that special enrollment periods are an absolute necessity for individuals who experience a change in life circumstances. Situations like childbirth, marriage, and a change in employment should clearly create a SEP allowing an individual to apply for coverage outside of traditional open enrollment periods. Unfortu-

nately, reports suggest that SEPs have been so broadly interpreted at the Federal level that they are almost akin to a permanent open enrollment period. Broadly defined SEPs discourage individuals from applying for coverage during open enrollment periods and instead allow individuals to access health insurance benefits only when health care is an immediate necessity. This obviously has a negative impact on the overall health of the individual market pool if coverage is purchased only when necessary to cover procedures or treatment.

Extended grace periods have had the unintended consequence of adding administrative costs to insurance carriers. The 90-day grace period potentially allows gaming of the insurance system by allowing a policyholder to stay on a plan well past the time that premium payments have been discontinued. Congress and/or the Administration should considering shortening that grace period to around 30 days to provide certainty to insurance markets.

CONCLUSION

The ACA introduced new policies, new concepts, and at times new rigidity to our insurance marketplace. Rates have gone up, consumer choice and marketplace competition has gone down. While policies are more robust than pre-ACA policies and so-called grandfathered plans, policy options and regulation has become more of a one-size-fits-all, Washington, DC-approach, rather than an innovative and flexible State-based solution.

As this committee continues its work to stabilize individual insurance markets, I would again stress two points. First, States should be empowered to regulate our markets. Additional flexibility from Congress and the Administration will help the States tailor insurance regulation to our unique markets and medical and insurance communities. Second, please continue to be as open and transparent in this process as possible. Markets need clarity and opportunities like this hearing today can help provide that clarity so that we do not see carriers exiting markets in bulk when they do not have an idea of what to expect in terms of regulation over the next several years.

Thank you again for the opportunity to discuss the Tennessee experience with this committee. I look forward to your questions on my testimony today and am happy to provide additional thoughts related to the regulation of insurance markets and the ACA.

The CHAIRMAN. Thank you, Ms. McPeak.

Ms. Tavenner.

STATEMENT OF MARILYN TAVENNER, PRESIDENT AND CEO, AMERICA'S HEALTH INSURANCE PLANS, WASHINGTON, DC

Ms. TAVENNER. Thank you, Mr. Chairman, and I will be brief because many things that Julie discussed I will concur.

Let me start by saying Chairman Alexander, Ranking Member Murray, and members of the committee, I am Marilyn Tavenner, president and CEO of AHIP which serves as the national association whose members provide coverage for healthcare and related services to millions of Americans every day. We appreciate this opportunity to testify about what is needed to stabilize the individual health insurance market.

It is clear that certain parts of the ACA have not worked as well as intended and the individual market does face serious challenges. It is also true that the ACA has expanded coverage to more than 20 million Americans through expanded Medicaid and through the individual exchange marketplace.

I am here today to offer our recommendations for both the short-term solutions, as well as longer term principles for lasting improvements.

First and foremost, immediate policy steps are needed to help deliver an effective transition and continuous coverage. Strong signals of certainty can help stabilize this market avoiding even higher costs and fewer choices. Specifically we recommend continuing

to provide subsidies such as the Advanced Premium Tax Credits and Cost-Sharing Reduction Payments in their entirety. The absence of this funding would further deteriorate an already unstable market and hurt the millions of consumers who depend on these programs for their coverage.

Second, make full Federal reinsurance payments for 2016. This funding is important for plans to effectively cover the needs of high-cost patients including those with chronic conditions.

As discussed in my written testimony, while continuing the CSRP and reinsurance payments are critical, they are not sufficient to ensure stable and workable transition for consumers and patients. Additional policies such as recalibrating premium subsidies to encourage younger folks to participate, Federal risk pool funding, and continuous coverage incentives will be necessary to promote a more stable and workable transition for consumers and families.

My testimony also outlines longer term principles for lasting improvements that can actually deliver real choice, high quality, and access to affordable care in the individual market.

These policies include bringing down the cost of coverage, guaranteeing access to affordable coverage for all Americans including those with pre-existing conditions, continuous coverage incentives, effective risk pooling mechanisms, adequate and well-designed tax credits that promote affordability, and State flexibilities to promote innovation and choices for consumers.

AHIP, and the health plans we represent, look forward to working with this committee, with all Members of Congress on a bipartisan basis, and with this Administration as it works to improve healthcare for all Americans.

We can only achieve this by working together in good faith and a bipartisan manner to fix critical problems while preserving expanded coverage and enhanced affordability of coverage for millions of our patients and their families.

Thank you.

[The prepared Statement of Ms. Tavenner follows:]

PREPARED STATEMENT OF MARILYN TAVENNER

EXECUTIVE SUMMARY

Chairman Alexander, Ranking Member Murray and members of the committee, I am Marilyn Tavenner, President and CEO of America's Health Insurance Plans (AHIP). AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day.

We appreciate this opportunity to testify about what is needed to stabilize the individual health insurance market. It's clear that certain parts of the Affordable Care Act (ACA) have not worked as well as intended and the market faces serious challenges. It is also true that the ACA has expanded coverage to 20 million Americans through expanded Medicaid and through the individual exchange marketplace.

I am here today to offer our recommendations for both short-term solutions as well as longer-term principles for lasting improvements.

• **Immediate policy steps that can help deliver an effective transition and continuous coverage.** These policies include continuing to provide cost-sharing reduction (CSR) payments during the entire length of the transition and making full reinsurance payments. Recalibrating premium subsidies to encourage younger adults to participate, Federal risk pool funding, and continuous coverage incentives are also necessary to promote a more stable and workable transition for consumers and families.

• **Longer term principles for lasting improvements that can deliver real choice, high quality, and access to affordable care in the individual market.** These policies include bringing down the cost of coverage, guaranteeing access to coverage for all Americans—including those with pre-existing conditions, continuous coverage incentives, effective risk pooling mechanisms, adequate and well-designed tax credits that promote affordability and State flexibility to promote innovation and choices for consumers.

AHIP and the health plans we represent look forward to working with the committee, Members of Congress on a bi-partisan basis, and the Administration as it works to improve health care for all Americans. We can achieve this by working together in a good faith and bi-partisan manner to fix critical problems while preserving the expanded coverage and enhanced affordability of coverage for millions of patients and families.

I. INTRODUCTION

Chairman Alexander, Ranking Member Murray and members of the committee, I am Marilyn Tavenner, president and CEO of America's Health Insurance Plans (AHIP). AHIP is the national association whose members provide coverage for health care and related services to millions of Americans every day. The coverage and benefits that our members offer improve and protect the health and financial security of consumers, families, businesses, communities and the Nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for every consumer.

We appreciate this opportunity to testify about the actions that are needed to stabilize the individual health insurance market. It is clear that certain parts of the Affordable Care Act (ACA) have not worked as well as intended, especially for individuals who purchase coverage on their own. This year, many consumers face fewer health plan choices and significant increases in average premiums. These increases have been driven by underlying growth in medical and prescription drug costs as well as the sunset of the transitional reinsurance program. In addition, we know how bureaucratic rules, requirements, and red tape have complicated the market. Ineffective regulations have raised costs and limited choices for consumers leaving hard-working Americans struggling to make ends meet. We have witnessed firsthand how higher costs are a barrier to access and the sustainability of the delivery system—and we are committed to working with you to fix this.

At the same time, the ACA has succeeded in expanding coverage to 20 million Americans and the percentage of Americans without health insurance has dropped to historical lows—down from 16.0 percent in 2010 to 8.6 percent in 2016.[1] These gains have been achieved through the expansion of Medicaid as well as through the coverage offered in the ACA exchange marketplace.

Our members have long supported an approach to health care that brings as many people as possible into the system. Broad coverage improves the availability and affordability of health insurance coverage options. While the challenges of providing broad access to affordable choices remain significant, we are strong believers in private-sector solutions. Health insurance plans have a proven track record of providing more affordable, high quality, efficient choices. As just one example, America's seniors and disabled persons in the Medicare Advantage and Part D programs have benefited tremendously from innovations advanced by our members. Our plans deliver better value, better services, and better results for beneficiaries and taxpayers alike.

Health insurance plans also provide coverage to 70 percent of all Medicaid beneficiaries. These plans promote better care coordination for patients with chronic conditions, improve health outcomes, and maximize efficient use of public funds.

Together we have an opportunity to deliver the same level of success in the individual market. We have an opportunity to improve the individual market for years to come, so that consumers have access to quality, affordable coverage that best meets their specific needs. I am here today to offer our recommendations for short-term solutions that can deliver long-term benefits for consumers: lower costs, more choices, and better quality care. An effective transition can deliver a strong, stable market that will help ensure public confidence, encourage them to participate in the market, and increase the health care access and financial security that the American people deserve. I will focus on two key priorities:

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[1] Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January-March 2016. *https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf*.

• **The immediate policy steps that can help deliver an effective transition and continuous coverage.**
• **The long-term principles for lasting improvements that can deliver real choice, high quality, and access to affordable care in the individual market.**

II. IMMEDIATE STEPS FOR STABILIZING THE INDIVIDUAL MARKET

As the American people think about the care and coverage they want and need, they are looking for strong signals that the individual health insurance market will remain viable this year, next year and for the duration of any transition period. There are several steps that can be taken to ensure that Americans have quality coverage options as policymakers and industry collaborate to build an improved, sustainable health care system.

First and foremost, we need to ensure that consumers have quality coverage options. This market continues to face challenges, and additional market uncertainty will likely exacerbate these challenges. But strong signals of certainty can help stabilize the market, avoiding even higher costs and fewer choices. Specifically, we recommend:

• **Continuing to provide subsidies such as the advanced premium tax credits (APTC) and cost-sharing reduction (CSR) payments in their entirety.** The absence of this funding would further deteriorate an already unstable market and hurt the millions of consumers who depend on these programs for their coverage.
• **Making full Federal reinsurance payments for 2016.** This funding is important for plans to effectively cover the needs of high-need patients, including those with chronic conditions.

While these policies are critically important, they by themselves are not sufficient to ensure a stable and workable transition for consumers and patients. This is especially the case if the requirement to have insurance or pay a tax penalty is eliminated this year without workable alternatives to promote continuous coverage and market stability. As long as current market rules that prohibit the exclusion of preexisting conditions, require guaranteed issue of insurance policies and impose community rating requirements on insurers remain in place, there is a corresponding need for incentives for people to purchase and keep continuous coverage.

Our members have strongly supported an approach to health reform that brings everyone into the system. Broad coverage can ensure the availability of affordable options. Health insurance only works when everyone is covered: those who utilize insurance to obtain quality care as well as those who are healthy but have insurance to protect them in case they get sick. Both types of consumers must be insured for coverage to remain affordable. The following policies can work to help promote a more stable and workable transition for consumers and families.

• **Using premium tax credits to encourage younger people to get coverage.** There is no question that younger adults are under-represented in the individual market. Recalibrating and reforming the way in which the current APTC subsidy is structured will encourage younger Americans to get covered. This will strengthen the risk pool, expand coverage, and avoid increasing premium costs for everyone. We propose modifying the existing tax credit formula to factor in age bands, based on a 5:1 ratio, thus adjusting the required individual contribution amounts for individuals with incomes between 100 and 400 percent of the Federal poverty level (FPL).
• **Creating incentives for people to keep their coverage through the transition.** Absent the establishment of alternative solutions to promote continuous coverage, the elimination of the tax penalties associated with the individual coverage requirement would likely create further market instability, raise costs for insurance, and result in the loss of coverage for millions of Americans. We recommend that continuous coverage requirements be communicated to enrollees this year to encourage enrollment during 2018 open enrollment and to prevent individuals from dropping their coverage. All eligible consumers should be allowed to enroll during 2018 open enrollment regardless of current coverage status without continuous coverage incentives or penalties. Beginning in the 2018 benefit year, special enrollment period (SEP) enrollees must meet continuous coverage requirements, defined as 12 months of creditable coverage. For individuals without continuous coverage, potential policy options include adopting late enrollment penalties and/or waiting periods similar to Medicare Part D.
• **Establishing transitional risk pools starting in 2017.** A federally funded, transitional risk pool program would offset some of the costs of serving patients who have the most complex health conditions and need the most care—to help promote market stability. Guidelines for how payments will be determined would be estab-

lished by the Department of Health and Human Services (HHS), and payments would be based on available funding. States could have the option of administering their own risk-pool program, subject to approval by HHS.

• **Providing relief from taxes and fees that hurt consumers.** Eliminating taxes and fees such as the health insurance tax, will reduce premiums and promote affordability. Although Congress has taken action to suspend the health insurance tax for 2017, the most recent estimates from the Congressional Budget Office (CBO) indicate that this tax, if it goes back into effect in 2018, will impose additional costs of $156 billion over the next decade (2016–26).[2] According to an analysis by Oliver Wyman, repealing the HIT would have as much as a 3-percent impact on premiums for 2018—reducing premiums by an average of $220 per year.[3]

• **Effectively verifying the eligibility of those signing up for coverage during special enrollment periods, and shortening the 3-month grace period for non-payment of premiums so that it is better aligned with State laws and regulations (e.g., 30-day period).** The market must be fair if it's to be affordable. While most consumers play by the rules, many do not—and that raises costs for everyone. Too many Americans have incentives to game the system by applying for coverage only when they need care. We must eliminate opportunities for fraud if we are to make care more affordable for everyone.

• **Protecting people who are eligible for public programs from being inappropriately steered into the commercial insurance market.** People should be enrolled in programs that are designed for them. Many people enrolled in Medicare or Medicaid receive additional protections and non-medical services that are not typically available in individual commercial coverage. Inappropriately steering people into a commercial market that does not meet their needs—through third-party payments of premiums and other mechanisms—is inappropriate and unfair to the patient, and creates further imbalance in the risk pool that leads to increased costs for everyone. Patients should have the coverage that best meets their needs, not the financial interest of providers. To that point, the recent district court decision enjoining, on procedural grounds, the new CMS rule requiring patient education of dialysis patients and notice of intent to make third party payments is a setback for patients, consumers, and the stability of the marketplace.

Throughout the discussions on short-term solutions and a stable transition, we must provide plans sufficient time to adjust products. Under current Federal rules, health plans must file individual and small group exchange products for the 2018 marketplace by May 2017. Health plans should have sufficient time to modify products and pricing to reflect any changes that policymakers may make.

III. PRINCIPLES FOR THE DEVELOPMENT OF LONG-TERM REFORMS TO THE INDIVIDUAL MARKET

As stated above, the most immediate need is to deliver an effective transition that ensures continuous coverage. We can achieve that goal by working together to develop and deliver smart solutions. The solutions outlined here will allow us to build a strong, stable individual market that serves our citizens well. As Congress and the Administration debate long-term reforms for strengthening the individual market, we have identified several key principles for ensuring a stable, competitive market that delivers real choice, high quality, and affordable care.

1. **Bringing down the cost of care and coverage.** Rising healthcare costs have been a financial burden for too many families for too long. From out of control drug prices to bureaucratic regulations to outdated payment models, we need effective solutions that bring down the cost of care for families. More market competition, better coordination, using evidence-based medicine, and prioritizing value can deliver the affordable coverage and quality care that every American deserves.

2. **Guaranteeing access to coverage for all Americans—including those with pre-existing conditions.** No individual should be denied or priced out of coverage because of their health status. However, with this as a principle, modifications to existing insurance reforms are needed—e.g., such as greater State flexibility to adopt wider age-bands to make coverage more affordable to younger adults—while retaining core insurance reform elements that guarantee access to coverage for those with pre-existing conditions. However, in order to ensure these reforms work

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[2] *https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf*.

[3] Oliver Wyman—Estimated Impact of Suspending the Health Insurance Tax from 2017–2020. December 16, 2015. *https://ahip.org/wp-content/uploads/2015/12/Oliver-Wyman-report-HIT-December-2015.pdf*.

effectively, they would need to be coupled with strong incentives for individuals to maintain continuous coverage.

3. **Promoting public policies that encourage individuals to purchase and maintain continuous coverage.** Strong, stable markets are the result of everyone having coverage—those who utilize insurance to obtain quality care and those who are healthy but have insurance to protect themselves in case they get sick. We need effective incentives to encourage consumers to get and keep insurance so coverage can be affordable for everyone.

4. **Implementing more effective risk pooling programs.** An improved and reformed risk-adjustment program and permanent Federal funding for State-based risk pool programs, such as reinsurance, will improve risk sharing and deliver more market stability.

5. **Assuring adequate and well-designed tax credits to promote access to affordable coverage.** Any new coverage options will be meaningless if consumers cannot afford them. Those who live paycheck to paycheck and struggle to make ends meet should have more generous tax credits and be protected from excessive out-of-pocket costs. Assistance that is annually indexed with medical inflation will help even further.

6. **Expanding consumer control and choice.** Consumers and patients need more control over their health care. Nearly 20 million Americans have Health Savings Accounts (HSAs) because they deliver affordable coverage and more consumer control. We need to expand HSAs so they can accumulate savings for the future, enable them to buy affordable coverage today, and encourage them to take a more active role in making decisions about their care.

7. Promoting State innovation and State flexibility. Consumers do not want one-size-fits-all approaches. That's why States should have more flexibility to develop affordable and lower premium individual market plans. States should also have additional flexibility around coverage requirements; State benchmarks; 1,332 waivers; risk-pool mechanisms; and plan designs that promote innovations in care delivery, such as value-based insurance designs. We caution, however, that State flexibility should not come at the expense of consumers and their coverage.

These principles reflect our members' priorities for long-term improvements to the individual market. As specific legislation is developed in the coming weeks and months, we will offer more detailed recommendations for strengthening the individual health insurance market and more specific guidance on legislative proposals.

IV. CONCLUSION

AHIP and the health plans we represent look forward to working with the committee, Members of Congress on a bi-partisan basis, and the Administration as it works to improve health care for all Americans. We can achieve this by working together in a good faith and bi-partisan manner to fix critical problems while preserving the expanded coverage and enhanced affordability of coverage for millions of patients and families. Thank you again for the opportunity to work with you on these important issues.

APPENDIX: CONSIDERATIONS TO SUPPORT IMPLEMENTING A BETTER, MORE EFFECTIVE MARKET

We are committed to making healthcare work for every American. As policymakers develop and debate the long-term solutions to improve the individual market, the following considerations are important factors to guide new solutions:

- Allow time to develop new products. Health plans need at least 18 months to create new products, gain approval from State regulators, and introduce them in the marketplace.
- Question whether new rules are needed. New rules will require time for draft rulemaking notices, comment periods, final rulemaking and timing for implementation.
- Understand that States may need to repeal current statutes tied to current Federal law or enact any necessary changes.
- Allow time for consumers to become informed and educated on changes and options. This includes changes to the purchasing process and any new requirements related to getting and staying covered.
- Make changes effective at the start of a new benefit year. Mid-year changes to rules and regulations may lead to more confusion in the market, creating unnecessary disruption for consumers and businesses alike.
- Engage the States as a key stakeholder. Every consumer is different—and every State is different. States should have a voice in deciding what is best for their people, and letting the people decide what is best for themselves. By granting States

more flexibility to serve their citizens, reforms can encourage innovations that deliver better quality and lower costs.

The CHAIRMAN. Thank you, Ms. Tavenner.

Ms. Trautwein, welcome.

STATEMENT OF JANET STOKES TRAUTWEIN, CEO, NATIONAL ASSOCIATION OF HEALTH UNDERWRITERS, WASHINGTON, DC

Ms. TRAUTWEIN. Good morning, Chairman Alexander, Ranking Member Murray, members of the committee.

My name is Janet Trautwein. I am the CEO of the National Association of Health Underwriters. NAHU is the leading professional association for health insurance brokers, agents, and other professionals. We represent more than 100,000 benefit specialists nationally. I do thank you for inviting me here today to talk about immediate steps to stabilize the health insurance market.

Passage of the ACA brought health insurance with no health questions asked, no pre-existing conditions clauses, and tax credits to pay for the coverage. It also allowed adult children to stay on a parent's health insurance policy until age 26.

Over the years since it was enacted, especially in the individual market, we have also seen fewer coverage and provider choices, and higher and higher premiums and cost sharing. This trajectory cannot be sustained. The individual market has become very unstable and immediate steps need to be taken to stabilize it.

I have heard recent reports that premiums have gone up because carriers made errors in estimating what their costs would be, and that rates should now be stable. I think a bigger question is why those costs were higher in the first place than they were predicted to, and whether there is a flaw in the system that we have that resulted in these higher costs?

The problem is that we have created a system that operates under a set of rules that can be broken. We see people who come in during open enrollment and drop out a few months later after they get the services they need. They maintain coverage only during their period of illness.

Special enrollments are not requiring up front documentation of a qualifying event and many of them are subjective in nature. Our members even report stories of call center staff coaching enrollees on what their reason should be for their special enrollment period.

Affordable coverage requires a stable risk pool made up of healthy and less healthy individuals on a year-round basis.

To stabilize the market, we need to address what is really wrong and we need to not make matters worse. I do not think any of us wants to go back to the times of health questions and pre-existing conditions, but in order to operate in a guaranteed issue environment, we have to be sure we do what is needed to plan for high risks and ensure that healthy people enroll and stay enrolled for coverage.

First, the reinsurance program and cost sharing subsidies scheduled to run through 2017 should be allowed to continue. These are market stabilizers and removal of either of them would increase market instability and hurt consumers who would likely be faced with either fewer or no plan choices in 2018.

Second, regardless of any other legislative efforts undertaken by Congress, some regulatory action could offer virtually immediate benefits. The most important of these are significant changes to the rules surrounding special enrollment periods and changes to the ACA tax credit grace periods.

Changes to the types of plans that must or may be offered would also help, such as not requiring standardized plan offerings and allowing flexibility for grandmothered and grandfathered plans.

Redefining the formula for the medical loss ratio could provide important relief for consumers and compensation relief for brokers who help them get covered. Easing the reporting burden for employers would ensure that employers could continue to offer coverage to employees, which also helps the individual market.

These are just a few issues that could be easily addressed by the new Administration and would increase stability in the health insurance markets. Of course, many of these needed actions cannot be done on a regulatory basis and would require bipartisan cooperation for enactment.

First, we could allow premium tax credits to be used outside of the marketplace. This would ensure that those who are eligible for a tax credit can actually use it to purchase coverage given the current scarcity of coverage options.

Since coverage outside of the marketplace is also subject to ACA regulations, it includes the same covered services and is of equal quality. Getting and keeping people covered is the best tool that we have to fight adverse selection.

Second, we could allow any person to purchase the catastrophic category of coverage regardless of their age or income status and allow premium tax credits to be used for this coverage. This provides an additional option for getting and keeping people insured.

Third, the current structure of open enrollments and special enrollments must be addressed. We recommend making the open enrollment less frequent than the current annual enrollment period and tightening special enrollment opportunities significantly to remove subjective eligibility.

Once the initial enrollment opportunity expires, we would recommend that any person enrolling with more than a 60-day break in coverage be subject to late enrollment penalties. A late enrollment penalty has been very successful in preventing adverse selection of Medicare Part B. In fact, the recommendations that we make are far less punitive than what we actually see in Part B. It allows us to preserve guaranteed issue without applying pre-existing conditions, but still discourages the person to wait until they are ill to obtain coverage. It also encourages a person not to drop coverage, so that penalties will begin anew. It would really keep people insured.

In conclusion, the issues that we have talked about, and that we elaborate on much further in our written testimony, are suggestions for immediate action to stabilize the private health insurance market.

Other recommendations are included in our written comments. For example, we recommend a new type of high risk pool that would ensure risk rather than issue coverage so that no one cov-

ered by the pool would actually pay a higher premium as a result of being covered by that pool.

We also, as our other witnesses have commented on, would like more flexible rating rules and a greater State flexibility in essential benefits packages.

I would be happy to answer any additional questions as time permits and thank you for this opportunity to be here today.

[The prepared Statement of Ms. Trautwein follows:]

PREPARED STATEMENT OF JANET STOKES TRAUTWEIN

EXECUTIVE SUMMARY

The National Association of Health Underwriters (NAHU) is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. NAHU members experience the realities of the current State of the health insurance market every day. While many people have gained coverage as a result of the ACA, our members are finding it increasingly difficult to help their clients find affordable high-quality health insurance coverage, particularly in the individual health insurance market.

The problems the individual market is experiencing are largely due to adverse selection, which occurs when people either wait until they are sick to obtain coverage or drop coverage as soon as they have been treated for their illness. This causes an imbalance in the insurance pool, with not enough healthy people in the pool to offset those in poorer health.

As lawmakers move forward with changes to the ACA, it will be important to take immediate steps to stabilize the health insurance market since some actions they might take could create problems in an already troubled market. If repeal of the ACA via budget reconciliation is pursued, the effective date of repeal should be delayed for premium tax credits to allow alternative measures to be put into effect first. Immediate regulatory action should be taken to address problematic open- and special-enrollment issues.

The most significant changes will need to be addressed by Congress on a bipartisan basis. It is possible to retain provisions of the ACA like guaranteed issue of coverage, no pre-existing conditions, coverage to age 26 and other important protections while making other significant changes that will bring down the cost of coverage and enhance coverage options. Consideration will need to be given to how we enroll people for coverage and how we encourage them to remain covered. We will need to look at creative solutions to address high-risk individuals in a way that does not discriminate against them but instead acknowledges the increased risk and mitigates it so that it does not increase costs for others who are insured. A most significant concern should remain making sure most people are covered somewhere, either through their own policy or through their employer, and that younger people understand and embrace the importance of continuous health insurance coverage. Continuous coverage can be encouraged and achieved with the right incentives.

The following pages detail our recommendations in these areas. We welcome the opportunity to work with members of this committee and others interested in enhancing market stability, health insurance choices and affordability.

Good morning. My name is Janet Trautwein and I am the CEO of the National Association of Health Underwriters. NAHU is the leading professional trade association for health insurance agents, brokers and consultants, representing more than 100,000 benefit specialists nationally. Thank you for inviting me here today to talk about immediate steps to improve the stability of health insurance markets and increasing the affordability and availability of coverage.

NAHU members work on a daily basis to help individuals, families and employers of all sizes purchase health insurance coverage. They help their clients use their coverage effectively and make sure they get the most out of the policies they have purchased. Since the passage of the Affordable Care Act, our members have spent enormous amounts of time educating their clients about the law's provisions and helping their clients comply with its regulations.

Some provisions of the Affordable Care Act have been noteworthy and helpful to people seeking health insurance coverage. They no longer have to answer health questions to qualify for coverage, they are no longer penalized if they have a pre-existing condition, and dependent children up to age 26 may now remain covered

under a parent's health insurance plan. Premium tax credits are available for the purchase of private coverage for those without a valid offer of employer-sponsored coverage to help with the cost of coverage for people from 100 percent to 400 percent of the Federal poverty level.

On the negative side, these benefits have come with a cost. Although everyone can obtain coverage regardless of health status, coverage and provider choices are fewer and premiums and cost-sharing are higher, particularly in the individual market. Even though tax credits have helped people afford coverage, the overall cost has increased so much that, for many, their share of the cost is still more than they can afford. This is the current state of the market and does not take into consideration the effect of any new changes that may be made relative to the ACA—the individual health insurance market is already unstable and immediate steps need to be taken to stabilize it.

The problems the individual market is experiencing are the result of coverage being offered on a no-questions-asked basis without adequate mechanisms to ensure that the pool of insured individuals is made up of both healthy and unhealthy individuals on a continual basis. The structure and the process related to the current system encourage individuals to wait until they are sick to obtain coverage. In fact, much of the problem in the market today stems from the fact that people are signing up for coverage during open- or special-enrollment periods, obtaining the care they believe they need and then dropping coverage. This means that the overall pool of covered individuals is sicker than average. We call this phenomenon "adverse selection."

To prevent adverse selection, the Affordable Care Act included an individual responsibility provision requiring people to continually be covered by health insurance. In addition to preventing adverse selection, the individual responsibility requirement was intended to ensure that people were continuously covered and able to obtain preventive and other care they needed on a timely basis. Unfortunately, while well-intended, the requirement did not provide an adequate incentive to maintain coverage continuously and has not been effective in preventing the adverse selection we see today.

MARKET CORRECTION

There are steps that can be taken to stabilize markets. Some should be taken immediately, while others could come into effect over the next few years. It is very important to address things in the proper order to ensure that one modification or improvement builds on the one before it. So the things that need to be done are important, but it is important not to randomly pick and choose what is done, but to methodically address stability in the correct order.

Before we outline these steps, it is important to address the item of immediate pending changes that could occur in connection with repealing some parts of the ACA via budget reconciliation. It is a given that we do not want to make changes that will cause the health insurance market to deteriorate even further. While we can begin to work on strategies to correct market problems now, some corrections will take time to come into effect for both practical and political reasons. Some key items to consider relative to reconciliation are:

1. Allow those already receiving premium tax credits and those who might become eligible for them during the next 3 years to continue to receive them until January 2020. This keeps people in coverage and works against adverse selection.
2. Retain the small business tax credit for a similar period of time to allow those who have selected coverage based on presumed receipt of a tax credit to receive it.
3. Repeal the medical loss ratio requirement—it creates the wrong incentives relative to cost-effective care and can increase overall premium levels.
4. Repeal the Excise/Cadillac Tax to provide premium relief to businesses and incentives to continue offering coverage to employees.
5. Repeal the Health Insurance Tax to provide premium relief for all fully insured health plans.
6. We strongly advise that the repeal of the reinsurance program scheduled to run through 2017 **not** be repealed even though it was a part of the prior reconciliation effort to repeal. Coverage pricing for 2017 has already factored in reinsurance. Removal would increase market instability and hurt consumers, who would likely be faced with fewer or no plan choices in 2018. Some carriers might even be forced to leave the market during 2017.
7. For the same reason, we recommend no action to remove cost-sharing subsidies prior to the effective date of repeal of the current premium tax credits. Many who are receiving these credits are young families who serve to stabilize the overall mar-

ket. They are likely to drop coverage if the cost of using their coverage is no longer affordable.

Whether or not parts of the ACA are repealed via reconciliation, action must be taken to enhance health insurance market stability. Since not all desired elements of a reformed marketplace can be achieved via reconciliation, if reconciliation successfully repeals some provisions, taking immediate action in a number of areas becomes even more imperative. Those items that can be corrected on a regulatory basis offer virtually immediate benefit for market stabilization.

IMMEDIATE REGULATORY ACTIONS TO INCREASE STABILITY OF THE INDIVIDUAL AND SMALL-EMPLOYER MARKETS

The ACA has had an enormous impact on the private health insurance marketplace, including the availability and affordability of health insurance options for individual consumers and on the ability of employers to offer affordable and comprehensive health insurance coverage to their employees. In addition to the breadth of the ACA statute itself, the resulting regulations and guidance, totaling more than 40,000 pages to date, have had a profound effect on our economy and all aspects of our national health coverage system.

NAHU has identified a number of these regulations that could immediately improve the stability of the health insurance market. We address these immediate action items here and have attached an appendix of others that may be pending or eligible for congressional review that could provide important relief for individuals and businesses purchasing health insurance. We present these recommendations for administrative and congressional action in the very near future, which we believe will significantly reduce costs and increase access for business and individual consumers of private health insurance coverage.

Some of the areas where NAHU believes that the new Administration could positively impact via thoughtful and targeted regulatory change include but are not limited to:

1. Special enrollment periods should be limited *only* to those clearly defined in the ACA and should require submission of documented proof by the 15th of the month **before** coverage will be effective.
2. The extended 90-day grace period for individuals who are receiving premium tax credits should be reduced to the same 30-day grace period for other covered individuals.
3. HIPAA Certificates of Credible coverage, which for many years documented periods of coverage and showed when coverage began and ended, were discontinued in conjunction with the ACA. Immediate restoration of those certificates would facilitate proof of dates of coverage for multiple purposes, including documentation of continuity of coverage and loss of coverage for special enrollment purposes.
4. Allow continuation of "grandmothered" policies beyond the scheduled expiration date of 2017.
5. If the medical loss ratio is not repealed via reconciliation and until it can be repealed legislatively, there should be regulatory action to redefine the formula for MLR to specifically exclude broker commissions in the same way taxes are excluded from the formula.
6. Allow a more robust form of composite rating in fully insured plans to allow ease of administration for small employers that provide coverage for employees.
7. Remove the requirement for standardized benefit plans to be offered in Marketplaces.
8. Simplify the structure and burden of IRC §§6055 and §§6056 employer reporting requirements.
9. Remove limitations on keeping grandfathered plans to allow greater changes in employee contributions toward coverage, deductibles and other benefit changes based on an annual allowable change vs. lifetime change.

LEGISLATIVE ACTION IN REGULAR ORDER

NAHU recognizes that many actions that are needed to stabilize the individual market cannot be done on a regulatory basis, nor are they likely to be eligible for inclusion in a reconciliation repeal effort. For this reason, we have developed a set of recommended actions to increase market stability.

The following recommendations are made in the order they appear to importantly address "first things first." Randomly selecting from these items when the correct stabilizing actions have not been taken will not provide the desired market outcome.

Our recommendations, in order, are:

1. While ACA tax credits are still in effect, allow premium tax credits to be used outside of the Marketplace if there are fewer than two choices offered in a State. Alternatively, this could apply in certain counties within a State. This would ensure that those who are eligible for a tax credit have a place to use the credit. It does not require the creation of new infrastructure: The Marketplace would still be used for eligibility determination and tax credits would be sent to insurance carriers as they are today. Since coverage outside of the Marketplace is currently still subject to ACA regulations, coverage outside of the Marketplace would be of equal quality to that being offered inside the Marketplace. **The purpose of this provision is to ensure continuous coverage and prevent adverse selection.**

2. Allow any person to purchase the catastrophic category of coverage regardless of age or income status. Since market stabilization has not yet been achieved and premium levels are high, many people are priced out of coverage. This provision would allow purchase of some level of affordable coverage for all. We further recommend that the current schedule of ACA tax credits be permitted to apply to this type of coverage. Right now, only those who are exempt from the individual mandate and those under 30 are allowed to purchase catastrophic coverage, and tax credits may not be used for this category of coverage. **The purpose of this provision is to create incentives and affordable access for at least a baseline of coverage. Currently, many people are unable to afford their share of the premium for Bronze-level coverage even with a tax credit. This provides an additional option for bringing people into the insurance pool rather than remaining uninsured.**

3. The current structure of open enrollments and special enrollments must be addressed. We recommend changing the current annual open enrollment to a one-time or less-frequent-than-annual open-enrollment period. We further recommend that special-enrollment opportunities be tightened significantly to remove subjective eligibility and be allowed only for lifestyle changes such as loss of coverage (documented), marriage, divorce, death of a spouse or birth or adoption of a child, and that a person be permitted a maximum 60-day break in coverage. Once the initial enrollment period opportunity expired, we recommend that any person enrolling with more than a 60-day break in coverage be subject to late enrollment penalties for 5 years with a mandatory 6-month waiting period for those who do not meet a continuous-coverage requirement. **This type of provision will be a strong incentive to maintain coverage and has worked very well in Medicare Part B. It allows the preservation of guaranteed issue without application of preexisting-conditions limitations, but discourages people from waiting until they are ill to obtain coverage. It also encourages a person not to drop coverage so that the penalties would begin anew. The 5-year period is less than the lifetime penalty imposed by Part B but enough of an incentive that it encourages continued coverage.**

4. Begin action on allowing **and providing funding** for States on **hybrid high-risk pools** (hybrid version to insure risk and not be coverage-issuing pools) to be in effect by January 1, 2019. These special high-risk pools would be available as a State option where carriers could cede risk relative to individuals who had not maintained continuous coverage, for a reasonable fee. If a carrier cedes risk for an individual, any late-enrollment penalties are paid to the pool, minus the pool fee for ceding the risk.

A number of State high-risk pools are still in existence and could be converted to this model. The advantage of this model is that the insured individual still receives coverage through a traditional insurance plan and is not turned down for coverage due to a health condition. The insurer is able to either cede the risk to the pool and forego late-enrollment penalties or retain the risk and receive late-enrollment penalties. The other market stabilizer is the mandatory waiting period (similar to Part B).

This avoids the undesirable elements of the high-risk pools of the past; individuals in the pool would have the same coverage as anyone else could have. Premiums would not be based on health status. At the same time, it allows the risk of unhealthy individuals to be offset by the pool. This means that the cost of the high-risk individuals would not be borne by everyone in the regular insured pool, and overall premiums would go down.

5. If ACA tax credits are repealed via reconciliation or some other mechanism, they will need to be replaced with another type of tax credit. NAHU feels that the greatest market stability would be obtained by making these credits income-adjusted, which would provide for a larger credit for those who most need it so that they can afford to remain continuously insured. This income adjustment does not need to replicate what is in place today, but assistance is particularly needed for those below 300 percent of FPL.

If the credit is not income-adjusted, it should, at a minimum, be refundable and advanceable and age-rated with at least five rating categories. Weighting should encourage younger individuals to enroll.

The purpose of this provision is to provide assistance to those without an offer of employer-sponsored coverage to enhance their ability to afford coverage and increase the number of people continuously covered—thereby increasing overall market stability.

6. Allow States to regulate their markets by allowing them to modify age-rating rules for their individual and small-employer markets. Create a fallback level for rating rules of 5:1 if a State does not actively elect another formula or does not elect to retain 3:1 rating. Retain prohibition of rating based on health status by issuers in the individual and small-employer markets. **The purpose of this provision is to bring more younger individuals into the insurance pool and enhance market stability.**

7. Allow States flexibility in plan design relative to coverage for an essential benefits package but retain coverage for dependents to age 26, prohibition on lifetime limits, mental health parity and prohibition on pre-existing conditions. States would elect one plan offered in the State in the small-employer market annually to indicate which covered items and services would be included in the essential benefits package for that State. This would not dictate plan design but would indicate what must be covered by a plan. This provision is a consumer protection to ensure that adequate coverage is available for all. Using benefits in the small-employer market ensures an adequate level of coverage regardless of the content or even the existence of a federally prescribed package of benefits.

The following items could also enhance market stability but only after initial stabilization occurred in the areas above:

1. Allow States that wish to increase competition to permit coverage to be offered in the individual market from carriers domiciled in other States. Coverage offered must reflect the essential benefits package in the domiciled State or the State where coverage is being offered.

2. Allow States that wish to increase competition to permit coverage to be offered through bona fide association health plans. Coverage offered must reflect the essential benefits package in the domiciled State or the State where coverage is being offered.

3. Increase flexibility for HSAs, for example, by allowing contributions equal to the out-of-pocket maximum and a limited number of office visits to be covered before the deductible each year. This would encourage more people to be covered by giving them the advantage of a HSA combined with an underlying health plan that would have more practical features important to the average individual and family.

CONCLUSION

The items discussed here are suggestions for immediate action to stabilize the private health insurance market. There are other actions that need to be addressed, particularly relating to employer-sponsored coverage and maintaining the integrity of those programs. However, NAHU sees these items as important immediate steps to ensuring the affordability and availability of private health insurance coverage for all Americans.

We appreciate the opportunity to provide these comments and would be pleased to respond to any additional questions or concerns of the committee.

Appendix A

REGULATIONS IMPACTING EMPLOYERS AND HEALTH INSURANCE CONSUMERS THAT HAVE BEEN PROPOSED BY THE OBAMA ADMINISTRATION BUT HAVE NOT BEEN FINALIZED

PROPOSED REVISION OF 5500 ANNUAL INFORMATION RETURNS AND REPORTS

The Obama administration proposed an enormous overhaul and expansion of the 5500 annual information returns and reports most employer-sponsored group benefit and retirement plans must submit annually to the Departments of Labor and Treasury. Not only would the rule require entities that currently have to comply with reporting requirements to drastically expand the amount of information they provide annually to the Federal Government, it would also expand reporting obligations to over 2 million new small businesses. The proposed reporting expansion will be extremely expensive and complicated for employers of all sizes to implement.

Furthermore, it is unclear what the Departments of Labor and Treasury will even do with the new data they plan to collect. Comments were due on this proposed rule on December 5, 2016, and it has yet to be finalized. NAHU recommends that the Trump administration rescind this proposed rule.

PREMIUM TAX CREDIT NPRM VI

On July 8, 2016, the Department of Treasury issued proposed regulations that address the treatment of cash incentives provided to employees who waive coverage under an employer's health plan. The proposed rule sets out very complex requirements for employers to follow, and places liability and requirements on employers to police the veracity of employee attestation. If finalized as proposed, employers will likely cease providing any type of compensation to employees who do not need coverage through the employer group plan. **NAHU recommends that the Trump administration rescind this proposed rule.**

INFORMATION REPORTING OF CATASTROPHIC HEALTH COVERAGE AND OTHER ISSUES UNDER SECTION 6055

On July 29, 2016, the IRS issued a proposed rule to clarify a number of technical issues related to information reporting under IRC §6055. This proposed rule does provide employers with some guidance to avoid liability for reporting errors, but the compliance date is for the 2016 plan year, which is much too soon. **NAHU urges the Trump administration to make the effective date of any TIN-solicitation requirements, processes and timelines the 2017 plan year, reported on in 2018.**

EXPATRIATE HEALTH PLANS, EXPATRIATE HEALTH PLAN ISSUERS AND QUALIFIED EXPATRIATES; EXCEPTED BENEFITS; LIFETIME AND ANNUAL LIMITS; SHORT-TERM, LIMITED-DURATION INSURANCE

On June 10, 2016, the Departments of Health and Human Services, Treasury and Labor issued a proposed rule to provide implementation guidance on the Expatriate Health Coverage Clarification Act (EHCCA), which was signed into law on December 16, 2014. The rule also imposed significant limitations on short-term, limited-duration insurance policies.

Relative to expatriate health plans, NAHU members who work with expatriates to find coverage both on the group and individual level believe that some provisions of the proposed rule, as drafted, would have a burdensome and negative effect on many expatriates, particularly those doing missionary work overseas. Furthermore, we have concerns that the language in the proposed rule will impair the ability of U.S. insurance companies to compete with foreign competitors. **NAHU urges the Trump administration to review the comments of all stakeholders with regard to the EHCCA provisions of the proposed rule and make the various suggested amendments that will ensure that American insurers will be on a level playing field with foreign competitors—and that American expatriates doing missionary work will not be penalized.**

With regard to the proposed additional standards for short-term, limited-duration health insurance policies, requiring that the coverage must be less than 3 months in duration and may not be renewed, will result in hundreds of thousands of people being shut out of needed coverage options for part of each year. Furthermore, the new proposed cap on the duration of such policies and the restriction on policy renewals raise enormous enforceability, claims-processing and fraud concerns. Also, we believe the rule, as proposed, would limit coverage choices for consumers who currently buy short-term coverage to meet a gap in their group coverage options and never intend to seek individual-market coverage. NAHU agents report that this kind of consumer represents over half of the short-term coverage marketplace today. NAHU feels that the Obama administration exceeded the bounds of its regulatory authority in this area. The primary responsibility to regulate excepted benefits rests with the States, and therefore the requirements in the proposed rules are wholly inappropriate and unnecessary. As for the proposed design restrictions for these policies, particularly with regard to fixed indemnity policies, the proposed rule will significantly alter common benefit-design options already available to employers and employees in the marketplace and negatively impact employee choice. **NAHU urges the Trump administration to rescind the excepted-benefit provisions of the proposed rule.**

HEALTH REFORM RULES THAT HAVE NOT YET BEEN ISSUED/ARE NOT BEING ENFORCED BY THE OBAMA ADMINISTRATION

AFFORDABLE CARE ACT §2716 NON-DISCRIMINATION PROVISIONS APPLICABLE TO INSURED GROUP HEALTH PLANS

The ACA required that existing IRS benefit plan non-discrimination requirements and related annual testing requirements that self-funded employer plans must abide by be extended to all employer-sponsored health benefit plans of all sizes. However, these existing requirements, which were originally designed for large-employer pension plans, cannot easily be expanded in a way that would make any sense for smaller-employer and fully insured group health benefit plans. NAHU analysis done in 2010 in anticipation of this requirement being imposed on small-group benefit plans showed that up to 80 percent of small-group benefit plans of less than 50 employees would fail the current non-discrimination testing imposed on large self-funded plans simply because too many of their employees are covered under other minimum essential coverage, such as a spouse's plan. As such, the IRS issued Notice 2011–1 in January 2011 noting that the Treasury Department and the IRS, as well as the Departments of Labor and Health and Human Services (collectively, the Departments) determined that compliance with §2716 should not be required until after regulations or other administrative guidance of general applicability has been issued under §2716. To date, no regulations have been issued to enforce compliance with this ACA requirement. **NAHU strongly urges the Trump administration to continue the Obama administration's policy of not issuing regulations to require expanded compliance with §2716 and to publicly announce its intention to not enforce compliance beyond the requirements currently in force on self-funded employer group plans.**

W–2 REPORTING FOR SMALLER PLANS

While the ACA statute requires virtually all employers that offer health insurance coverage to employees to report information about their benefits to employees via the Form W–2, in 2011 the IRS issued *Notice 2011–28*, which made the reporting optional for smaller employers that file fewer than 250 Forms W–2 for the prior calendar year until further notice. The IRS has not issued any further guidance mandating reporting for smaller employers so, for the 2016 tax year W–2 reporting cycle, which is due by January 31, 2017, only employers that issue 250 or more forms W–2 have to comply. **NAHU strongly urges the Trump administration to continue the Obama administration's policy of not issuing regulations to require expanded compliance with W–2 reporting for smaller employers.**

RECENTLY FINALIZED REGULATIONS THAT COULD BE SUBJECT TO CONGRESSIONAL REVIEW

NON-DISCRIMINATION IN HEALTH PROGRAMS AND ACTIVITIES

On May 18, 2016, the Obama administration finalized a regulation implementing the prohibition of discrimination under §1557 of the ACA. This rule imposes significant costs and mandates on health plan design that must be implemented for the 2017 plan year, which in many cases starts for employer plans on January 1, 2017. Even though not all employers should be affected by the rule, since most employer groups will get their coverage through a health insurance carrier or work with a TPA that is covered by the new rule, the construction of the health insurance policies most employer groups will be able to buy will be affected, which can be confusing to employers. **NAHU recommends that this final rule be revised so that only entities directly under the control of HHS must comply with these new requirements.**

ERISA FINES

On June 30, 2016, the Department of Labor issued an interim final rule that significantly increases various penalties under the Employee Retirement Income Security Act of 1974 (BRISA). NAHU recognizes that the amount of the civil penalties that were adjusted in many cases had never been adjusted previously, and we believe that the formula used to increase the penalties was fairly applied in the interim final rule. However, we question the need for an interim final regulation that raised fines almost immediately rather than the use of the traditional regulatory process. Further, we question why health benefit plan fines needed to be raised at this time. Given that the fines established originally to help ensure compliance with BRISA and subsequent health plan requirements have always been significant and

are still intimidating to employers in some cases over four decades later, we do not believe that the increase is needed at this time. **NAHU recommends that the Trump administration issue a final regulation setting the fine rates at their pre-August 2016 levels.**

EEOC WELLNESS PROGRAM RULE

On May 17, 2016, the Equal Employment Opportunity Commission published final rules on wellness programs under the Americans with Disabilities Act and Genetic Information Nondiscrimination Act. These rules are intended to provide clarity about how employers can operate wellness programs and not run afoul of either the ADA or GINA. These rules were proposed and finalized after the EEOC initiated three lawsuits against high-profile employers for allegedly committing ADA violations in the Administration of their wellness programs, which have so far all been decided in favor of the employers.

The finalized rules raise a number of concerns for employer-sponsored wellness plans. First, the wellness-program standards imposed by these new rules are different, and in some cases more extensive, than the pre-existing HIPAA and ACA wellness-program rules. With regard to the value of the wellness incentives, the EEOC standard actually conflicts with, and reduces, the discount standard specifically allowed by the ACA and discourages the use of wellness programs by employers. **NAHU recommends that Congress and Trump administration suspend implementation of the new EEOC wellness program rules.**

RECENTLY FINALIZED REGULATIONS WITH QUESTIONABLE STATUS

DOL FIDUCIARY RULE

The Obama administration finalized a version of the fiduciary rule on April 6, 2016, so it is likely to be outside of the scope of congressional review. However, we know there is significant interest in making changes to the rule as soon as possible and want to highlight a rarely noted but extremely problematic provision of the rule that negatively impacts health plans. In the final rule, the definition of "plan fiduciary" was expanded to cover not only service providers who assist employers and employees with individual retirement account (IRA) options, but also those who assist with Health Saving Accounts (HSAs) and Archer Medical Savings Accounts (MSAs), including providing advice on a one-time basis. NAHU is concerned that, as this provision of the rule is implemented, both employers and licensed agents and brokers will be inclined to eschew the HSA option for employees in favor of other benefit designs due to the new complexity and liability that will be associated with HSAs. **NAHU recommends that in any revision of plan fiduciary requirements, to preserve the group HSA marketplace and protect employee access to the HSA option and its many benefits, the Trump administration exclude HSAs and MSAs from the scope.**

NOTICE OF BENEFIT AND PAYMENT PARAMETERS 2018

The Obama administration released the proposed 2018 Notice of Benefit and Payment Parameters on August 31, 2016. This proposed rule contains a wide range of provisions impacting the individual and group health insurance markets and the health insurance marketplaces. The White House Office of Management and Budget is currently reviewing the rule and every indication is that the Obama administration plans to finalize it before the end of the term. As such, this regulation would certainly fall under the bounds of congressional review. If so, NAHU urges Congress and the Trump administration to review the provisions of the new rule thoroughly and seek input from stakeholders right away about what changes could be made using the rule as a vehicle to improve health insurance market competition, lessen the cost and access burdens on employers and individual health insurance market consumers, and improve the functionality of health-reform programs that may continue on at least a short-term basis.

IMMEDIATE REGULATORY ACTION TO IMPROVE MARKETPLACE OPERATION

NAHU has worked extensively to try to improve conditions in the Federal Marketplace, including participating as a vendor for broker training. While some improvements have occurred, it has been extremely frustrating for our members to try to assist their clients. Although we understand there may be little impetus for improving the Marketplace at this juncture, we list below some outstanding items that are very problematic to our members and their clients. Some of these serve to desta-

bilize the individual health insurance market so we include them here for your review.

NAHU REQUESTS TO CMS THAT HAVE NOT BEEN RESOLVED

- A dedicated portal for brokers to submit individual exchange applications and manage their clients' individual exchange coverage choices throughout the plan year and from year to year. **This has already been achieved through State-run marketplaces.**
- A customer-service channel dedicated to brokers for client-specific individual exchange issues outside of the traditional call center.
  - A broker call center number was made available this year, but only assists with password resets and questions regarding SEPs. **This has already been achieved through State-run marketplaces.**
- Amendments to the marketplace coverage application and transaction records to track and record the identifying numbers for all navigator/non-navigator assisters, call-center support personnel and certified agents who assist an enrollee. This will provide better consumer protection and inspire greater cooperation among the various types of individuals providing consumers with application and coverage assistance.
- Enhanced priority to technology efforts that will allow both agents and individual consumers access to direct-enrollment portals through health insurance issuers and web-based brokers.
- Access to participating carrier plan designs at least 2 weeks in advance of open enrollment so agents and brokers may adequately prepare to assist their clients on the first day of open enrollment.

APPLICATION IMPROVEMENTS

- Once the application has been completed, an "application review" screen should appear showing the application as it will be submitted so that the applicant can review the application in its entirety for accuracy one last time before submission.
- In its current State, in order to edit the application, the applicant must go through the entire application in order to make any changes. The ability to open the application for specific changes (address, income, birth of child) without revisiting each question would be very beneficial.
- Uploading requested documents through the application process often results in errors in uploaded documents that are not retained in the healthcare.gov system. A confirmation page or e-mail receipt to the applicant signifying that a document was successfully uploaded would largely alleviate this.
- An application identifying number (ID) is generated once an application has been successfully submitted and provided on-screen to the beneficiary. We would like to request that this application ID, or another identifier provided to the beneficiary, be used to mark all FFM communications regarding a specific beneficiary or applicant. Often, calls are made to the call center, no reference number is given and consumers are told there is no way for the call center to trace past communication with healthcare.gov. Using the application ID assigned by healthcare.gov or another unique identifier to effectively link the consumer to all of their interactions with the FFM would provide a level of accountability and a smooth and easy conduit to connect conversations over the course of multiple touches.
- Throughout a coverage year, one spouse may obtain employer-sponsored coverage. Often, this coverage is deemed "affordable," causing a married couple enrolled in a subsidized plan on the exchange to lose their subsidy. However, NAHU members have come across instances in which the couple calls to cancel the plan for the spouse who has obtained employer-sponsored coverage, but they are never asked why the spouse is canceling their plan, whether the employer-sponsored coverage is affordable or whether a change in income should be reported. This results in the remaining spouse, and possibly other family members, continuing to receive subsidized coverage, only to be faced with a large tax bill once their income and employer-sponsored coverage of one spouse is reconciled at the end of the tax year. When a couple calls to cancel the plan of a spouse, this should trigger questions in the script of the call center to inquire about employment-sponsored coverage of the spouse, and a change in income in order to prevent couples such as these to receive inaccurate subsidies that they will then have to pay back through their taxes the following year.

AGENT ACCESS

• Agents and brokers are only able to access their accounts by going in to each separate client's account. A single certified agent account would be extremely beneficial to allow agents to access a list of all of their clients' accounts, and the ability for agents to review the applications and receive communication on any status or actions required on the account would ensure that their clients' applications are complete and accurate. In addition, the system should also allow agents to log in to the CMS Enterprise Portal to enroll a new consumer, renew an existing consumer's application and re-enrollment, and make updates to a consumer's application throughout the plan year.

• There have been several instances in which agents have called healthcare.gov to act on their client's behalf only to be told that they are no longer authorized to do so even though the client has authorized the agent to act on their behalf for the allotted 365 days. There should be no change to the "Agent" or "Authorized Representatives" field unless the consumer requests such a change, and the agent of record should be on display if accessed by a call-center representative.

• Currently, all correspondence regarding an applicant is sent to the applicant via the HIM Message Center. We would like to request that agents and brokers be included on all correspondence to the applicants. Often, the agents are not alerted to a problem until after an insurance claim has been denied or coverage has been discontinued. If agents were included in the client communication from the initial message, these issues could be resolved before a denial of coverage is issued.

CONSUMER ACCESS TO AGENTS

• Earlier this year, NAHU wrote to HHS Secretary Burwell to address the troubling and increasing prevalence of insurers reducing or eliminating broker commissions during the plan year. While CMS has been very clear that it does not require or regulate broker compensation for marketplace products, CMS does stipulate that if an issuer provides broker compensation, then the issuer must provide the same level of compensation for all substantially similar QHP products whether they are sold via the exchange Marketplace or in the off-exchange Marketplace.

• NAHU also believes that CMS has the responsibility and authority under its rate-review and QHP-certification processes to ensure that issuers maintain the services that they promise via filed and approved rates throughout the plan year. Much like CMS stipulates that issuers may not change and reduce their initially specified service areas mid-plan year, we believe it is appropriate for CMS to stipulate that the services promised as part of approved rates, including access to the purchasing services and plan year, and renewal of consumer support offered by a licensed health insurance agent or broker, not be eliminated partway through a given plan year. Otherwise, consumer services that are promised as part of the approved rates of the policy may be reduced, and the consumer would see no corresponding premium reduction.

• Ultimately, consumers, especially those most at risk, are left with fewer choices and without experienced and educated insurance professionals. At a time when the market is changing and becoming more complex, this is unacceptable.

Note: We believe this adverse selection that has resulted in commission cuts, narrow provider networks, increasing out-of-pocket expense and premium increases can be corrected with many of the recommendations we are making in this document.

Attachment

BUDGETARY TREATMENT OF PROPOSALS TO REGULATE MEDICAL LOSS RATIOS

CBO has been asked to review a proposal that would require health insurers to provide rebates to enrollees to the extent that their medical loss ratios are less than 90 percent. (A medical loss ratio, or MLR, is the proportion of premium dollars that an insurer spends on health care; it is commonly calculated as the amount of claims incurred plus changes in reserves as a fraction of premiums earned.) In particular, CBO has been asked to assess whether adding such a requirement to the provisions of the Patient Protection and Affordable Care Act (PPACA) put forward by Senator Reid (as an amendment to H.R. 3590) would change its judgment as to how various types of health insurance transactions that would occur under that legislation should be reflected in the Federal budget.

In May, CBO released an issue brief entitled *The Budgetary Treatment of Proposals to Change the Nation 's Health Insurance System*. That publication identified the primary elements of proposals that CBO thought were relevant to whether pur-

chases of private health insurance should be treated as part of the Federal budget. CBO concluded (on page 4) that,

> "At its root, the key consideration is whether the proposal would be making health insurance an essentially governmental program, tightly controlled by the Federal Government with little choice available to those who offer and buy health insurance—or whether the system would provide significant flexibility in terms of the types, prices, and number of private-sector sellers of insurance available to people."

(Note: CBO estimates the budgetary impact of legislation as it is being considered by the Congress; if legislation is enacted into law, the Administration's Office of Management and Budget ultimately determines how its effects will be reflected in the Federal budget.)

The PPACA would make numerous changes to the market for health insurance, including requiring all individuals to purchase health insurance, subsidizing coverage for some individuals, and establishing standards for benefit packages. Taken together, those changes would significantly increase the Federal Government's role in that market. Nevertheless, CBO concluded that there would remain sufficient flexibility for providers of insurance and sufficient choice for purchasers of insurance that the insurance market as a whole should be considered part of the private sector. Therefore, except for certain transactions that explicitly involve the government, CBO would treat the cash-flows associated with the health insurance system (for example, premium and benefit payments) as nongovernmental.

Certain policies governing MLRs, particularly those requiring health plans whose MLR falls below a minimum level to rebate the difference to enrollees, can be a powerful regulatory tool. Insurers operating at MLRs below such a minimum would have a limited number of possible responses. They could change the way they provide health insurance, perhaps by reducing their profits or cutting back on efforts to restrain benefit costs through care management. They could choose to pay the rebates, but if they raised premiums to cover the added costs they would simply have to rebate that increment to premiums later. Alternatively, they could exit the market entirely. Such responses would reduce the types, range of prices, and number of private-sector sellers of health insurance—the very flexibilities described in CBO's issue brief.

In CBO's judgment, an important consideration in whether a specific MLR policy would cause such market effects is the fraction of health insurance issuers for whom the policy would be binding. A policy that affected a majority of issuers would be likely to substantially reduce flexibility in terms of the types, prices, and number of private sellers of health insurance. Taken together with the significant increase in the Federal Government's role in the insurance market under the PPACA, such a substantial loss in flexibility would lead CBO to conclude that the affected segments of the health insurance market should be considered part of the Federal budget. (CBO made similar judgments in its issue brief in assessing the level of required coverage that would, in combination with a mandate to purchase coverage, make the purchase of insurance essentially governmental.)

Setting a precise minimum MLR that would trigger such a determination under the PPACA is difficult, because MLRs fall along a continuum. However, CBO has identified MLRs in the principal segments of the insurance market above which a significant minority of insurers would be affected; if a minimum MLR were set at or below those levels, CBO would not consider purchases of private health insurance to be part of the Federal budget. Compared with MLRs anticipated under current law, MLRs under the PPACA would tend to be similar in the large-group market, slightly higher in the small-group market, and noticeably higher in the individual (nongroup) market—for reasons that are discussed in CBO's November 30 analysis of the effect of Senator Reid's proposal on insurance premiums. Taking those differences into account, CBO has determined that setting minimum MLRs under the PPACA at 80 percent or lower for the individual and small-group markets or at 85 percent or lower for the large-group market would *not* cause CBO to consider transactions in those markets as part of the Federal budget.

A proposal to require health insurers to provide rebates to their enrollees to the extent that their medical loss ratios are less than 90 percent would effectively force insurers to achieve a high medical loss ratio. Combining this requirement with the other provisions of the PPACA would greatly restrict flexibility related to the sale and purchase of health insurance. In CBO's view, this further expansion of the Federal Government's role in the health insurance market would make such insurance an essentially governmental program, so that all payments related to health insurance policies should be recorded as cash-flows in the Federal budget.

The CHAIRMAN. Thank you, Ms. Trautwein.

Governor Beshear, welcome.

STATEMENT OF STEVEN L. BESHEAR, GOVERNOR, COMMONWEALTH OF KENTUCKY, 2007–15; MEMBER, STITES & HARBISON, LEXINGTON, KY

Mr. BESHEAR. Thank you very much, Mr. Chairman, Ranking Member Murray, and members of this committee.

I am here today to share a perspective of an 8-year Governor whose job it was to improve the lives of the families in his State and to strengthen its economy.

You know, Kentucky is a long way from the partisan debate over the ACA here in Washington. And I would submit to you that that distance gives my words some credibility. Why? Because to me, the ACA was not, and is not, a partisan issue. Rather, it was a powerful tool that I used to attack one of Kentucky's biggest and most stubborn problems, poor health.

Five years ago, Kentuckians were among the least healthy people in this Nation. We were sicker than most. We died too early. We went bankrupt paying to treat diseases and chronic conditions.

Furthermore, there was a direct line between poor health and almost every challenge that Kentucky faced including poverty, unemployment, lags in education attainment, substance abuse, and crime. Our problem, in a nutshell, was lack of access to care.

Before the ACA, almost one out six Kentuckians had no health coverage. After hiring two outside experts, who told me that Kentucky could afford to do so, I both expanded Medicaid and created a State-operated health benefit exchange called Kynect. And for the first time in history, we made affordable health coverage available to every single person in the commonwealth.

In just over a year, we enrolled over a half a million Kentuckians in health coverage, and the positive impact on both their lives, and the State's economy, has been phenomenal.

Kentucky led the Nation in reducing the number of uninsured people, in one poll moving from 20.4 percent to 7.5 percent.

Furthermore, Kentuckians began to access care in record numbers. I am talking especially about preventive care and substance abuse treatment, both of which change lives and head off expensive and serious problems later.

It typically takes years for policy changes to be reflected in surveys of health outcomes. But in Kentucky, we are already seeing signs of better health. In addition, a study of performance data from Kentucky's first year of expanded Medicaid showed dramatic positive financial benefits in terms of jobs created, a boost to our State General Fund, and the bottom lines of our rural hospitals.

If I had time, I could overwhelm you with research, with numbers, with studies describing this impact because I have got a mountain—a mountain—of nonpartisan, objective evidence.

I could overwhelm you with hundreds of stories of Kentucky families for whom the ACA has meant better health, a saved life, or financial security.

I cannot leave my home or my office without running into somebody who tells me how they now have hope and they now have better health. They are farmers. They are entrepreneurs. They are construction workers. They are nurse's aids, cleaning staff, teach-

ing assistants, and new graduates working at a high tech startup. I could go on and on.

These are real people, not "Republicans and Democrats." They are Kentuckians. They are Americans. Kentucky's experience is just a microcosm of the country where 20 million previously uninsured people now have coverage. This is not a partisan issue. This is a people issue. And it is time to put people over politics.

The ACA is not perfect and we all know that, and there are things you can do to improve it. But you need to do it in a deliberate and a thoughtful manner. Because one thing you must not do is go backward.

In 2010 with the adoption of the ACA, this country committed to its people, they committed to make affordable health insurance a reality for every American. This is a time for measured, thoughtful steps that improve our healthcare system and continue the ACA's guarantee of affordable health coverage for all Americans because Americans deserve that guarantee.

You must not rush to repeal or put in place a plan that reduces either the number of people who are covered or the benefits they can access because this tool is working.

Newfound access to affordable care is saving lives. It is strengthening our workforce, it is improving health, and it is helping our children get off to a better start in life.

But I promise you this, if you rush to repeal, especially if you do it without a comprehensive plan that strengthens the core elements of the ACA, you will throw the market into chaos. You will hurt American families, and some of those folks are going to die. And those folks are not aliens from some distant planet. Those folks are our neighbors, our family, and our friends.

Our experience in Kentucky proves that the ACA works. We just need you to make it work better.

Thank you, Mr. Chairman.

[The prepared Statement of Mr. Beshear follows:]

PREPARED STATEMENT OF STEVEN L. BESHEAR

EXECUTIVE SUMMARY

Chairman Alexander, Ranking Member Murray and members of the committee, thank you for the opportunity to speak today about the importance of preserving and protecting the health progress that the Affordable Care Act has made possible, both in my home State of Kentucky and nationally. I would like to share with you a Governor's perspective on the critical benefits the Affordable Care Act brought to my State and many others, including significant gains in health, economic activity, and overall well-being.

For me, the ACA was never a partisan issue. Rather, it was an invaluable tool to address my State's longstanding poor health. And it worked. In a transformative way, it helped me improve the future of our State and the lives of our families. Today, having seen the objective evidence that proves that the ACA benefited not only Kentuckians, but also tens of millions of other Americans, it is vitally important that we build on that success rather than simply repeal the ACA to make a political statement and jeopardize the gains the country has begun to realize.

No one has ever claimed that the Affordable Care Act is a perfect plan. But the ACA has been undeniably successful in its core aims of increasing the number of individuals covered by insurance and in improving the quality of the coverage provided. Still, there is room for improvement. Congress should increase subsidies to improve the affordability of insurance for middle-income families, consider broadening the services that are covered with no cost-sharing to beneficiaries, take steps to address prescription drug prices, and support continued implementation and expansion of value-based payment initiatives.

The path forward is *not* to make it more difficult for people to afford insurance, nor to offer skimpier benefit plans that fail to cover people when they most need help, nor to retreat to the days when insurers could refuse to cover pre-existing conditions or cancel policies when individuals became ill. Rather, any replacement plan must be judged on how well it achieves the objectives of a universal coverage program like the ACA: will everyone have a realistic path to coverage, and will the insurance cover people both for preventive care and when they get sick? As a former Governor, I urge all Governors to reject any proposal that will leave their States with less Federal funding, reduced coverage, and less robust benefit package—and this includes a rush to repeal the ACA without a viable plan in place to help people get the care they need.

I. INTRODUCTION

Chairman Alexander, Ranking Member Murray and members of the committee, thank you for the opportunity to speak today about the importance of preserving and protecting the health progress that the Affordable Care Act has made possible, both in my home State of Kentucky and nationally. I would like to share with you a Governor's perspective on the critical benefits the Affordable Care Act brought to my State and many others, including significant gains in health, economic activity, and overall well-being.

As Governor of Kentucky, I embraced the Affordable Care Act for one simple reason: Kentucky's collective health had long been terrible, and what we'd been doing for generations wasn't working. In almost every measure of health, Kentucky ranked near the bottom or at the bottom, and had done so for a long time. The suffering was deep, and it took a toll on my State. Kentuckians were sicker than most, we died too early, and our families were going bankrupt paying to treat diseases and chronic conditions.

It is undeniable that there was and remains a direct line between poor health and almost every challenge Kentucky faces, including poverty, unemployment, lags in education attainment, substance abuse and crime. And Kentucky's poor health had devastating consequences for the State as a whole, including decreased worker productivity, depressed school attendance, a poor public image, difficulty in recruiting businesses, enormous healthcare costs, and a lower quality of life for Kentuckians. And while Kentucky was very slowly improving on some health metrics, such as smoking rates and enrollment of eligible children in health insurance, I knew that incremental progress was no longer sufficient. In the 50 years since the Medicaid program's inception, Kentucky had spent over $100 billion in public funding on health care for the most vulnerable, but remained one of the sickest States in the Nation, with one of the Nation's highest uninsured rates.

The ACA gave us an opportunity to change that using a State-based, market-driven approach, and I seized the chance. For me, the ACA was never a partisan issue. Rather, it was an invaluable tool to address my State's longstanding poor health. And it worked. In a transformative way, it helped me improve the future of our State and the lives of our families. Today, having seen the objective evidence that proves that the ACA benefited not only Kentuckians, but also tens of millions of other Americans, it is vitally important that we build on that success rather than simply repeal the ACA to make a political statement and jeopardize the gains the country has begun to realize.

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II. KENTUCKY'S AFFORDABLE CARE ACT SUCCESS

Kentucky's success in implementing the Affordable Care Act was shaped by many things, and many people, but two primary decisions strongly influenced the positive results in the Commonwealth: the expansion of Medicaid and the creation of a State-run health benefit exchange.

As Governor, my decision to expand Medicaid rested not only on the morality of providing much-needed health care to the most vulnerable Kentuckians, but also on the economic sustainability of the program. Like Governors around the country, I was concerned about the affordability of expansion. So before I committed to the Medicaid expansion, I engaged Pricewaterhouse Coopers and the University of Louisville's Urban Studies Institute to conduct an economic analysis of Medicaid expansion. The results were compelling. The study concluded that expanding Medicaid would inject $15.6 billion into Kentucky's economy over 8 years, create nearly 17,000 jobs, shield Kentucky hospitals from the impact of scheduled reductions in funding for indigent care, and create an overall positive budget impact of $802 million over 8 years. With that evidence, it became clear that Kentucky couldn't afford *not* to expand Medicaid.

The decision to create a State-run health benefit exchange was even more straightforward. Virtually every stakeholder in Kentucky—from healthcare providers to business organizations to advocates for the poor—urged me to create, manage and operate a State exchange. It would give us control, flexibility and accountability, and we could customize the experience to meet Kentuckians where they were, rather than imposing a "one-size-fits-all" model through the Federal exchange. And we did that by calling our exchange "kynect" and engaging in an extensive marketing and outreach campaign designed and led by Kentuckians. The choice to create our own exchange paid off. In the early days of the ACA, when the Federal exchange struggled, Kentucky had a virtually seamless enrollment experience that continued through subsequent enrollment years. And by creating a Kentucky "look and feel" to our exchange, Kentuckians were more easily able to overcome their personal political preferences and embrace the lifesaving potential of the ACA. Not only that, our commitment to making kynect and the ACA work allowed us to form strong partnerships with our insurance companies to create a competitive market, and during my time as Governor we saw continued increases in the choice of plans offered to consumers.

The results of Kentucky's intentional decision to seize the opportunity presented by the ACA speak for themselves. By creating kynect and implementing the Medicaid expansion, more than 500,000 low-income Kentuckians became insured, including more than 400,000 through the Medicaid program, and Kentucky experienced the sharpest decline in the Nation of residents with no health insurance. As of February 2016, Gallup polling data showed that Kentucky experienced the largest drop in its uninsured rate of any State in the country since the ACA took effect in 2014, from 20.4 percent to 7.5 percent, lower than the national rate of uninsured. This nation-leading progress was confirmed in late 2016 by U.S. Census data, which found Kentucky's uninsured rate to be 6 percent, an all-time low for Kentucky and among the lowest rates of uninsured in the country.

Moreover, according to independent research commissioned by the Foundation for a Healthy Kentucky, since the implementation of Medicaid expansion Kentucky has seen an increase in preventive care and substance abuse treatment utilization by Medicaid enrollees and a drop of 78.5 percent in uncompensated care (inpatient and outpatient charity and self-pay from rural and urban hospitals, 2013–15). The increase in substance abuse treatment is critically important in Kentucky, which has suffered more than most States from the opioid epidemic. And although improved health outcomes typically lag behind health policy changes (often years behind), a recent study found that low-income adults in Kentucky and Arkansas received more primary and preventive care, made fewer emergency room visits, and reported higher quality care and improved health compared with low-income adults in Texas, which did not expand Medicaid.[1] In short, as a result of the ACA, all evidence indicates that Kentuckians are seeing improved health and beginning to reverse decades of poor health statistics. And this evidence is consistent with the countless stories that Kentuckians, including farmers, teachers, students, entrepreneurs, and others have shared with me about how the ACA has positively changed their lives.

Beyond improvements in health, research shows that the ACA has conferred a tremendous economic benefit on Kentucky and States across the country. Numerous studies show the expansion of Medicaid is financially sustainable, and is in fact beneficial both for the State budget and the Kentucky economy as a whole. For example, after the first full year of Medicaid expansion, I retained Deloitte Consulting and the University of Louisville Urban Studies Institute to update prior projections on the economic impact of Medicaid expansion using the actual performance data from the first year of implementation. That study revealed that the economic bene-

[1] Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance. *JAMA Intern Med.* 2016;176 (10):1501–09.

fits of Medicaid expansion were even more than had originally been anticipated, concluding that Medicaid expansion had already generated 12,000 new jobs and $1.3 billion in new revenues for providers (growing to almost $3 billion in the first 18 months of expansion). In addition, the study found that Medicaid expansion was projected to have a $300 million positive impact on the State's 2016–18 biennial budget. And by 2021, Kentucky would see the creation of 40,000 new jobs, as well as a nearly $900 million positive State budget impact and a $30 billion overall economic impact. These projections included the State Medicaid funding match required beginning in 2017. So with the jobs created and revenue generated, expanded Medicaid is sustainable and is paying for itself for the foreseeable future.

The economic benefits of expansion are not unique to Kentucky—as the Robert Wood Johnson Foundation recently confirmed, considerable economic benefits of Medicaid expansion exist in every State that has expanded. In April 2016, RWJF found that the 30 States, plus Washington, DC, that expanded Medicaid in 2014 reported general fund savings and new revenue, along with both higher rates of health sector job growth and slower growth in State Medicaid spending relative to non-expansion States. In addition, RWJF found that rural hospitals in expansion States are significantly more financially stable than those in States that have not expanded. In short, there is simply no data to support partisan claims that Medicaid expansion is unsustainable. On the contrary, all the data point to the conclusion that Medicaid expansion is a great deal for Kentucky and every other State. In fact, Medicaid expansion has transcended politics in a number of States, with Republicans like Gov. John Kasich, Gov. Rick Snyder, former Gov. Jan Brewer, Gov. Brian Sandoval, and even now-Vice President Mike Pence adopting the Medicaid expansion in their States. In short, the ACA has helped States create healthier workforces, improve their economic competitiveness, stabilize rural hospitals, and improve the health of their populations.

III. THE PATH FORWARD: BUILD ON THE SUCCESS OF THE AFFORDABLE CARE ACT

No one has ever claimed that the Affordable Care Act is a perfect plan. But the ACA has been undeniably successful in its core aims of increasing the number of individuals covered by insurance and in improving the quality of the coverage provided. Today, more than 20 million previously uninsured individuals have gained health insurance. But the benefits of the ACA affect every American, not just those 20 million. Under the ACA, individuals cannot be discriminated against based on a pre-existing condition, nor can insurers impose restrictions such as annual and lifetime limits on coverage, which cutoff benefits when they are most needed.

Women are no longer charged more for health insurance as a result of their gender, and Americans have been freed from so-called "job lock," allowing them to start new businesses without fear of losing their health insurance.

Still, there is room for improvement. Congress should increase subsidies to improve the affordability of insurance for middle-income families, consider broadening the services that are covered with no cost-sharing to beneficiaries, and take steps to address prescription drug prices. And last week, more than 100 healthcare organizations signed a letter urging the Trump administration to continue the work that has begun on value-based payment initiatives. These are all sensible proposals that would, if implemented, help to stabilize the market, improve the affordability of insurance, reduce healthcare costs, and improve the quality of care.

In stark contrast to that are most of the so-called "replacement" proposals that have circulated in recent weeks and years. Governors should be exceedingly wary of block grants or other capitated funding mechanisms for the Medicaid program. As a Governor, I certainly would have enjoyed having more flexibility to administer Kentucky's Medicaid program. But flexibility becomes considerably less useful when accompanied by significant funding cuts—without adequate funding, Governors will have to use their enhanced "flexibility" to make impossible choices of which individuals to cut from the program, or which benefits to eliminate. In a State like Kentucky, which suffers from poor health on virtually every front, a Medicaid block grant would be a disaster, leading to fewer people having coverage, a reduced benefits package, and a reversal of the progress we have begun to see.

Likewise, in the Marketplace, any proposal that results in fewer people being covered, or in benefits being reduced, should be rejected. Replacing the subsidies with tax deductions or tax credits unrelated to financial need will be an enormous hardship for middle-income families, most of whom will lack the ability to prepay for health insurance and wait for reimbursement in their tax refunds the following year. Relatedly, the use of Health Savings Accounts will be meaningless for most American families, who lack the discretionary income to fund the accounts.

Similarly, proposals that would lock individuals out of the market for lengthy periods of time for failure to maintain continuous coverage are unnecessarily punitive and misunderstand the financial realities faced by most Americans. And the idea that high-risk pools are a viable mechanism to insure the sickest and most vulnerable Americans is unsupported by the evidence, for the simple reason that high-risk pools operate in a way that is fundamentally contrary to the purpose of an insurance market. High-risk pools are enormously expensive to fund and cover very few people for the dollars invested. For example, in Kentucky, the high-risk pool that existed prior to the ACA was subsidized through a combination of tobacco settlement money and an assessment on all insurance plans sold within the State.

Even so, the program covered only about 4,000 individuals at a time and only 18,000 total over its 13-year life span, premiums were too expensive for all but upper income families, and the coverage was not as robust as that offered by the ACA. Finally, the sale of insurance across State lines will eviscerate the ability of States to regulate insurers, creating a race to the bottom and destabilizing insurance markets across the country.

In short, the path forward is not a "replacement" plan that covers fewer people and provides less robust benefits. Rather, Congress should build on the progress to date by continuing and expanding measures that already have bipartisan support, such as value-based payment initiatives, and seeking solutions that improve the affordability of coverage while maintaining the robust consumer protections of the ACA. The starting place for discussion must be how to make Americans better off, not worse.

IV. CONCLUSION

It is now apparent that it will be difficult at best to move forward on the heated campaign rhetoric promising to "repeal and replace" the Affordable Care Act. Remember, polls show that most Americans want the ACA to be fixed rather than repealed. And it will not be possible to keep the most popular parts of the ACA, like the ban on discrimination based on pre-existing conditions and allowing children to remain on their parents' plans until age 26, without retaining its other core provisions. So rather than push forward with a rushed repeal, which will almost certainly destabilize the insurance markets and may well cause millions to lose coverage, we must pause to consider the consequences of a rush to action. The campaign is over, and it's time to govern.

There is a choice to be made. The ACA has saved lives, led millions to gain coverage, and benefited every American. Repeal without a broad, comprehensive replacement will cause millions to lose their insurance, and many will die. Americans value pragmatic, practical solutions that improve their lives. As Governor, I put politics aside and made decisions based solely on what was best for Kentuckians—and the evidence shows that the ACA worked in Kentucky. If Congress can adopt the same approach in reforming the Affordable Care Act, Americans will thank them.

The CHAIRMAN. Thank you, Governor and thanks to all the witnesses for your specific testimony and for coming such a distance.

We will now move to a 5-minute round of questions.

Senator Murray characterized the Republican position on the Affordable Care Act. Let me characterize it the way I think about it.

Our goal is to repair the damage caused by Obamacare where we find damage. We want to do that by moving decisions. Our goal in that sense is to give Americans more choice of insurance at a lower cost. Our method of doing that would be gradually to move decisions out of Washington and back in the hands of consumers and of States. That is what we intend to do.

I think of the work we have in the way the chart is behind me. You see Medicare at the top. We are not talking about Medicare. Put it aside.

We are talking about employer insurance where most people get their insurance; that is not in crisis right now. We are talking about Medicaid; that is a discussion to have with Governors.

Today, we are talking about the individual market which is in trouble. It is 4 percent of the people who are insured and buy on the exchanges, and 6 percent total buy on the individual market.

The 4 percent affects the 6 percent. So the question is, is it in trouble? What should we do and how soon should we do it?

My first question of you, Ms. McPeak, you are the president-elect of the State Insurance Commissioners. Is it possible to work just on the individual market?

If we were to come to some agreement here about the individual market for the next 2 or 3 years, Republicans doing some things we would not normally do, Democrats doing some things they would not normally do, and stabilize it as you have suggested. Could we do that and leave for a separate discussion what we do about Medicaid and what we do about the employer market?

Ms. MCPEAK. Absolutely. I think that you can address the individual market separately from the other categories of care, and that is where the real need is, and the timing is critical.

As mentioned by one of my colleagues, right now plans are calculating whether they want to participate for 2018 because under current——

The CHAIRMAN. Well, let me get to that and let me ask you and Ms. Tavenner that as well.

If you accept the fact that the individual market is in trouble, when do we have to act so there will be insurance available in the States in 2018? And in how many States is there trouble?

Ms. MCPEAK. Well, for individual State filings, our policy forms are due by companies in May for 2018. Rates by mid-July for approval by August by the individual States with rate review authority under current HHS guidelines.

The CHAIRMAN. But when do we have to act?

Ms. MCPEAK. I think that you need to provide some indication to plans as quickly as possible. March would be, I think, extremely helpful.

The CHAIRMAN. Ms. Tavenner, what would you say?

Ms. TAVENNER. I would say the same thing. Right now, plans are trying to price for 2018. The uncertainty around cost-sharing subsidies and the tax credits would cause them to hesitate to price because we need to understand what the funding support is going to be because that affects premiums.

The CHAIRMAN. Ms. Trautwein.

Ms. TRAUTWEIN. I would say the same thing. I think the latest would be the end of March because with carriers having these filling requirements that is after they have already made their decision. The decisions are made much earlier than the actual filing deadline.

The CHAIRMAN. It is getting clear what this would mean.

How many States, if we do not act, is it likely or possible that there would be no insurance to buy? In two-thirds of the counties in Tennessee there is only one insurer, how many counties might there be no insurer? You might have a bus ticket without a bus running through town. Ms. McPeak.

Ms. MCPEAK. I can only speak to Tennessee's experience, but we have significant concern that we may have some uncovered areas in 2018 and that number might be significant.

The CHAIRMAN. Ms. Tavenner.

Ms. TAVENNER. I think without the cost-sharing subsidy and tax credit confidence, we would lose counties and markets across the country.

The CHAIRMAN. OK, Let me stick with that in my remaining minute. You suggested two things that Republicans might not want to do, which is to continue cost-sharing for 2 or 3 years or reinsurance for 2 or 3 years in order to stabilize the market.

How essential is cost-sharing and reinsurance at least temporarily in order to avert a serious emergency in the individual market for between 11 million and 20 million Americans?

Ms. TAVENNER. I think they are critical. They are required and I think what happens——

The CHAIRMAN. In other words, you mean insurance companies would pull out of those States if they did not have either of those things?

Mr. TAVENNER. I think we would lose more insurance companies. We have already lost significant in 2017 and I think we would lose more in 2018. And those who would stay in would have to price over those hurdles, which means we would face probably somewhere in the 20 percent or greater premium increase on top of medical cost and everything else. So it is important.

The CHAIRMAN. Thank you, Ms. Tavenner. My time is up.

Senator Murray.

Senator MURRAY. Thank you, again, Mr. Chairman.

I think we all agree that improvements could be made and do it in a bipartisan way. Those are good discussions. But we cannot repair the roof while the President and Republicans are burning the house down, and that, I think, is creating a lot of the chaos and concern that most people have.

As I said, the very first action out of the box has been the budget reconciliation to allow Republicans to repeal apparently fairly soon the healthcare, leaving a lot of crisis and chaos out there. And, of course as I said, the President is issuing Executive orders, as we all know, that are also creating chaos and confusion.

As I said, President Trump signing Executive orders on his very first day in office that is going to have a devastating impact on America's health and economic security. Experts have suggested that it will create even more instability and risk in our healthcare system, causing costs to go up for all of our families, and we really do not yet know the full impact.

Without a plan, and as Ms. Tavenner has said, some of the main parts of healthcare ACA need to remain intact. If that is just repealed, then we tinker on the individual market, we are going to create considerable chaos and uncertainty.

Ms. Tavenner is it not true that insurance carriers need certainty in order to price and develop health plans that work for consumers?

Ms. TAVENNER. Absolutely. Insurers price on an 18-month interval. They are pricing now for 2018 and it takes time. They look at their previous year's results. They look at their reserves. They need certainty.

Senator MURRAY. If Congress were to just vote to repeal, and the President continues to issue Executive orders that put this in chaos

and uncertainty, and then work around trying to develop a plan for some amount of time, what happens?

Ms. TAVENNER. I think to the extent that whether we talk about repair and replace and reform, we need stability and predictability for a longer period of time.

I think we can work in a bipartisan way to transition to improvements. We just need to understand what that timeline looks like, and how long we are operating in this environment, and when we would predict a move.

Senator MURRAY. And I would add, what the consequences of those improvements are having worked on the ACA many years ago, tinkering here can cause big things happening on the other side if you do not actually really consider what you are doing. Rushing down the road to have some kind of plan of replacement in several months, could create all kinds of uncertainty in the future. I am pretty sure that is what insurance companies do not want.

Governor Beshear, are you worried about the impact the President's Executive orders will have on the market and families and, more specifically, States?

Mr. BESHEAR. Very much so, Senator. Let me just say a word about this market chaos. Obviously, the market is different in different places in the country. In Kentucky, it is fairly stable; in other States, it is stable; and in some States, it is not.

I would agree with everybody up here. The reason for that is uncertainty. Put yourself in the place of a CEO of a healthcare company. They get this huge sea change in 2010 and they have got to figure out how to handle it, and they do. They get their arms around it. And then, over the next few years, they are faced with defunding of the quarter payments, which was supposed to help them transition over the first few years as the more sick people get into the plan.

Sixty votes to repeal, but with no mention of what we are going to be replaced with, a reconciliation vote to repeal, but nothing to replace it. Of course, they are uncertain. And, of course, they are pulling back because of that. I would submit to you that tinkering around with this right now is not the answer and is not going to create the certainty they need.

What they need is a strong statement from this Congress that says,

> "Look. We are committed to every American to give coverage to them. We are going to do that. We are going to take the ACA, we are going to make some changes, but we are going to go slow, and we are going to do this the right way. And you are going to know what the replacement or the repair is going to be overall. Not just for 2 years, but forever until we have to do something else."

So that it will bring stability to the marketplace. That is the answer to this.

Senator MURRAY. What I feel like is there is a lot of instability because of the reconciliation rush to repeal because the President is issuing Executive orders that are unclear in their consequences. And to me that is creating a chaos.

Certainly the fear of what I hear people come up to me every time I even step off a plane in my home State, or go to the grocery store, or answer my phone is,

> "Well, OK. So you are going to tinker. We hear there is tinkering, but what happens to me? I have a son with diabetes who is going to be 21. Am I going to lose my ability to cover them?"

The uncertainty of that to individuals is horrific, but I am certain it is to the insurance market as well really horrific.

I appreciate all of you being here. I have more questions. Thank you.

The CHAIRMAN. Thank you, Senator Murray.

Senator Collins.

STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

What has been lost in this debate is regardless of who was elected President, we were going to have to do major repairs on the Affordable Care Act. Let me just give some examples of some of the issues.

First of all, we still have nearly 30 million Americans who are still uninsured. I looked at someone in Aroostook County, ME, my home area, who makes $12,000 a year. That is just over the poverty rate. So that person is in a bind.

When we look at how much that individual under the ACA exchange in Maine is responsible for out-of-pocket, it is $2,592. That is nearly 20 percent or about 20 percent of the income of that individual. No wonder this 44-year-old individual that is using the Silver Plan benchmark is going to opt to pay the penalty. It is a lot cheaper to pay the penalty and he is still uninsured.

We have a problem where we are seeing nationwide average premium increases of 25 percent. In Arizona, it is 116 percent. In Maine, it is 22 percent. Insurers are fleeing the marketplace. That means that there are far fewer choices for consumers; 18 out of the 23 co-ops have failed, and the other 5 are struggling.

I think we have to acknowledge up front that we have a real problem with the individual market. It is a problem that exists with the ACA that was not created by the new President or Republicans. And we need to work together across the aisle to develop solutions to address this problem.

Ms. McPeak, I know you are the incoming president of the National Association of Insurance Commissioners, NAIC. Is my analysis correct from your perspective, looking across the country?

Ms. MCPEAK. I think your description is absolutely accurate for what we are experiencing across the Nation.

Senator COLLINS. I hope we can get away from trying to make this a partisan debate.

That is what Senator Cassidy and I have done in introducing our bill to return more power to the States, to use a combination of federally funded Health Savings Accounts for low-income people to enroll individuals into a basic insurance plan that would include substance abuse, the mental health coverage, for example, that would have a high deductible plan associated with it. You could also use

your HSA for first dollar costs. And that attempts to broaden the number of people that we are insuring.

We want to see everyone have access to affordable health insurance. That is our goal.

Ms. Tavenner, do you see any potential in that kind of approach where we would give more choices to the States? They could continue with the Affordable Care Act, if that is working well for them. Or they could go to an approach where they would auto-enroll their uninsured population into a plan with Health Savings Accounts, a high deductible insurance plan, and keep the consumer protections that are in the Affordable Care Act.

Ms. TAVENNER. Senator Collins, first of all, we are in the process of reviewing the bill that you and Senator Cassidy submitted and we appreciate the work.

I would say that we definitely believe that the individual market has a long history of instability. Part of that is because people turn over so quickly in this market. We certainly would support an HSA-type approach.

We currently have over 20 million Americans who depend on HSA's, and I know there is a lot of work going on in a bipartisan way to try to make improvements in HSA policy.

These are all things we need to do. Right now, we need to understand what is going to happen for 2018. So we need some signals about stability, 2 to 3 years of stability, and then work together in a bipartisan way to say, "How do we make a long term principle work?"

Certainly the issue of the high co-paying deductible is one where if you get more insurers back in the market and you have more flexibility at the State level, competition increases, premiums get better, and consumers have choices.

Senator COLLINS. Thank you very much.

A related issue, which I do not have time to get into, are the cliffs that are in the ACA. So if you make a dollar more than 250 percent of the poverty rate, then you lose all assistance with co-pays and deductibles. A dollar more than 400 percent, you lose your assistance with premiums. And that is another real problem with the law that is creating wage loss, where people cannot accept promotions. They cannot work more hours because they are going to lose those subsidies.

The CHAIRMAN. Thank you, Senator Collins.

Senator Murphy.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you, Mr. Chairman.

I appreciate your response to Senator Kaine's letter that I was a signatory to. I would love to be able to take the politics out of this issue, but we are at a hearing entitled, "Obamacare Emergency," which does not necessarily suggest that we are taking the politics out of this issue. In part, because I think we need to look at the full scope of the individual market in this country.

I can paint you a pretty clear picture that suggests that the individual market was absolutely in emergency status before the Affordable Care Act. What the Affordable Care Act did was take that emergency patient, bring them into the emergency room, and sta-

bilize them. It does not mean that that patient is fully well today, but I think it is important to get a baseline here and to understand where that market was, where individuals were before the Affordable Care Act, and compare it to where they are now.

I just want to try to get that baseline here and I am just going to ask you all some questions. I do not expect you to know the answers to all these. If you do not know the answer, just tell me, but I think we can maybe get a baseline here, and I can help you with the numbers.

Ms. McPeak, let us just start with you. Today, nobody can be denied healthcare because of a pre-existing condition or because of medical acuity. Do you know offhand in Tennessee or nationally what the denial rate was in the individual market prior to the Affordable Care Act? I do not mean these to be got-you questions, but that is fine.

Ms. MCPEAK. I can certainly only speak to our Tennessee experience. I do not know the denial rate, but I can certainly look into that for you.

I will tell you, though, we had 18 insurers writing in our market before 2014, and we have 6 now. So we had much more affordable options for consumers.

Senator MURPHY. Here is what I know. I think the denial rate nationally was 20 percent, 1 out of every 5 were denied healthcare because of a pre-existing condition. I think the number in Tennessee was much higher. I think it was closer to 30 percent and above 30 percent in other States like Kentucky, for instance, prior to it.

Ms. Tavenner, do you know what the uninsured rate was nationally before the Affordable Care Act for individuals compared to what it is today?

Ms. TAVENNER. If I remember correctly, probably in the 15 to 16 percent range. I think the most recent estimates are about 8.6 percent.

Senator MURPHY. Yes, that is why there are some estimates for adults in particular that have the number of uninsured above 20 percent. I think for a total population, your numbers are right. In Connecticut, that number was 8 percent; today it is 4 percent.

We talk about the lack of competition in these markets. Ms. Trautwein, do you know how many of these markets today are uncompetitive? Meaning they only have one choice or no choices versus how many markets are competitive? Do you have a sense of that?

Ms. TRAUTWEIN. Well, I think we define what is competitive differently than we did in the past. Now we say competitive is you have four carriers there, four or five carriers. In the past, as Ms. McPeak said, you might have had 14 or 15.

I think we do have—based on what my members are saying, there are a large number where I only have one or two carriers across the country, not just county by county, but in some States there is only one carrier or two carriers in the entire State.

It is definitely less than it was, fewer choices for consumers, and the prices and cost sharing are a lot higher.

Senator MURPHY. Here are the numbers, 8 out of 10 Americans—8 out of 10 Americans—have access to an exchange that have more than one carrier, that have competition.

Let us just, for a baseline, compare that to the employer-based system where estimates are that up to 70 percent of Americans do not have any choice when they are in an employer system. Eighty percent of Americans in these exchange markets have competition, a much lower number have competition in their employer-based systems. And by the way, before the exchanges existed, affordable healthcare was unavailable to millions of Americans.

Last, Governor Beshear, how about approval rates? Do you have a sense of how many people that are on exchanges are satisfied with the coverage they get? Because, in the end, that is kind of what it is all about. Do people like the coverage they have or do they not like the coverage that they have?

Do you know what the satisfaction rates are?

Mr. BESHEAR. Senator, what I can tell you is I cannot go out of my house or my office every day without somebody grabbing me and thanking me for having affordable healthcare, most of the time for the first time in their lives. They are excited about it.

As I said, in the 18 months, we went from 20.4 percent uninsured to about 7.5 percent. In addition, we went from uncompensated care of about 25 percent down to less than 5 percent. Our providers love this because they are finally getting paid for what they do.

Senator MURPHY. The number nationally is 77 percent.

My last quick comment, Mr. Chairman, is I think it is really interesting that none of the people testifying today suggested repealing the Affordable Care Act and starting from scratch. I think they had really good suggestions about how to make this Act work better.

But that is not what we are doing. That is fundamentally not what the President is proposing. I think if we did have a conversation about good ideas to make this work better, we could get to a place where Republicans and Democrats would support it. But this hearing kind of exists in an alternative universe to the reconciliation process and the Executive orders of this President, which are not recommending some of the commonsense changes that this panel has.

I thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy.

Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you.

By the way, I will echo what Senator Collins said about the unaffordability of the Affordable Care Act, and I appreciate what Senator Murphy said.

On the other hand, having worked in a public hospital for the uninsured, when I look at somebody who makes $47,000 a year and having a deductible of $7,500. I can just tell you, my practice with the patients I had, why do you not make it $7 million. Because if you are making $45,000 and unless you are a very frugal person, you probably do not have $7,500 to put up front before you start

getting benefits. That is why we prefund the Health Savings Account in the Patient Freedom Act, Governor Beshear.

That said, President Trump has said that he wants everyone covered and take care of those with pre-existing conditions without mandates at a lower cost. Now, one of the debates is, do we repeal, get rid of all of the Obamacare pay-for's up front? The $48 billion that pharma said, "We will put in because universal coverage benefits our business plan," we are going to give that to pharma.

It may end up that we want to fund the proposals that we begin to tax employer-sponsored insurance. That will give us roughly 20 percent of the revenue that we would get from the pay-for's. We already have that pharma, insurance and hospitals put forward by and large.

Could you run a Medicaid expansion program with 20 percent of the revenue that you currently have?

Mr. BESHEAR. No.

Senator CASSIDY. One of the arguments that you could do so is that the legislation that gives States more flexibility in benefit design, et cetera. Would that make up for the 80 percent drop?

Mr. BESHEAR. That would be what I would call a Trojan horse. The flexibility sounds great, but when you give me about 50 percent less money or whatever, all you are doing is saying, "Governor, you are the one that has got to cut people off the rolls. You are the ones that have to reduce."

Senator CASSIDY. I spoke to a Republican Governor. He was a tad more vulgar than you.

Mr. BESHEAR. Yes.

Senator CASSIDY. Just to say that.

Ms. McPeak, again, one of the proposals is that we stop the pay-for's and we have a transition period of high-risk pools, but basically, no expansion and no subsidies for those on the exchanges that kind of withers away. On the other hand, we give healthcare plans back the flexibility on benefit design. We hope that rising economy puts more people on employer-sponsored insurance. But still, we are talking about somebody who makes $18,000 not having assistance.

What would happen, do you think, to uninsured rates should that occur?

Ms. MCPEAK. Well, the situation that you describe is exactly what we are experiencing in Tennessee. We have coverage that is available, but it is not affordable. And even if it is affordable, it is not something that they can use because of the high deductibles and cost sharing requirements.

So again, being able to provide more choices, more basic benefits to allow consumers to have a policy that they could actually afford and therefore use, would be a huge benefit to the State.

Senator CASSIDY. Ms. Tavenner, we in our plan prefund Health Savings Accounts. So we know one of the knocks on HSA's is that lower income people cannot fund them. But we prefund it and you could do some other stuff, make it not subject to the deductible, that sort of technical stuff that would make it useful and more used.

Ms. McPeak speaks about how these high deductibles are thwarting people's ability to receive care. Can you speak about the poten-

tial of prefunding the Health Savings Account, giving someone first dollar coverage, the potential that has for making primary care and other services truly accessible to someone who is otherwise low income?

Ms. TAVENNER. Thank you, Senator Cassidy.

I think that this is an area where we need to do something—if you will—State creativity, waivers, and innovation. We are uncertain exactly how this works.

I know we are not here to talk about Medicaid today, but in the Indiana model of Medicaid expansion, they prefunded HSA accounts to low-income people. We have a demo underway that we can run from and I think that is what we should do. We should be open-minded.

Senator CASSIDY. I think we have seen in Indiana that the Indiana plan has actually worked. That prefunding of those HSA's has both improved outcomes and decreased the number of E.R. visits. In a sense, the demo is quite promising.

Ms. TAVENNER. I think we need more of those experiences and evaluate those.

Senator CASSIDY. Governor Beshear and Ms. McPeak, let me ask you this. In our bill, we have a spirit of federalism, a good conservative value that maybe even our Democrats would agree to in which we give States the option.

What are the options, frankly, as stated in the ACA? "We think it is a bad decision, but Massachusetts, we love you. We will let you do it."

On the other hand, if a State chooses to go in a different way, giving you and Ms. McPeak the options to put in a system; we put in safeguards. You cannot use the money for a racetrack. It has to be used for healthcare. The patient has the power, not a State bureaucracy. I do not trust either one of you any more than I trust anybody up here. I trust the patient if she has the power. It lines up for her.

What do you think of a federalist approach allowing States to choose that which works best for their State recognizing that California is different from Alaska different from Maine different from Louisiana?

Mr. BESHEAR. I think what you end up with is backing off of a commitment this country has made to make sure that everybody has affordable healthcare.

Senator CASSIDY. Even if you end up with the same amount of funding or approximately the same?

Mr. BESHEAR. Oh, yes. Because you have got some Governors who do not believe in this, you may have some Governors who think we need to be back in the 18th century and everybody fends for themselves.

Senator CASSIDY. I will concede that one of our options is that the Governors would say, "We do not want the Federal money." So you are saying that some Governor may say, "Keep your billions. We do not want it."

Mr. BESHEAR. Yes. I think you will have Governors going all different ways and you will end up with no coverage for a lot of people.

Senator CASSIDY. Ms. McPeak.

Ms. MCPEAK. I cannot overstate how much we would appreciate it if the State of Tennessee has the ability to craft a system that works for the consumers in our State. The counties that have only one option on the exchange are the rural areas of our State, and those individuals have very unique challenges that we think we can better address at the State than at the Federal level with a one-size-fits-all solution.

Senator CASSIDY. Thank you both.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman.

President Trump and the Republicans have said they are going to repeal the Affordable Care Act within weeks, but so far, President Trump has not produced any plan for helping millions of Americans who will lose their coverage the day the repeal goes into effect.

The President also has no plan for the rules that will affect everyone else with insurance like questions about pre-existing conditions, and lifetime caps, and that sort of thing.

A lot of people in Massachusetts are stuck in limbo and they are really worried about what happens next. Will they lose coverage for mom's cancer treatment? Will they still be covered for their child's asthma medication? Will a nearby hospital or community health center be able to survive and still offer services?

On his first day in office, President Trump signed an Executive order telling Federal agencies and, I want to quote here, "To waive deferred grant exemptions from, or delay implementation of, parts of the Affordable Care Act."

Ms. Tavenner, your organization represents health insurance companies. Has the President or his Administration specified what waivers the Federal Government will issue to carry out this Executive order?

Ms. TAVENNER. Senator Warren, he has not.

Senator WARREN. He has not. Has the President or his Administration said what exemptions will be granted?

Ms. TAVENNER. He has not.

Senator WARREN. Has the President or his Administration listed what parts of the Affordable Care Act would be deferred under his Executive order?

Ms. TAVENNER. We do not have any details on the Executive order.

Senator WARREN. So he has not?

Ms. TAVENNER. Right.

Senator WARREN. s. Tavenner, if so much of what this order means is unknown, do your members face significant challenges in pricing health insurance through the exchanges or through private markets?

Ms. TAVENNER. I think this is part of what I have tried to stress in this hearing. We need predictability and we need predictability for long periods of time in order to price and price effectively.

Senator WARREN. OK.

Ms. TAVENNER. Consumers win in that environment.

Senator WARREN. Last week the President did take one action that everyone could understand. He shut down millions of dollars already budgeted to help people sign up for healthcare.

Ms. Tavenner, if fewer people signed up for coverage last week in the open enrollment period, does that help or hurt the stability of the individual market?

Ms. TAVENNER. Senator Warren, we released a statement the day that announcement was made encouraging we needed full and robust enrollment periods.

Senator WARREN. Any attempt to undermine the enrollment?

Ms. TAVENNER. Well, if you assume that the risk pool is a young and healthy risk pool, and young people act like my children, they wait until the last minute to sign up for everything. OK? So we want to keep the enrollment open and robust.

Senator WARREN. OK. I take that as it hurts the stability of the individual market and is particularly acute because of the timing on it.

Governor Beshear, you know more probably than anyone what is actually at stake in these debates because you set up an individual mandate in your State, and you expanded coverage for millions of people in Kentucky.

What does it mean to the families in Kentucky to be able to get affordable care through the ACA?

Mr. BESHEAR. Senator, as I mentioned, we were one of the least healthiest States in the country. And there was no way we were ever going to really change that. We could peck around the edges, but we did not have the resources to do that.

Then along came the ACA and it gave us the most powerful tool in our lifetimes to finally get everybody in our State healthy, and that is what the bottom line is. I do not care what you call it. I do not care what party did it. It is getting all of our people healthy because with healthy people not only is their quality of life better, but our workforce will be more productive. And we will create a lot more jobs because of it.

Senator WARREN. Thank you, Governor.

The official topic for today's hearing is "Obamacare Emergency," and I have to say, I could not agree more. President Trump is creating chaos, and sabotage, and his own special baked up emergency here.

Insurance companies cannot figure out what is going on. Families cannot figure it out. The only part that is clear is that he is trying to undermine the Affordable Care Act by getting fewer people to sign up.

This is an emergency. And I sincerely hope that the politicians who are creating this emergency will come to their senses before millions of Americans are hurt.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

Senator Scott.

STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thank you, Mr. Chairman.

I thought that I had a little more time, but I am glad that you called on me.

I have sat here and listened to my good friends who are seriously concerned about the healthcare of Americans on the left. I would imagine that those of us on the right are seriously concerned as well. I have heard a baked up emergency on the matter of the ACA from Senator Warren. And the Ranking Member talked about without Obamacare the rates would go up by 25 percent.

Ms. McPeak, can you help me understand the definition, the phrase, "stability of the individual market," what that means and how you destabilize that market? I am going to give you a couple of options and you help me understand whether these things destabilize the market.

The current definition of essential health benefits, does that destabilize the market?

Ms. MCPEAK. It has, yes, because consumers do not have a tremendous amount of options under that provision.

Senator SCOTT. The current definition, is that the product of an Executive order by Trump or was that already there before Trump became President?

Ms. MCPEAK. The definition of essential health benefits is in the original law of the Affordable Care Act.

Senator SCOTT. That would be under the previous Administration?

Ms. MCPEAK. That is correct.

Senator SCOTT. The use of special enrollments to—from my words, not yours—gain the system. Does that destabilize the market?

Ms. MCPEAK. There is no question that that destabilizes the market.

Senator SCOTT. Did that happen before or after the election?

Ms. MCPEAK. The actual definition of special enrollment periods is contained in the law, and then some Federal interpretations by the prior Administration have allowed the system that I described.

Senator SCOTT. The extended grace period, having sold insurance, giving folks 90 days to figure it out as opposed to 30 days is consistent with the reality that existed beforehand. Does that destabilize the market?

Ms. MCPEAK. Absolutely, it destabilizes the market.

Senator SCOTT. Was that before or after the election?

Ms. MCPEAK. That was in the original law of the Affordable Care Act.

Senator SCOTT. The medical loss ratio that restricts and constricts what health insurance companies can do in the marketplace. Does that destabilize the marketplace?

Ms. MCPEAK. It does destabilize the marketplace in terms of not being able to recoup any significant losses sustained by the insurers.

Senator SCOTT. Was that before or after the election?

Ms. MCPEAK. That was in the original law of the Affordable Care Act.

Senator SCOTT. OK. Now according to my insurance commissioner, the rates in South Carolina have experienced, since 2014, a rate increase of around 45 percent if you take out the subsidies that the taxpayers are paying.

With Obamacare, the situation as we know it is crumbling. Crumbling to the point where the No. 1 hospital in South Carolina is a hospital called the Medical University of South Carolina. It is a top rate hospital in the country in five adult categories and in six pediatric categories.

Unfortunately for those folks on the exchange, so to speak, they have gone from a dozen carriers down to a single carrier and almost lost the opportunity to go to the Medical University of South Carolina because the one carrier that was left in the market did not have that, MUSC the hospital, as a part of their package. Thank God for last minute negotiation. My understanding is that that negotiation also happened before the election.

The results of the current quagmire, call it Obamacare, is that yes, you may have a card that suggests you have access, but it does not guarantee you coverage. And the State of the individual market is getting worse and worse by the day. Not because of a new administration, but because of the basic foundation of Obamacare, which was somehow, someway in some world that does not exist in this universe, there is a way to get 7 million young people to buy a policy that costs more than the actual penalty for not buying the policy.

Does that stabilize the market or does that destabilize the market?

Ms. MCPEAK. That destabilizes the market. That encourages individuals that only need to access healthcare to actually pay that additional premium amount over the penalty.

Senator SCOTT. My last question, because my time is running out. This was such a quick time with you, we will have to do this again.

Looking for ways to actually create access to healthcare, and as our Governor from Kentucky has suggested in his State, it got down to about 7 percent of those folks in the State perhaps uninsured. I just checked the numbers; around 695,000 of the 4.2 million people in Kentucky today do not have health insurance.

If we were looking for ways to drive down the uninsured market in the individual market specifically, how do we do that?

Ms. MCPEAK. I think we have to offer products that are affordable to the people that are currently uninsured, and that might be a very basic set of benefits, not something as rich as the defined essential health benefits that exist today.

Senator SCOTT. Is it then safe to say that the essential health benefits, be as prescriptive as they are, eliminates competition and makes it more expensive for the average person in the average market in the average State to find affordable coverage?

Ms. MCPEAK. Yes, because it completely restricts the ability of insurers to compete on the benefits that they offer. It limits the areas that an insurer can compete with other insurers on, and therefore it limits the participation in the market.

Senator SCOTT. The house may be on fire, but it was on fire before we got here.

Thank you.

The CHAIRMAN. Thank you, Senator Scott.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman.

Many of my colleagues on the other side of the aisle charge that the Affordable Care Act—and I think the Senator from South Carolina is basically saying—is failing, collapsing, that the market is in a death spiral.

Senator SCOTT. Yes.

Senator FRANKEN. And, in fact, we are here today for a hearing entitled "Obamacare Emergency." For them, the only solution is immediate and swift repeal. Let us be clear. This is just wrong.

News reports indicate that enrollment is surging. The law's popularity has jumped and in the most recent poll, more Americans approve of the ACA than disapprove. Ratings, even S&P Global Ratings reported that markets were stabilizing barring an additional uncertainty.

Since the ACA passed, 20 million Americans gained health insurance coverage, young adults can stay on their parents' plan, lifetime and annual caps were eliminated, people received free preventive services, and health insurers can no longer deny coverage or charge people more because they have a pre-existing condition.

We bent the cost curve. We improved healthcare quality. We improved value and we extended the life of the Medicare trust fund by 11 years. These changes affect not just those people on the individual market, they affect everyone. Everyone on those markets have these benefits.

Yes, premiums have gone up, but so too have the tax credits, which means the majority of families enrolling in individual coverage still have access to high quality affordable health insurance.

Let us talk for a minute about why these premiums went up so quickly over the past 2 years and why some insurers have left the exchanges. But who should Americans blame for this? Well, I would say Republicans.

You see, the Affordable Care Act was designed to keep insurance companies in the game. The law included several programs including the Risk Corridor Program to stabilize the individual market and make sure that even though insurance companies could not refuse coverage to sick people, they would not lose money on them either.

In the 2015 budget bill, and last minute in a bill that had to be passed, Republicans unexpectedly inserted a provision that crippled the Risk Corridor Program. Suddenly, without warning, insurance companies that had to insure sick people were no longer protected from losses if they got a higher risk pool. That drove Blue Cross Blue Shield in Minnesota out just as the Chairman described in Tennessee.

Ms. Tavenner, as someone who represents health insurance companies, did this change cause any insurance companies to lose money? Did any plans enter the market after incurring these losses?

Ms. TAVENNER. Senator Franken, when the Risk Corridor funding issue became known, there were plans that were dependent on that money and had significant losses. Some did exit the market. Certainly the story of the co-ops has been pretty public, but there

were also health insurance plans that could not survive without that support.

Senator FRANKEN. Right. As a result of this change, health insurers receive slightly more than 12 percent of the funding they were due to cover market losses. And as I said, Minnesota Blue Cross Blue Shield plan left the individual market and I suspect that is why the markets the Chairman enumerated, they lost Blue Cross Blue Shield.

Would you, Ms. Tavenner, say that these losses caused insurance companies to increase or decrease their premiums in 2016?

Ms. TAVENNER. Without——

Senator FRANKEN. And then this other, the competition dropping out as a result?

Ms. TAVENNER. Right. The Risk Corridor Program was temporary funding for 2014, 2015, and 2016. It certainly started to affect 2016 once the information was known. 2017 and beyond, they have priced assuming there is no Risk Corridor funding, and it is hard to go back and re-price for past losses. How it did affect premiums is in your access to risk capital or reserves required at the State level, so it added upward pressure on premiums.

Senator FRANKEN. I know I am out of time, but let me just wrap up. Republicans jammed through a provision that undercut the Risk Corridor Program, led to huge financial losses for insurers and market exits, which drove up premiums. This is not in a death spiral. In Minnesota, 3 percent more enrolled this year. S&P is saying the price on this was a 1-year spike.

My colleagues on the other side took away this Risk Corridor and as a result, we saw insurance companies like Blue Cross Blue Shield drop out of the market in Tennessee and in Minnesota driving up prices because all I keep hearing about is the counties that have just one choice. Well, they had more choices if it were not for the Republican party of the United States of America. I got a smile from Senator Collins.

Senator COLLINS. It was not a smile of agreement, just so we are clear on that.

[Laughter.]

The CHAIRMAN. Senator Young.

Senator FRANKEN. It was a sardonic smile.

The CHAIRMAN. Senator Young.

STATEMENT OF SENATOR YOUNG

Senator YOUNG. Well, the title of this hearing "Obamacare Emergency," I do believe we have an emergency on our hands, whether we happen to be a Republican or Democrat. I was not here when we had, blessedly, the debate about and the vote on the Affordable Care Act, but I want to be part of the solution. One would hope this could be a bipartisan solution where perhaps we retain some of the features of current healthcare law that are working for Americans and look to replace it.

However we characterize that, however you wish to characterize that among one's Democrat base or Republican base is every member's prerogative. But I know it is the hope of the Chairman and many others, many other members present here, that we can solicit the best ideas, come up with a good work product.

The reality is the ACA, as it existed just days ago, will no longer exist. And I now reveal my opinion and bias; I think that is a good thing.

I want to hone in on one particular area and it pertains to unaffordable coverage, something that is impacting people across this country.

According to a new survey from Bankrate.com, 6 out of 10 Americans do not have enough savings to pay for a $500 or $1,000 emergency. Now the ACA exacerbates this problem, to my mind, by capping how much individuals can save tax free for their healthcare costs.

Ms. Tavenner, you spoke favorably, at least generally, about Health Savings Accounts and some of the incentives they create and disincentives will be part of the solution here. They are part of the Cassidy-Collins Plan, which I am still studying, but the prefunded HSA, I think, is an intelligent part of the overall solution here.

Most popular plans in the marketplace in my home State of Indiana now require Hoosier families to pay, on average, between $6,400 and $11,600 in out-of-pocket deductibles before their coverage kicks in.

Ms. Trautwein, a couple of quick questions for you. What is the first thing that we, as a congress, should do to help address this dynamic of unaffordable coverage; the first thing?

Ms. TRAUTWEIN. Well, we are very much in favor of Health Savings Accounts and things like that. But I have to tell you, I do not think that is the first thing that you do.

Senator YOUNG. OK.

Ms. TRAUTWEIN. The first thing you do is you have to figure out why is that cost sharing so high? Why? There is a reason for that. And it was actually an attempt to make coverage more affordable, so that people could buy anything, so if they could afford the basic level of premiums.

So why are those premiums so high? It is because of the adverse selection we have in the individual market. Before we do anything with HSA's, which are a marvelous idea, we have got to look at why those premiums have risen like that. Why people do not continuously stay covered. Why they come in and out, and why the special enrollments are working like that.

We really have to figure out this whole enrollment process, no matter what else we do. And we have to understand that the individual market at any time always required some additional backing because it does not operate like other markets. There is no employer contribution. People pay for it themselves. And so the structure and the function of the tax credits are really important.

We need to straighten out a few things first before we move into other aspects like that. That would be really helpful for people with that cost sharing because it might as well be a million dollars to them if it is a deductible that is that high for some people.

Senator YOUNG. Ms. Tavenner, your thoughts on this. Do you agree with that assessment or perhaps you would start somewhere else?

Ms. TAVENNER. No, I absolutely agree. I agree that HSA's are important. I agree that changing co-pays and deductibles are important.

But first, we have some basic rescue work that has to go on, and that has to do with, how do we stabilize special enrollment periods? How do we handle grace periods? We get some kind of finality to keep people in as long as possible. We need to talk about if we want lower premiums, we need to continue the cost-sharing subsidies. We need to continue the tax subsidies or tax credits.

There are other issues. There are health insurance taxes, medical cost trends, I can go on and on.

I think that is our whole point today. I think the four of us would agree. We need predictability. We need long-term predictability, not what is going to happen for 6 months.

Senator YOUNG. I believe that every member of this committee aims to provide that predictability. There is disagreement about whether or not some measure of short-term disruption needed to occur in order to change what everyone agrees was a suboptimal system.

I would hope we could work together to provide more predictability. I hear a lot of commonalities between the testimony regardless of my suspicions about political affiliation, and the merits and demerits of the previous approach. I really hope that we continue to work on this effort and with a bipartisan spirit in mind.

With that, I yield back.

The CHAIRMAN. Thank you, Senator Young.

Senator Kaine.

STATEMENT OF SENATOR KAINE

Senator KAINE. Thank you, Mr. Chair and thank you to the witnesses.

It is rare that I actually go to a hearing and I then take all the testimony back to my office because there are so many good ideas in it that I want to digest them further. I appreciate that.

Mr. Chair, I appreciate your words at the opening about the letter that 13 of us on the Democratic side sent to you, Senator Hatch, and Leader McConnell at the start of the session. I think I can speak for everyone on the Democratic side, none of us believe any law is perfect. Certainly not the ACA, and we would love to work on improvements, and many of us have ideas or have introduced legislation to make improvements to the ACA or to our health system generally.

I actually think hearings like this, and we can use more of them, will be more likely to make improvements if we spend more time listening to stakeholders than listening to each other, listening to stakeholders, patients, providers kind of gets out of the Democratic versus Republican tug of war. Hearings like this are very helpful.

The letter that you sent last night in response to ours was a positive one, encouraging us to work together. And just a quote from your letter, "To stabilize the individual insurance market." There are other issues other than the individual insurance market, but I like the word stabilize.

I think stabilize is a very good word and I think we should work to stabilize our healthcare system, but I think stabilization is com-

pletely contrary toward repeal with no replacement and rushing. I do not think you can stabilize and rush. I do not think you can stabilize and repeal with no known next chapter.

Congressman Price was here before us a week or so ago in his confirmation hearing and he said, "We need to bring the temperature down." I agree with that too. We need to bring the temperature down and listen to each other, but that is also contrary to rushing. And I think it is also contrary to repealing with no known next chapter.

For the panel, the title of this hearing today is "Obamacare Emergency." Would it be an emergency to fully repeal the Affordable Care Act with no replacement? I would like to have any of you answer that question.

Mr. BESHEAR. It would not be an emergency. It would be a disaster.

Senator KAINE. Does anybody disagree that it would be an emergency if we repeal the Affordable Care Act with no replacement?

The estimates are that 30 million people would lose their health insurance, that millions more would lose other protections. A full repeal would increase the deficit by $350 billion over 10 years and it would inject uncertainty into the largest sector of the American economy; healthcare is one-sixth of the American economy.

I hope we can all agree, stakeholders I hope we can all agree that a repeal without a replacement would be an emergency or worse. Does anybody want to challenge me on that? OK. Let me ask you another one.

If we agree that a repeal with no replacement would be an emergency or worse, then what we are talking about is replacement, repair, reform, fix, improve. Again, I am like Senator Young. I do not care about the word. I just want to get this right for people.

Whatever we call what we are doing, replace or repair, do you agree with me that doing it in a way that is careful, considerate, and open is better than doing it in a way that is secret, rushed, and careless? Is that generally agreeable?

Does anybody think that secret, rushed, and careless is a better way to approach this challenge than open, considerate, and careful?

In fact, some of the testimony, I would read the testimony of Ms. McPeak,

> "Please continue to be as open and transparent in this process as possible. Markets need clarity and opportunities like this hearing so they can help provide that clarity so that we do not see carriers exiting markets in bulk when they do not have an idea about what to expect in terms of regulation over the next several years."

Ms. Tavenner, your testimony,

> "First and foremost, we need to ensure that consumers have quality coverage options as this market continues to face challenges and additional market uncertainty will likely exacerbate these challenges. But strong signals of certainty can help stabilize the market."

Careful, considerate, and open—open and transparent is the way we ought to be doing this. The last thing I will ask you is, Were we in an emergency before the Affordable Care Act was passed?

Forty-five million people did not have insurance. Premiums were going up in a dramatic way, hundreds of thousands going bankrupt every year because of medical bills.

Do any of you challenge where we were pre-ACA would meet the definition, a fair definition, of emergency?

I do not have any other questions, Mr. Chair. Thanks.

The CHAIRMAN. Thank you, Senator Kaine.

Senator Murkowski.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

Mr. Chairman, I want to thank you for conducting, not only this hearing this morning, but the informational sessions that we have had where we have gained information from various States' insurance commissioners. Because I believe you are proceeding in a manner that is very open, very careful, and really very considerate just as Senator Kaine has asked be done. I appreciate that a great deal.

I appreciate the fact that you are trying to focus us as policymakers on the area that is really troubled right now, and this is the individual market, and to look specifically to how we can provide for the stabilization.

Senator Murphy asked or raised the issue of we need to know the baseline. Well, I can tell you in my State, in Alaska, before the ACA was passed, the information that we got just this morning from our State's Insurance Commissioner—who is here with us this morning at the hearing, as well as our Commissioner of Commerce and Economic Development—before the ACA we had four carriers in the State. That is not a lot, but we had four. Now we are down to one and the real concern is whether we will even have one next year in 2018.

Before the ACA, the average cost for an individual for their plan was $251 a month and now with implementation of the ACA, and the fact that we do not have competition and that we are a high cost State, it is $800 a month for an individual.

If you are a family of four, Alaskans are suffering and the decisions that they are making, they have to make a decision as to whether they pay the mortgage or whether they cover their families. This is a situation that is not sustainable. So the focus is on what we can do to provide some level of stability.

I appreciate the very concrete suggestions that have been laid down here this morning, whether it is the grace periods, the special enrollment, talking about essential health benefits flexibility. There has been some discussion about the age bands, but drilling down into some of these things that could make a difference for families like mine in Alaska.

We are talking in our State about the need for an Alaska Plan, something that is very Alaska-specific. Ms. McPeak, you kind of talked about the flexibility to have a Tennessee Plan. Whether it is the Cassidy-Collins and the direction that they are taking to be able to recognize that flexibility is clearly what we need given the situations that we have in each of our States.

In Alaska right now, we are doing some innovation that is helping to stabilize. We have worked on some major reforms through

the State in the creation of a reinsurance program for high-cost, high-risk individuals. It has helped. It still leaves us with high costs, but it has helped keep the premiums from skyrocketing and we have moved forward with a Section 1332 Innovation Waiver.

Mr. Chairman, if I may, I would like to submit for the record the letter from our State's Director of Insurance to you outlining the situation in Alaska, and some of the innovations that we have seen, if I may.

[The information referred to was not available at press time.]

The CHAIRMAN. Yes, it will be included.

Senator MURKOWSKI. A question to you, Ms. McPeak, and this will relate to the State Innovation Waiver, the 1332.

We have worked through the process. It has been difficult. It has been costly. It was about $200,000 just to submit it. Can you speak as a member of the NAIC to what you have heard from various States that might be pursuing these types of waivers, what the challenges are?

We look at this as one way to gain flexibility and it has not been raised in this discussion yet this morning. How we can either improve or evolve this process so that it allows the States the flexibility that they would need.

Ms. MCPEAK. Thank you, Senator.

The information that I receive from my colleagues across the Nation in terms of insurance commissioners is that the Innovation Waivers might be helpful, but the time and the expense associated with completing the application and shepherding it through the process is only one that is undertaken when there are really no other options available in the State as Alaska has experienced.

Senator MURKOWSKI. Which is our situation.

Ms. MCPEAK. Absolutely. I think other States might be interested in pursuing an Innovation Waiver if the process could be simplified or streamlined in any regard.

Senator MURKOWSKI. Would you be in a position to help us divine what we could do to make it more efficient, to make it a more simplified process? We are pioneering with the Alaska 1332 Waiver, but we recognize that we have to make this more user friendly.

Ms. MCPEAK. Our members are absolutely willing to work with you to provide some recommendations on streamlining that process and improving the system.

Senator MURKOWSKI. Thank you.

And Mr. Chairman, it came up in discussion this morning that these State Commissioners, again, are an amazing resource and can help us identify those areas that we might be able to move more readily to provide this stabilization in the short term through the administrative rather than the more lengthy legislative process that we engage in here.

I would certainly encourage recommendations from our States' commissioners as to how, from an administrative perspective, we can be the rescue team that we need to be more readily.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman.

I want to thank our witnesses for being here to share your expertise. But I have to share with you that it is troubling to me that at our first hearing on President Trump's and the Republican plan to take away coverage for millions of Americans that our committee is not going to hear from somebody who would be directly and immediately impacted by repeal of the Affordable Care Act.

The stakes are really too high for so many of the people that I represent in Wisconsin and elsewhere who will see coverage and protections disappear. Let me just share one with the committee and the panel.

I recently heard from Sydney in Sheboygan, WI. She recently started her own small business. She calculated that without the Affordable Care Act premium tax credits and other cost-sharing mechanisms that her premiums would triple and her deductible would more than double.

She writes, "I and many other small business owners rely on the Affordable Care Act." She wrote, "By supporting the ACA, you also support America's many small business owners."

The ACA also provides people like Sydney cost sharing subsidies that help reduce their deductibles and out-of-pocket costs. These have specifically been targeted by Republicans who want to immediately stop this assistance that would impact more than 120,000 people in the State of Wisconsin all while they are trying to rush to really take apart our healthcare system with no plan in place to replace it.

I recently sent a letter calling on President Trump to avoid further damage from his health plan by protecting access to the cost-sharing subsidy assistance.

Ms. Tavenner, I am hoping you can explain what is at stake for roughly over 6 million Americans who receive the cost-sharing assistance under the ACA if the Trump administration were to halt those payments?

Ms. TAVENNER. Thank you, Senator Baldwin.

The most recent estimate is about 65 percent of those individuals on the exchange who receive tax credits also receive the cost-sharing subsidies. So they are vital. These are low-income people—as you know, less than 250 percent of the poverty level. We have said that it is, when we talk about immediate stability, that is critical. Without that, then obviously individuals——

First of all, insurers may not stay in the market because they understand these people have to have this assistance.

Second, they would have to move premiums to price above that, which there was a recent study by Covered California that said it is about a 15 percent premium increase. So you take the affordability issue and you make it worse.

If I do not leave with any message today, I hope I leave the message of, this is something that we need to resolve in the next 30 days. It is very important to the stability of the individual market.

Senator BALDWIN. Thank you.

I want to quickly, in my minute left, touch on another topic I have heard some discussion of, the essential benefit package.

Governor Beshear, I know that Kentucky, like my home State of Wisconsin and many other States that we represent, has been hit hard by the opioid and heroin epidemic. We have made some bipartisan progress on this issue in the Congress in recent months. But President Trump and Republicans are working to undo this progress and perhaps worsen the epidemic in our communities by repealing the Affordable Care Act.

What would happen to States like your State of Kentucky, my State of Wisconsin, struggling with this opioid abuse and substance abuse disorders if Republicans really do take away the guaranteed coverage of essential health benefits like substance abuse treatment?

Mr. BESHEAR. Senator, do you want to talk about a real emergency? Opioid abuse in this country is one of the biggest issues that we have got to face and we have got to face it quickly. It is all over Kentucky. It is all over everyplace.

We went hard at first, prescription drug abuse while I was Governor because that was sort of the drug of the moment—prescription drugs. We ran the pill mills out of the State. We did a lot of things that got that under control, but it is kind of like the game of whack-a-mole. You know, you knock that down and some other drug pops up. And now it is heroin. It is Fentanyl.

We tried to do some legislation on that, but you cannot incarcerate yourself out of an opioid emergency. You have to treat your way out of it. We have got to provide more treatment so that our people can get back on their feet, get back into society, become productive members of society again.

The essential benefit of substance abuse treatment in the Affordable Care Act has been monumental in helping to do that. You take that away and we have got an emergency now. You can almost write off half the country if we do not start treating our people and getting them back into society.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Hassan.

STATEMENT OF SENATOR HASSAN

Senator HASSAN. Thank you, Mr. Chair and Ranking Member, and thank you to all of our panelists for being here today.

Governor Beshear, I am sure that you have seen firsthand, just as I did as Governor of New Hampshire, all the benefits that the ACA led to in your State. I reviewed your testimony and I understand that that is what you talked about in it.

From one Governor to another, I can tell you how much the ACA has helped my State of New Hampshire. Approximately 55,000 Granite Staters have coverage under the State's bipartisan Medicaid expansion and 49,000 have private coverage through the exchange.

I truly worry that Trumpcare and efforts to sabotage the ACA, I worry about how those changes will strip access to care for tens of thousands of Granite Staters and how it will increase costs.

I also worry about how efforts to repeal the law will impact States' bottom lines including efforts to repeal Medicaid expansion and the efforts to turn the Medicaid program into some sort of a block grant program. That would leave people uninsured. It would

slash Federal funding and shift costs to States putting pressure on what, in most States, are already very strained budgets.

I am not the only Governor who has expressed this concern. Press reports show that Republican Governors share my concerns. According to Politico, at least 5 of the 16 Republican Governors of States that took Federal money to expand Medicaid are advocating to keep it or they are warning Republican leaders of the disastrous consequences if the law is repealed without a replacement that keeps millions of people covered.

Governor, your State expanded Medicaid. As I understand it, an estimated 151,000 Kentuckians have health insurance today because Kentucky expanded Medicaid. In all, your State has more than 1 million people on the Medicaid program.

What would it mean for a State budget like Kentucky's if some of us here in Washington get their way and the Republicans repeal Medicaid expansion and turn Medicaid into a block grant?

Mr. BESHEAR. Well, first of all, turn it into a block grant and you can pretty much write off a whole lot of people in your State in terms of getting coverage because it is a Trojan horse.

It sounds great, "Oh, flexibility." As you know, having been a former Governor, your eyes light up when you hear the word flexibility. But then when you open that horse up and see,

> "Oh, I am getting half the money to do the program that was going to be done and it is going to be up to me to cut people off and to cut benefits."

It looks like Congress is pulling the Pontius Pilate routine and washing their hands of all of our folks and then blaming it on me. That is a nonstarter and that would be a disaster.

Our State, obviously, has benefited tremendously by expanding Medicaid and by the Affordable Care Act. But not only in quality of life and quality of health, economically it has been a boon to us. This is not Steve Beshear talking. This is PricewaterhouseCoopers.

Senator HASSAN. Right.

Mr. BESHEAR. This is Deloitte Consulting who did studies and PricewaterhouseCoopers before I expanded Medicaid. I asked them, I said, "You have got to tell me what this is going to do to me or for me, because I have a budget to manage."

Senator HASSAN. Right.

Mr. BESHEAR. They came back in, in 6 months and said, "Governor, you cannot afford not to do this because it is going to be so good for your State."

Senator HASSAN. Right.

Mr. BESHEAR. Deloitte came in a year later and looked at actual data. We had already created 12,000 new jobs. You are going to create 40,000 overall. It is going to have a $900 million positive impact on the State budget over 8 years.

It is a no-brainer. It is a no-brainer both from the health of your people and from the budget that you have got to operate.

Senator HASSAN. Well, thank you. And thank you, again, for being here and for your work for the people of Kentucky.

Ms. Tavenner, I also had a question. It is clear that those who want to do away with the ACA have not been able to come up with a plan to replace it as of now. They have laid out a roadmap, though, of how to repeal it.

In 2015, Republicans passed the Budget Reconciliation bill that repealed major parts of the ACA. It was vetoed by President Obama. Had it been signed into law, it would have had devastating impacts. It would have made the risk pools sicker. It would have stripped away premium subsidies, which help people afford their monthly premiums. In New Hampshire, more than 31,000 people get these subsidies, averaging $261 a month.

If Republicans were to pass a bill similar to the one they passed in 2015 this year, will not premiums on the individual market skyrocket?

Ms. TAVENNER. First of all, I think that what we would want to see is that we would work with, you could call it, repeal-replace. These two need to travel together.

Senator HASSAN. Right.

Ms. TAVENNER. We need to understand as the changes are made what is the length of time for the changes? And there are some improvements that could be made.

Earlier when we were talking about Executive orders and things such as special enrollment periods could be handled today, grace periods could be handled today, and have immediate benefit in terms of some relief of premium uncertainty and keeping people in the market and not using it as just-in-time.

The devil is going to be in the details. The message that we are sending today is we want to work with you to have a logical way to move to make improvements in the individual market and that has been challenged. It is undergoing some unique challenges today. There are low-income people who cannot pay co-pays and deductibles. So there are improvements to be made all around. That is what we want to see.

Senator HASSAN. Well, and certainly, I think there is not anybody up here who does not agree that there are flaws that we need to work on in the ACA. But what we are trying to point out is that just a straight out repeal destabilizes the market.

I just know that before the ACA came along, when I entered the State Senate in New Hampshire, we were seeing insurance premiums skyrocket and we were seeing insurers leave our State. Since we have passed the ACA and passed bipartisan Medicaid expansion, because we did it in a market-based way, we have attracted new insurers into our markets and more people are covered.

I appreciate your willingness to work. My biggest concern is that the current plan from the majority seems to be just to repeal without a replace plan.

Thank you.

The CHAIRMAN. Thank you, Senator Hassan.

Senator CASEY.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you.

I want to thank you and the Ranking Member for having this hearing. By the way, I would agree with the last statement, and several others, that Senator Hassan made.

This idea of repealing the ACA, better known as the longer and more accurate title of the bill, the Patient Protection and Afford-

able Care Act. I will talk about that patient protection part in a moment, but this idea of doing this and everything is just going to be tranquil and without impact for peoples' lives is a big lie if someone is professing that. I am not sure anyone is.

It leads to, at least in my judgment, chaos, uncertainty, and real adverse consequences for a lot of people. And really risk, in some cases risk to human life, but even if it does not rise to the level of the kind of chaos that will lead to someone losing their life, there are going to be a lot of Americans who will be in jeopardy.

We are grateful that you are here to give us testimony, and expertise, and insight that we may not have otherwise.

I wanted to start with a chart that the Chairman put up earlier in the hearing today, and he had on display before, and I appreciate the fact that he did because it reminded us of some of the big numbers here.

One of the health insurance coverage categories that he had on the board that was up a little while ago was 178 million Americans get employer-sponsored coverage, but according to that chart, about 61 percent of the American people.

That is who that patient protection part comes in. If those 178 million Americans did not have the kind of protection that they have now, in fact, they had almost no protections.

An insurance company could say to you,

> "I know you are paying your premiums. I know you have had insurance for years. I know you care about your kids. But we can tell you that your kids do not get coverage because we are the insurance companies and we have the power to do that."

That ended with this legislation.

The patient protection part, forget the exchanges. Forget all the things that we have to work on to improve this. The fact of the matter is this legislation brought protections to 178 million Americans who never had it before. Some think it was 150 million. So, I will go with the higher number.

Here is one of the main issues, pre-existing conditions. If we are going to maintain that protection, and a heck of a lot longer list of protections, you have got to be able to pay for it. You cannot just say it is a goal and say, "That is good. We want to keep what is good." And then talk in ways that undermine that completely.

Governor Beshear, I was going to ask you first, as someone who has governed a rural State and a large part of your State is similar to Pennsylvania. We have in our State a huge population, about 3.5 million people live in rural areas. Allow them to get the protection of Medicaid or get healthcare through Medicaid. We know that kids get the disproportionate share of that in parts of the country like that.

I wanted to ask you about pre-existing conditions. What does this repeal effort—and the other effort to pass what has been known as the Ryan Budget block granting Medicaid—what does that mean to the part of your State that is both rural and focused on rural children? What does it mean?

Mr. BESHEAR. If you block grant Medicaid, in essence, you are going to send me less money than it takes to run the program. And I am going to have to turn around and say, "OK. We are going to have to reduce the people in the program and we are going to have

to reduce the benefits in the program." People are going to lose their care. Lots of people are going to lose their care.

These are people that, in one sense, need the care more than anybody else, and so many of them do not know how to access healthcare until they are covered by this care. You are going to hurt a lot of families. Some people will die because they do not have the coverage that they need.

Talking about pre-existing conditions, let me just give you a little, quick story. I went down right after we expanded Medicare, right after we fully implemented the ACA in Kentucky, and I was going to be on one of those television shows, and they had to do this satellite thing.

I am in Louisville and I go to this small television studio run by this independent television producer guy and he says, "Here is where you sit," and all of that. And he said, "What are you going to talk about?" I said, "Well, the Affordable Care Act. There are some folks here in our political scene in Kentucky that are not too thrilled with what I have done."

And he said,

> "Well, let me tell you something. I am thrilled because I have had a heart condition for the last 8 years and I could not get insurance. But I went down and signed up this morning."

That is what is going on out here.

Some folks talk about all these people involved in this like they are, I said, "aliens from some distant planet." These are people that we sit in the bleachers with on Friday night. We go to the grocery with on Saturday. We sit in the pews on Sunday with them. They are you and me. They are family and they are friends.

We ought to be putting them first and forgetting all this political mess that goes on up here, and deal with them as Kentuckians and Americans.

Senator CASEY. Governor, thank you very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Casey.

Senator Whitehouse.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thank you very much, Chairman.

Just from a Rhode Island perspective, I would like to congratulate Governor Beshear on his success with the Affordable Care Act and point out that Rhode Island has been a success with the Affordable Care Act.

Our Governor has written to the House Majority Leader to say,

> "By fully leveraging the flexibility and resources available to us under the ACA, Rhode Island has developed a more competitive environment for health insurance and positioned itself to make the healthcare system more efficient and affordable. We have been successful controlling Medicaid costs without reducing benefits or eligibility. Unlike some States which have seen dramatic premium growth on the exchange, we have actually seen exchange premiums decrease in 2 out of the last 3 years. In fact, some consumers are seeing a decrease of as much as 5 percent as they compare plans and enroll for 2017.

> Our aggressive rate review process strengthened by ACA funding has saved consumers nearly $220 million since 2012 in a State of 1 million people."

Mr. Chairman, our Health Insurance Commissioner wrote to you and said,

> "The ACA has worked in Rhode Island. We have a remarkable story to tell. Rhode Island has enjoyed market stability and has avoided dramatic increases in premiums seen in other States. Over the last 3 years, premium increases in the individual and small group markets have been relatively modest for Plan Year 2017. Average premium changes in the individual market will range from a 5.9 percent decrease to a 5.9 percent increase based on issuers. In the small group market, average premium changes in 2017 will range from a decrease of 3.1 percent to an increase of 3.6 percent based on issuer."

She concludes,

> "The answer is not to make health insurance coverage less comprehensive by weakening the essential health benefits covered or to throw people off the insurance rolls altogether. But to transform the healthcare delivery system and reconfigure payment methodologies to encourage more efficient, higher quality healthcare."

I have probably bored this committee to death with my persistent pursuit of delivery system reform efforts.

My point here is that we are seeing it work in Rhode Island. We are seeing costs come down among primary care provider groups that have become ACO's under the Affordable Care Act. If you strip out from them the Accountable Care Organization status, which is part of the Affordable Care Act, you leave them stranded after the investment that they have made. You are taking the people who are delivering care to folks and you are just throwing sticks in the spokes. It makes no sense. It hurts them and our providers are really concerned about what people are looking at.

Repeal without replace that focuses on the delivery system reforms as well as the patient protections that Senator Casey referred to is really, really, really important.

Let me make a second point, which is that I was our State's insurance commissioner at one point and as our director of business regulation. One of the tasks that I had to do was to run as receiver the bogus shutdown insurance companies that had come in when a previous Governor decided that it would be really smart to blow-out insurance protections at the State level, and let any slick operator come in and sign up in Rhode Island. They failed and I had to clean up the mess. And the mess was not pretty.

A lot of the stuff was taking advantage of the problem of serious injuries occasioned in schools and playground and so forth. I was talking on the telephone to people in other States—a lot of the stuff got sold across State lines—who had a son who was counting on this for insurance, and it was gone. The son is crippled for life and they have no place to go. They could get, maybe, onto Medicaid once they burned down all of their family resources to get to that point. If they went off the insurance that was covering the child in the family, if they moved, then they would get lost. They would

never be able to insure again, so they were job trapped in their jobs. The fallback was to go to the State hospitals and be charity cases in State hospitals.

One was from Texas and he said, "I do not know what you guys are like in Rhode Island, but our State hospitals in Texas are no picnic for the kids who are there."

There is a sea of misery lurking behind the process of letting insurers just come in at random. My experience has been if you are going to run a health insurance outfit, first of all, you need to have a good provider network. You cannot come in and just throw insurance around with no provider network. I see Ms. McPeak nodding her head. It is crazy. It does not work.

You have to have an adequate provider network. You have to arrange a payment structure which is a really important thing in terms of getting the best care at the best price out of that provider network.

You have got to have the requisite I.T. connections so that people are sharing data in the way that they should and that your health I.T. requirements are robust.

You have to have quality standards so people know when they are meeting your benchmarks for treating diabetes properly, treating congestive heart failure properly, and things like that.

If you are going to be a company that does not do any of that, frankly, you have no business coming into my State. I do not want you in my State if you are a fly by-night operator who will not put that basic investment into an adequate provider network.

If you are going to come in and buildup that provider network, guess what? It is not a big deal to go to the insurance commissioner and file for it.

This whole argument about how you are going to open this all up to competition is completely phony. It is completely phony because the real challenge of moving into a State is in setting up a proper provider network. If you are not going to do that, you are not doing fair business in the State. You are coming in to freeload and to cheat people. There is no other way around it.

One of the things that we want to do about this is to, and Senator Franken and Senator Brown and I have proposed it, is to add a public option. State by State, it actuarially has to be sound so you are not laying off onto other places. And add discipline to the market under the Ben Franklin Rule that the best way to show that a stick is crooked is to put a straight stick right down next to it.

This can be the straight stick. It can be Medicare. It can be things that people count on and trust, and it will protect this markets against market manipulation by private insurance particularly when it gets to be very small levels of competition and market manipulation becomes a really feasible technique.

I have run out on my time on those three points, but I appreciate the Chairman allowing me to make them.

The CHAIRMAN. Well, you always have good incisive comments. We are fortunate to have former State insurance commissioners on our panel. Senator Collins was one as well.

Senator Murray, do you have any concluding remarks?

Senator MURRAY. Mr. Chairman, I just want to say, I really appreciate what my Democratic colleagues have brought forward and the consequences, the real consequences of either tinkering or moving on without really thinking about what we are doing. What we are seeing is the reality that Republicans, despite your words, are rushing to repeal without replace under a budget reconciliation process that is rolling downhill at this point in my understanding.

Even as disconcerting a President who is actually creating Trumpcare by sabotage by putting out rules and regulations that have real impacts on the uncertainty that many of our witnesses have talked about and its impact on the system today.

I hope that our colleagues on the other side who come with real intention to help make things better stop the rush to repeal. And start really thinking about some of the consequences and encourage the President to do the same.

With that, Mr. Chairman, I do want to submit for the record some testimony of two small business owners from Kentucky and Pennsylvania, and a physician who participated with us in a press conference this morning about the real impacts of where they see this going right now.

Thank you.

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

The CHAIRMAN. Thank you, Senator Murray.

Senator WHITEHOUSE. I forgot to ask unanimous consent to put the letter from our Health Insurance Commissioner and the letter from our Governor into the record, if those could be added to the record.

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

The CHAIRMAN. They certainly will be.

Senator WHITEHOUSE. Thank you.

The CHAIRMAN. Let me thank the witnesses. This has been very helpful. We would like to have your further suggestions.

I said at the beginning that I hope—maybe I would have been better entitling the "Obamacare Emergency," I could have—because that seems to have roused my Democratic colleagues—what I really meant was "The Individual Market: Next Steps."

Senator FRANKEN. Oh, much better.

The CHAIRMAN. Is that better?

[Laughter.]

That brings it down just a bit.

What I was trying to do in the environment in which we have is to get us in the position, we are perfectly capable of doing, of addressing a real problem and doing it together. The witnesses were a big help in that today, everyone, all four, all of you.

Governor, thank you for your perspective, from my respect, of what a Governor brings to the table. And to the others, to have you come with a lot of background, Ms. Trautwein, in the provider area and those who are in the midst of writing healthcare plans all the time. Ms. Tavenner in the Obama administration and Governor Kaine's administration, and Ms. McPeak, you have done a terrific job in Tennessee.

I think our real issue still is next steps. I do not think the Senators did as well as the witnesses today in moving toward moving together. But even if we move 10 percent in that direction that is a good step forward.

From my point of view, just so we do not characterize the Republican position wrongly. President Trump has said, and I think very helpfully, that repeal and replacement of Obamacare should be done simultaneously. To me that means you have to know what you are going to replace it with before you have an effective repeal. I do not see how you do it any other way. That is what most of the discussion is today.

I have tried to just say that we can deal with Medicaid in a discussion with the Governors and we want to make improvements in it. We can deal with the employer market to the extent we need to. But the real issue for the moment is in the individual market, which we are told we can address separately and needs addressing.

I think of it as a collapsing bridge. In our State, Ms. McPeak said, it is like our market in the individual market. Now it is just the 4 to 6 percent that we are talking about is very near collapse. What do you do about a collapsing bridge? You do not go to the edge of the bridge and argue about whose fault it was that it is in disrepair.

You send in a rescue team and you go to work to repair it so nobody else is hurt by it. You start to build a new bridge and only when that new bridge is complete and people can drive safely across it, you close the old bridge.

In my view, the way you deal with the individual market is to address it carefully. Of course, we need to know what happened in the past, but we are more interested in the future and identify what needs to be done to give people real affordable choices of insurance and build that new bridge. When it is completed, we can close the old bridge. But in the meantime, we repair it.

No one is talking about repealing anything until there is a concrete, practical alternative to offer Americans in its place. We can do that with the individual market while having separate discussions about Medicaid with the Governors and separate discussions about the employer market, the extent to which it needs to be changed. And again, we are not even talking about dealing with Medicare. So that is what I am talking about and that is what I hope we can do.

The problem we have is that in the individual market in some States, really many States because one-third of the counties in the country this year, people only have one choice to buy their insurance, is leaving people in a condition of having a bus ticket with no bus running through town.

What we are being told is if we do not act by March or April that in many States, even if you have a subsidy through the Affordable Care Act, there will not be an insurance company there to sell you insurance. We should not let that happen.

Maybe the title of the next roundtable or hearing will be, "Individual Market: Next Steps," and maybe we can, as Senators, do as well as the witnesses have done today in helping us think about those steps. If you have any followup comments you would like to make, we would all welcome them.

The hearing record will remain open for 10 days. Members may submit additional information for the record within that time if they would like.

Thank you for being here. The committee will stand adjourned.

[Additional Material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF AMY SHIR, PATIENT AND CONSULTANT, LOUISVILLE, KY

Hello. My name is Amy Shir, I'm from Louisville, KY, and I'm a consultant who goes across the country delivering solutions to fight poverty. Specifically, I work in financial empowerment, and I've seen the devastation that medical bankruptcies cause for families.

I am a mother of two teenagers in public schools and I'm self-employed, as is my husband.

I was diagnosed with Crohn's Disease when I was 22 years old. I take medicines that would cost thousands of dollars each month if I didn't have health insurance.

This disease is also considered a pre-existing condition, which may prevent me from accessing health care in the future unless concerned citizens make their voices heard and stop repeal of the Affordable Care Act.

When the long-overdue Affordable Care Act was passed, my family's health insurance premiums dropped more than a third and included much better benefits thanks to a plan we found on Kynect—Kentucky's State-based exchange. This was an enormous improvement over what we had before the Affordable Care Act, when we were basically on our own trying to find an insurance company to sell us a policy.

Our State and Federal Government officials talk about helping "the little guy"—the small business person and entrepreneur—yet in reality, they're creating an environment where only employees of large companies will have access to affordable health care, especially the large numbers of people like me with financially ruinous pre-existing conditions like Crohn's Disease, diabetes, cancer or heart disease. And in 2015, there were 57 million small business employees, comprising 48 percent of all U.S. employees. We pay billions in taxes each and every year and deserve affordable health care just as much as employees of large corporations.

We must unite and send a strong message to our elected officials that affordable health care makes Americans great and productive.

Consumers should insist that the Affordable Care Act not be weakened or destroyed. If Congress truly wants to prioritize the needs of everyday Americans, they should focus on guaranteeing comprehensive, affordable health care to every American, like every other wealthy nation already does. Americans deserve health care every bit as much as people in other countries.

I'm here today because my health and my family's health are in serious jeopardy with the reckless talk of repealing the Affordable Care Act. To truly keep America great, Congress must guarantee universal, affordable health care for all.

PREPARED STATEMENT OF ANDREA DEUTSCH, OWNER, SPOT'S—THE PLACE FOR PAWS, NARBERTH, PA

Dear Chairman Alexander, Ranking Member Murray and members of the committee, my name is Andrea Deutsch, and I own Spot's—The Place for Paws in Narberth, PA. I am also affiliated with Small Business Majority, a nonprofit advocacy group that works on behalf of America's entrepreneurs. I respectfully submit these remarks so that you may understand why the Affordable Care Act (ACA) is essential to small employers like me.

At the age of 15 months I was diagnosed as a Type 1 diabetic. Today, I need four insulin shots and multiple blood tests daily just to stay alive, which is why I must have health insurance.

Prior to the implementation of the ACA, I was repeatedly denied coverage due to my pre-existing condition. The only reason I had any insurance was thanks to being grandfathered into a healthcare plan from a previous job, however, that plan cost me over $1,200 per month, with regular monthly increases. Paying for that coverage made it extremely difficult for me to put money back into my business.

After the ACA was enacted and I could no longer be discriminated against because of my pre-existing condition, my insurance rates dropped by almost two-thirds. The coverage I received was of the same quality as before, if not better, and the money I saved was used to grow my business.

If the ACA is repealed, and insurers are allowed to once again discriminate against those with pre-existing health issues, I will lose my insurance, and I will be forced to close my business and find work with an employer that can cover me under a group plan. I expect this will happen to many self-employed business owners across the country.

But the ACA isn't just about helping me or small business owners of my generation. If insurers are allowed to discriminate against anyone with a pre-existing con-

dition, young people who are diagnosed with a chronic health problem will be forever barred from creating their own business or working for themselves as adults.

I ask members of Congress to make sound policy decisions that will protect the health of their constituents as well as the health of small business owners like me. Small businesses create many of America's jobs, which is why protecting entrepreneurs protects our economy.

Thank you for the opportunity to contribute these remarks.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS,
PROVIDENCE, RI 02903–1196,
January 6, 2017.

Hon. KEVIN MCCARTHY, *Majority Leader,*
U.S. House of Representatives,
H–107, U.S. Capitol Building,
Washington, DC. 20515

DEAR LEADER MCCARTHY: The Affordable Care Act (ACA) is working in Rhode Island. Since 2011, when Rhode Island began the work of ACA implementation, our uninsured population has dropped from nearly 12 percent to under 4.5 percent, one of the lowest rates in the country. Nearly 110,000 Rhode Islanders now have access to affordable, life-saving care through the Medicaid expansion or our State health insurance exchange.

By fully leveraging the flexibility and resources available to us under the ACA, Rhode Island has developed a more competitive environment for health insurance and positioned itself to make the health care system more efficient and affordable. We have been successfully controlling Medicaid costs without reducing benefits or eligibility. Unlike some States which have seen dramatic premium growth on the exchange, we have actually seen exchange premiums *decrease* in 2 out of the last 3 years. In fact, some consumers are seeing a decrease of as much as 5 percent as they compare plans and enroll for 2017. Our aggressive rate review process, strengthened by ACA funding, has saved consumers nearly $220 million since 2012.

Our progress toward full insurance has enabled Rhode Island to set its sights on a full-scale health system transformation that would not have been possible prior to the ACA. We have been working to modernize our payment and delivery systems by focusing on the value, not volume, of care and services delivered to Rhode Islanders. There remains a lot of work to do, and the ACA is not perfect. It is clear, however, that these reforms could not be successful without the framework provided by the ACA.

Although the ACA has been successful in Rhode Island, it is clear that it could be improved. I would be open to discussing modifications to the law. However, I would urge that you and your colleagues grant the utmost priority to the following principles as you consider any changes to the ACA:

- Maintain the existing coverage gains States have realized under the ACA. We cannot allow the newly covered to lose access to care.
- Avoid transferring costs to States. Any such shifts would be unaffordable and unworkable for the States. Likewise, we must avoid increasing the burden of uncompensated care for our hospitals.
- Preserve the stability of the health insurance market. Any destabilizing changes to the financing structure or market structure could result in rate shock and insurer flight from the individual market.
- Continue to allow States the freedom to experiment and adopt reforms which are appropriate to their environment. In Rhode Island, the ACA model has proven successful, and we must be given the discretion to retain the pieces which work in Rhode Island.

Finally, I urge you to retain the critical public health investments included in the ACA. Federal support for public health and prevention infrastructure has been critical to improving the health of our most vulnerable populations and reducing rates of obesity, diabetes, heart disease, stroke, tobacco use, and other conditions. Dollars spent on prevention not only improve health, but they also help reduce utilization of more expensive forms of care.

Thank you for inviting me to provide you with feedback as you consider the value of the ACA and the progress that has been made over the past several years. I wel-

come the opportunity to discuss any of these matters further with you and your colleagues.

Sincerely,

GINA M. RAIMONDO,
Governor.

HEALTH INSURANCE COMMISSIONER,
STATE OF RHODE ISLAND,
January 16, 2017.

Hon. LAMAR ALEXANDER, *Chairman,*
U.S. Senate,
Committee on Health, Education, Labor, and Pensions,
Washington, DC. 20510–6300.

DEAR CHAIRMAN ALEXANDER: Thank you for the opportunity to provide input on potential congressional policy changes related to the Affordable Care Act (ACA). The ACA has worked in Rhode Island and we have a remarkable story to tell. As Rhode Island's Health Insurance Commissioner, I am, indeed, on the front lines of ACA implementation in our State. I lead Rhode Island's Office of the Health Insurance Commissioner (OHIC). Affordability and consumer protection are my agency's top priorities. My agency conducts comprehensive reviews of insurance premiums and plan designs and oversees the ACA's valuable consumer protection provisions. ACA funding built our comprehensive rate review program which has saved Rhode Island consumers and businesses nearly $220 million since 2012.

As I said, Rhode Island has a remarkable story to tell. Rhode Island has enjoyed market stability and has avoided dramatic increases in premiums seen in other States. Over the last 3 years premium increases in the individual and small group markets have been relatively modest. For plan year 2017, average premium changes in the individual market will range from a **5.9 percent decrease** to a 5.9 percent increase, based on issuer. In the small group market, average premiums changes in 2017 will range from a **decrease of 3.1 percent** to an increase of 3.6 percent, based on issuer. Despite these encouraging trends we still have much work to do to improve affordability.

The ACA has lead nearly 110,000 Rhode Islanders to gain access to health insurance through our State-based exchange (HealthSource RI) and Medicaid expansion. In fact, between 2013 and 2014, the size of our individual market more than doubled. The low-income, and those without access to employer-sponsored insurance, are among our most vulnerable citizens when it comes to accessing health insurance. For these citizens, who live on tight family budgets in a region hard hit by manufacturing losses in recent decades, health savings accounts and age-adjusted tax credits will likely not provide enough financial support to purchase health insurance, especially for our citizens in low-income households. Every State is grappling with the same complex problem: that is, how do we make health insurance more affordable and increase the value of our health care dollar? The ACA is a key ingredient to our State's solution and we ask that the law be kept intact.

Health insurance is expensive because health care is expensive. The primary driver of health insurance premiums is the cost of medical care. A brief look at medical loss ratios in our State shows that, on average, 85 cents of every premium dollar funds the cost of medical care. The answer is not to make health insurance coverage less comprehensive by weakening the Essential Health Benefits covered or to throw people off the insurance rolls altogether, but to transform the health care delivery system and reconfigure payment methodologies to encourage more efficient, higher quality health care. We can't truly transform our health care system unless everyone has access to insurance, providers are being compensated for the care they deliver, and we have predictability in Federal health care policy.

As I stated, Rhode Island is working on a solution to the problem of high health care costs. Our solution, and I believe that of every other State, requires a strong Federal-State partnership. Our State Medicaid program is leveraging authority and Federal financial support to transform care for Medicaid beneficiaries to save money without cutting eligibility and benefits. We are aligning Medicaid and commercial insurance payment policies with those endorsed by the bipartisan Medicare Access and CHIP Reauthorization Act of 2015. We are empowering primary care providers to deliver patient-centered team-based care through the patient-centered medical home. Our leading health systems and provider groups are organizing into accountable care organizations to manage the cost and quality of health care for their patients. These are community resources that serve patients across all payers. By working collaboratively with providers to improve care for our State Medicaid population and commercially insured population, we can improve care for the Medicare

population. This saves our State and the Federal Government scarce taxpayer dollars to support infrastructure, education, housing, and other investments.

In response to the question posed regarding the 1332 State Innovation Waiver, the rigidity of the regulations as written posed administrative hurdles for States to be able to successfully utilize it to make improvements to health coverage at the State level. However, with added flexibility, particularly around the demonstration of impact to Federal deficit, the 1332 waiver could prove to be a valuable tool to States across the country looking to lead and innovate.

Repeal of the ACA would harm our system transformation efforts and stall our momentum to make health care, and thereby health insurance, more affordable. Here are my specific concerns:

- **Loss of coverage:** For privately insured individual market consumers, the withdrawal of Cost-Sharing Reduction subsidies and Advance Premium Tax Credits would drive up consumer premiums and out-of-pocket costs. At the same time, withdrawal of Federal funds for Medicaid expansion would leave our most socially and economically vulnerable residents without coverage and access to life-saving care.
- **Destabilized Risk Pools:** Healthier members of the pool may choose to drop insurance coverage with no individual mandate, thereby leading to significant premium hikes for non-group consumers who remain. Keeping healthy people insured is the best way to protect the health of risk pools.
- **Economic losses:** The health care sector is a core component of Rhode Island's economy, contributing over $6 billion to our gross State product and employing thousands of Rhode Islanders. ACA repeal would increase the burden of uncompensated care and undermine the vitality of our local health economy.
- **Economic uncertainty:** Uncertainty regarding Federal law may impel insurers to withdraw from the market, thus reducing choice and competition. Fiscal uncertainly around where the burden of uncompensated care will land may lead provider organizations to halt investments that are geared to creating a more efficient, patient-centered health care system.

We are on the cusp of achieving unprecedented improvements in the quality and affordability of our State's health care system. I recommend that any policy changes to the ACA keep the existing financing structure intact, maintain the coverage gains of recent years, and preserve vital consumer protections to ensure financial stability and access to fair coverage for Rhode Island's families. I would be pleased to discuss any of these issues with you and your colleagues in the Senate.

Regards,

KATHLEEN C. HITTNER, M.D.,
Health Insurance Commissioner.

RESPONSE BY MARILYN TAVENNER TO QUESTIONS OF SENATOR ISAKSON, SENATOR FRANKEN AND SENATOR BENNET

SENATOR ISAKSON

Question 1. If the overall health of the individual market is dependent on the number and health of the people within it, how can we get employer-sponsored coverage in the market?

Answer 1. We believe continuous coverage incentives, as outlined in our written testimony, are needed to achieve a balanced mix of both young and healthy individuals along with older and less healthy individuals enrolled in the individual market. This can be achieved without combining the markets for employer-sponsored coverage and individual coverage.

Question 2. Should employers be allowed to give their employees a subsidy that enables them to buy plans on the individual market?

Answer 2. We support the system through which approximately 150 million Americans currently receive employer-sponsored health insurance. We believe Congress should proceed cautiously when considering proposals that would create incentives for employers to stop offering coverage or steer their employees into the individual market. We are looking at the impact of a new 21st Century Cures provision that will permit this for certain small employers.

SENATOR FRANKEN

Question 1. Some members have proposed to reinstate high-risk pools, but have authorized limited amounts of funding to support them. What will happen to insur-

ers, States, and patients if State high-risk pools are reinstated but not sufficiently funded?

Answer 1. We believe a transitional risk pool program—funded by the Federal Government with a State option to design and administer the program within Federal guardrails—could play a useful role in offsetting some of the costs of serving patients who have the most complex health conditions and need the most care. This approach, if adequately funded, would help promote market stability and place downward pressure on premiums. However, recognizing that historically there has been a problem with inadequate funding of State high-risk pools, we believe States should be given the opportunity to implement approaches that work best for their State residents—such as the reinsurance program approach adopted in Alaska and other States.

Question 2. Some Republicans are proposing a requirement of continuous coverage. Could you explain whether it would be better or worse for Americans in terms of making sure as many people as possible have affordable health insurance coverage than the individual mandate in the current system?

Answer 2. We strongly support an approach that brings everyone into the system. Past State experience in the 1990s—in States such as Washington and Kentucky—yielded important lessons about the unintended consequences of health reforms that create incentives for healthy people to forego the purchase of coverage. Absent an individual mandate to purchase coverage, it is critical that Congress implement effective and well-designed continuous coverage measures, along with additional stabilization solutions, to minimize the impact of eliminating the individual mandate. To effectively replace the individual mandate, a continuous coverage framework must incentivize consumers to maintain coverage, minimize movement in and out of the marketplace and not enroll only when they need care, and begin with a clear set of requirements, which must be clearly communicated to consumers.

SENATOR BENNET

Question 1. The Affordable Care Act (ACA) is not perfect but in Colorado there have been over 600,000 people covered including more than 27,000 children. Whether it's the President's Executive order or the lack of consensus on a comparable alternative to the ACA, there's a staggering level of uncertainty right now—for consumers, employers, providers, and health plans.

Health plans are making decisions for 2018 right now, with fast approaching deadlines for rate filings. How does this uncertainty affect them?

Answer 1. Health plans have a strong commitment to their communities and the millions of members they serve each day. But, every market is different, from the State regulatory environment and effectiveness of enrollment efforts, to the impact of provider consolidation and underlying health care costs. These are all considerations that differ from one company to the next, one market to the next.

First and foremost, we need to ensure that consumers have quality coverage options. While the individual market has been challenged, our commitment is to work with policymakers to find solutions that deliver immediate stability and long-term improvement. Without immediate action, costs will continue to increase, choices will continue to decrease, and coverage will not be there for millions. But strong signals of certainty in advance of the health plan filing deadlines for 2018 can help stabilize the market, avoiding even higher costs and fewer choices. As we approach the filing deadlines for 2018 coverage, it is critically important for insurers, as they make decisions about the pricing of their products, to have timely information about forthcoming policy changes that will take effect next year. The short-term solutions and long-term principles outlined in our written testimony will allow us to build a strong, stable individual market that serves our citizens well.

Question 2. As you know, the 10 Essential Health Benefits under the Affordable Care Act include outpatient care, emergency services, hospitalization, maternity and newborn care, prescription drugs, rehab services, lab services, preventative care such as mammograms, and pediatric services like routine dental exams for children.

Without a clear replacement for the ACA, how difficult will it be for insurers to design 2018 policies if they are unsure whether the Essential Health Benefits will be in effect?

Answer 2. Insurers are currently building individual products for the 2018 benefit year and will continue to operate under the laws and rules that currently remain in place—which include requirements for insurers to provide comprehensive coverage under the "essential health benefit" standards. At the same time, we believe improvements to the law and rules are critical to ensure that people get covered, stay covered, and get the care and services they need. It also is important to ensure

that any changes affecting 2018 benefits and coverage are finalized before insurers submit their product filings and premiums for next year. While the individual insurance market has been challenged, our commitment is to find solutions that deliver immediate stability and long-term improvement.

Question 3. Do you see any need for changes to the Essential Health Benefits?

Answer 3. We believe that the implementation of EHB requirements has generally been successful in striking an appropriate balance between comprehensive coverage, affordability and State flexibility and do not see the need for major changes at least in the short-term. Longer-term, we believe States, as the primary health insurance regulators, should have more flexibility to develop affordable and lower premium individual market plans for their markets. Policymakers should consider additional State flexibility around coverage requirements, State benchmarks, and plan designs that promote innovation in care delivery, such as value-based insurance designs. However, State flexibility should not come at the expense of consumers and their coverage.

RESPONSE BY STEVE BESHEAR TO QUESTIONS OF SENATOR FRANKEN AND SENATOR BENNET

SENATOR FRANKEN

Question 1. You were in Kentucky when the State phased out its high risk pool and enrolled individuals in the individual market. How did this help people with pre-existing conditions?

Answer 1. Prior to implementation of the Affordable Care Act ("ACA"), Kentucky maintained a high-risk pool known as "Kentucky Access" to facilitate access to insurance for individuals who found it difficult to obtain coverage in the private market due to high-cost medical conditions. Created in 2000 by Kentucky General Assembly, the program was administered under the Kentucky Department of Insurance from 2001–14. To participate in Kentucky Access, individuals were required to meet one of two conditions:

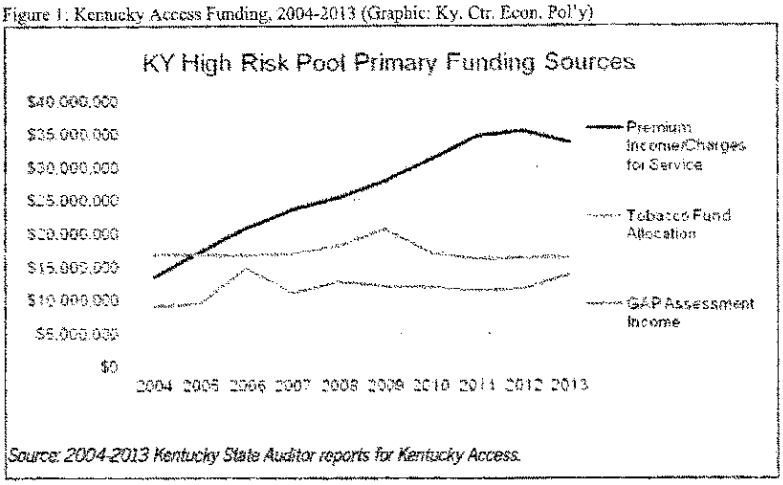
1. Being "medically uninsurable," defined as (i) rejection for coverage from at least two insurance companies based on a pre-existing medical condition or (ii) quoted premiums more expensive than Kentucky Access premiums. This eligibility group made up the vast majority of members.
2. Alternatively, loss of coverage due to termination of employment (voluntary or involuntary), would confer eligibility due to Health Insurance Portability & Accountability Act (HIPAA) of 1996.[1]

As in many States, the high-risk pool was extremely limited in its ability to expand coverage. In addition to sizable premium payments from members, Kentucky Access was subsidized through a combination of tobacco settlement money and an assessment on all insurance plans sold within the State (see Figure 1), but even so, the program covered only about 4,000 individuals at a time and only approximately 18,000 total over its 13-year life span. Moreover, premiums were too expensive for all but upper income families. For example, a 2014 article reported that "the average premium for individuals was $680 per month, with the most popular plan with a pharmacy rider having a monthly premium of $1,118 for a 64-year-old male."[2]

[1] *See*, Dustin Pugel, *Kentucky's Experience with High Risk Pool Shows Dangers of ACA Repeal*, Kentucky Center for Economic Policy (February 17, 2017).

[2] Joe Sonka, "Premium savings: Kynect Premiums for Private Coverage Slashed by 74 percent with Federal subsidies," LEO Weekly (July 9, 2014).

Figure 1. Kentucky Access Funding, 2004-2013 (Graphic: Ky. Ctr. Econ. Pol'y)



Not only were the plans prohibitively expensive for most Kentuckians who needed them, the coverage was also markedly inferior to coverage under the Affordable Care Act. As the Kentucky Center for Economic Policy recently documented, Kentucky Access plans failed to cover treatment for the conditions that made its members unable to obtain private insurance coverage (the entire reason they sought coverage via Kentucky Access) until they had been enrolled for a full year. Thus, for example, a member with cancer would receive no coverage for that cancer for 12 months after initial enrollment in Kentucky Access, leaving members faced with both expensive premiums and potentially astronomical out-of-pocket health care expenses (or, more likely, the possibility of medical bankruptcy). Moreover, there was a $2 million lifetime limit on coverage, so if a member with a serious health condition accrued more than $2 million in health care expenses, the coverage would simply terminate, leaving members back where they started—faced with impossible choices.

The Affordable Care Act was an infinitely better deal for Kentuckians than the high-risk pool. First, there was no longer a need for individuals with pre-existing conditions to be placed into a separate risk pool, because insurers were no longer permitted to deny coverage or to exclude coverage for pre-existing conditions for any period of time. Nor were they permitted to charge people higher premiums simply because of those pre-existing conditions, and the ACA abolished the annual and lifetime limits that capped coverage just when people needed it most. In addition, the existence of Federal subsidies to support the purchase of qualified health plans (QHPs) meant that premiums were capped for individuals between 100–400 percent of the Federal Poverty Level, and this group made up the vast majority of Kentuckians who purchased private insurance coverage under the ACA. And of course, the cost to Kentucky of insuring these individuals was considerably less—where Kentucky had to subsidize the high-risk pool with millions of State dollars, the Affordable Care Act was funded overwhelmingly by Federal funds, and the small amount of State funds required to support the Medicaid expansion was projected to create a net positive State budget impact of approximately $900 million through 2021. The proof of the success of the ACA relative to Kentucky Access is readily demonstrated by the enrollment figures—where Kentucky Access served only a tiny fraction of uninsured Kentuckians, the Affordable Care Act allowed Kentucky to enroll more than half a million people in insurance through Medicaid expansion and the purchase of QHPs on kynect, Kentucky's State-based health benefit exchange. Beyond that, every one of the estimated 1.9 million Kentuckians with pre-existing conditions[3] is protected under the Affordable Care Act.

Simply put, the ACA eliminated the need for Kentucky Access. Thus, when the ACA became fully effective in the individual market, the program was discontinued and the staff at kynect assisted program participants with finding new plans on the

[3] Dustin Pugel, *Kentucky's Experience with High Risk Pool Shows Dangers of ACA Repeal*, Kentucky Center for Economic Policy (February 17, 2017).

exchange. In short, in every respect—premiums, out-of-pocket costs, scope of coverage, number of individuals protected—individuals with pre-existing conditions are better off under the Affordable Care Act than under the high-risk pool.

Question 2. Do you think it's responsible that President Trump and other Republicans claim that selling insurance across State lines is an effective tool for lowering health care costs—an idea that has been tested in States like Georgia and has failed to produce the intended result?

Answer 2. It is speculative at best to suggest that the sale of insurance across State lines will lead to lower premiums for consumers. As you have correctly observed, the idea has been tested in Georgia, which in 2011 passed a bill allowing insurers to sell any policies in Georgia that they offer in other States. The expected benefits were to derive from sale of skimpier plans that did not meet Georgia's requirements for insurers (e.g., required cancer screenings), and from increased price competition among insurers. However, as of December 2016, not a single insurer has chosen to offer out-of-State plans in Georgia. The experience of the very few additional States that have passed similar laws has been the same—no discernible impact on cost.

Moreover, it is important to note that the sale of insurance across State lines actually undermines State authority to regulate insurance. While the Affordable Care Act established a minimum "floor" of required benefits for plans (except in the case of self-insured employers, who generally offer robust benefit packages already), it retained the traditional State authority to mandate additional benefits and otherwise regulate insurers. Interstate sales would virtually eliminate that authority, as the National Association of Insurance Commissioners has explained:

> In reality, interstate sales of insurance will allow insurers to choose their regulator, the very dynamic that led to the financial collapse that has left millions of Americans without jobs. It would also make insurance less available, make insurers less accountable, and prevent regulators from assisting consumers in their States.[4]

In short, there is simply no evidence that interstate insurance sales will help lower costs, and plenty of evidence that insurance markets will be destabilized through the evisceration of State regulatory authority.

SENATOR BENNET

Question 1. Under your leadership in Kentucky, you moved to expand Medicaid, which resulted in coverage for thousands in your State. In your testimony, you highlighted that Medicaid enrollees had better access to care and hospitals in Kentucky saw a decrease in uncompensated care. We had similar results in Colorado. Over 130,000 Coloradans gained access to coverage through Medicaid Expansion. When we look at how this affected hospitals, there was a 30 percent drop in uncompensated care. Some of these hospitals, especially those in rural areas, were at risk of closure before the Affordable Care Act.

Based on your experience, what factors should we keep in mind to ensure that States have the resources they need and to build on these gains in coverage?

Answer 1. From a Governor's perspective, one of the most significant aspects of Medicaid expansion is the economic benefit to States that chose to expand their programs under the ACA. In Kentucky, approximately 400,000 individuals were able to access health insurance via Medicaid expansion, which had considerable economic benefits to the State as a whole, particularly for financially vulnerable rural hospitals.

As Governor, my decision to expand Medicaid rested not only on the morality of providing much-needed health care to the most vulnerable Kentuckians, but also on the economic sustainability of the program. So prior to committing to Medicaid expansion, I engaged PricewaterhouseCoopers and the University of Louisville's Urban Studies Institute to conduct an economic analysis of the program. The results were compelling. The study concluded that expanding Medicaid would inject $15.6 billion into Kentucky's economy over 8 years, create nearly 17,000 jobs, shield Kentucky hospitals from the impact of scheduled reductions in funding for indigent care, and create an overall positive budget impact of $802 million over 8 years. With that evidence, it became clear that Kentucky couldn't afford not to expand Medicaid.

A year into the Medicaid expansion, I retained Deloitte Consulting and the University of Louisville Urban Studies Institute to update prior projections on the economic impact of Medicaid expansion using the actual performance data from the first full year of implementation. That study revealed that the economic benefits of

[4] Nat'l Ass'n of Ins. Comm'rs, *Interstate Health Insurance Sales: Myth* vs. *Reality*.

Medicaid expansion were even more than had originally been anticipated, concluding that Medicaid expansion had already generated 12,000 new jobs and $1.3 billion in new revenues for providers (growing to almost $3 billion in the first 18 months of expansion). In addition, the study found that Medicaid expansion was projected to have a $300 million positive impact on the State's 2016–18 biennial budget. And by 2021, Kentucky would see the creation of 40,000 new jobs, as well as a nearly $900 million positive State budget impact and a $30 billion overall economic impact. These projections included the State Medicaid funding match required beginning in 2017.

The economic benefits of expansion are not unique to Kentucky—as the Robert Wood Johnson Foundation recently confirmed, considerable economic benefits of Medicaid expansion exist in every State that has expanded. In April 2016, RWJF found that the 30 States, plus Washington, DC, that expanded Medicaid in 2014 reported general fund savings and new revenue, along with both higher rates of health sector job growth and slower growth in State Medicaid spending relative to non-expansion States.[5]

The impact of expansion on rural hospitals deserves particular attention. As you noted, hospitals saw a considerable decline in uncompensated care, resulting from the availability of a payer source (Medicaid or private insurance) for the previously uninsured. In Kentucky, independent research commissioned by the Foundation for a Healthy Kentucky documented a drop of 78.5 percent in uncompensated care (inpatient and outpatient charity and self-pay from rural and urban hospitals, 2013–15) over the first 2 years of Medicaid expansion. This evidence is consistent with data from other States—for example, the RWJF report referenced above found that rural hospitals in expansion States are significantly more financially stable than those in States that have not expanded—as of September 2015, the percentage of rural hospitals at risk of closure was about twice as high in non-expansion States compared to expansion States (based on measures of financial strength, quality and outcomes, inpatient/outpatient share, and population risk).[6]

In addition to the economic benefits from Medicaid expansion, Kentuckians have seen markedly positive health impacts since implementation began. For example, the Foundation for a Healthy Kentucky has documented a meaningful increase in preventive care and substance abuse treatment utilization by Medicaid enrollees. The increase in substance abuse treatment is critically important in Kentucky, which has suffered more than most States from the opioid epidemic. And although improved health outcomes typically lag behind health policy changes (often years behind), a recent study found that low-income adults in Kentucky and Arkansas received more primary and preventive care, made fewer emergency room visits, and reported higher quality care and improved health compared with low-income adults in Texas, which did not expand Medicaid.[7]

Going forward, if States want to retain the benefits of the ACA they should be extremely wary of many of the so-called "replacement" proposals on the table. Governors should be skeptical of block grants, per capita allotments, or other capitated funding mechanisms for the Medicaid program. As a Governor, I certainly would have enjoyed having more flexibility to administer Kentucky's Medicaid program. But flexibility becomes considerably less useful when accompanied by significant funding cuts—without adequate funding, Governors will have to use their enhanced "flexibility" to make impossible choices of which individuals to cut from the program, or which benefits to eliminate. And all Medicaid expansion "replacement" proposals currently under public discussion involve significant cuts in Federal funding. In a State like Kentucky, which suffers from poor health on virtually every front, reduced Medicaid funding would be a disaster, leading to fewer people having coverage, a reduced benefits package, and a reversal of the progress we have begun to see.

Likewise, in the Marketplace, any proposal that results in fewer people being covered, or in benefits being reduced, should be rejected. Replacing the subsidies with fixed-dollar tax deductions or tax credits unrelated to financial need will be an enormous hardship for middle-income families, many of whom will face an effective tax increase because the subsidies they currently receive will be reduced, leaving many

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[5] State Health Reform Assistance Network, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, (March 2016).

[6] State Health Reform Assistance Network, *States Expanding Medicaid See Significant Budget Savings and Revenue Gains*, (March 2016) (citing Vantage Health Analytics. "Vulnerability to Value: Rural Relevance under Healthcare Reform." (2015)).

[7] Sommers BD, Blendon RJ, Orav EJ, Epstein AM. Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance. *JAMA Intern Med.* 2016;176 (10):1501–09.

unable to afford insurance. Relatedly, expanding the use of Health Savings Accounts will be meaningless for most American families, who lack the discretionary income to fund the accounts. Similarly, proposals that would lock individuals out of the market or otherwise penalize them for lengthy periods of time for failure to maintain continuous coverage are unnecessarily punitive and misunderstand the financial realities faced by most Americans. Finally, as discussed above, the sale of insurance across State lines will eviscerate the ability of States to regulate insurers, creating a race to the bottom and destabilizing insurance markets across the country.

In short, the path forward is not a "replacement" plan that covers fewer people and provides less robust benefits. Rather, Congress should build on the progress to date by continuing and expanding measures that already have bipartisan support, such as value-based payment initiatives, and seeking solutions that improve the affordability of coverage while maintaining the robust consumer protections of the ACA. The starting place for discussion must be how to make Americans better off, not worse.

[Whereupon, at 12:20 p.m., the hearing was adjourned.]

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