

**STABILIZING PREMIUMS AND HELPING
INDIVIDUALS IN THE INDIVIDUAL
INSURANCE MARKET FOR 2018: GOVERNORS**

HEARING
OF THE
**COMMITTEE ON HEALTH, EDUCATION,
LABOR, AND PENSIONS**
UNITED STATES SENATE
ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING STABILIZING PREMIUMS AND HELPING INDIVIDUALS IN
THE INDIVIDUAL INSURANCE MARKET FOR 2018, FOCUSING ON GOV-
ERNORS

SEPTEMBER 7, 2017

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STABILIZING PREMIUMS AND HELPING INDIVIDUALS IN THE INDIVIDUAL INSURANCE MARKET FOR 2018: GOVERNORS

THURSDAY, SEPTEMBER, 7, 2017

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

The committee met, pursuant to notice, at 9:05 a.m. in room SH-216, Hart Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Murray, Enzi, Isakson, Collins, Cassidy, Young, Hatch, Murkowski, Sanders, 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.

This morning we are holding our second of four hearings on stabilizing premiums and ensuring access to the individual health insurance market for the year 2018. That is our focus.

We are delighted and honored to have the Governors of five States here with us today. Thank you, gentlemen. We know how busy you are. You have come long distances to be here, and we appreciate it very much. We look forward to learning from you.

Senator Murray and I will each have an opening statement. We will introduce the five Governors. It almost sounds like a singing group. Does it not?

[Laughter.]

The CHAIRMAN. After that testimony, Senators will each have an opportunity to ask the witnesses 5 minutes of questions.

We just left a meeting where the Governors met with Senators not on our committee. We had 30 Senators there, similar to yesterday when we had the State insurance commissioners here. We had 31 Senators, most of them not on the committee, meet for an hour. And then at our hearing, we had 22 of our 23 committee members. For 2 consecutive days, we have had half the Members of the U.S. Senate focused in a bipartisan way on a single, narrow objective: what can we do in the next couple of weeks—that is a tall order—the next couple of weeks—that the Senate can pass, the House can pass, and the President will sign that will help 18 million Americans who are in the individual insurance market in the year 2018?

The individual insurance market is 18 million Americans. It is just 6 percent of those who have insurance, and about half of those do not have any government help to buy insurance. And it is those Americans who are getting hammered the most by the higher premiums and the higher co-pays and deductibles.

Tennessee's insurance commissioner testified yesterday. She said our State's individual market is very near collapse. At the end of September last year, Blue Cross pulled out of the individual market in Knoxville, Nashville, and Memphis, not just for Tennesseans with Affordable Care Act subsidies but for everybody. Even the people who did not get government subsidies could not buy it from Blue Cross in those markets.

Just yesterday, an insurer in Virginia announced it will pull out of parts of the State for the 2018 plan year, leaving 62,000 Virginians facing the very real prospect of having zero options for insurance next year.

This could happen again next year in Tennessee and in Virginia if Congress does not act. In our State, Tennessee, up to 350,000 Tennesseans, songwriters, the self-employed, farmers, and millions of Americans across our country could be literally left with zero options as some in Virginia may be.

If we do act, we can limit increases in premiums in 2018. We can continue support for co-pays and deductibles for many low-income families. We could make certain that health insurance is available in every county and lay the groundwork for future premium decreases.

Yesterday, we had a focused hearing on this narrow part of the market, the 6 percent. We asked our witnesses then, as we do today, to focus on the individual market and what we could do to help keep premiums down in 2018. Now, we are interested in anything you have to tell us, but that is our focus today.

Yesterday, I heard three things mostly: addressing high-cost individuals through reinsurance, or some other model; continuing the cost-sharing reduction payments; and third, more flexibility for States in the law's 1332 waivers.

One important discussion is how do we address the high cost of care for the sickest population. It seems to me that Senators on both sides of the aisle, as I listened to it, understand that that discussion is likely to be part of any long-term solution on the individual market because the individual market has some exceptionally sick people, it is small, and we have to find some way to deal with the complex cases. Some Senators have suggested a new Federal program. Under the Minnesota and Alaska plans, States are already using some of the Federal money they are already getting to set up reinsurance programs through the 1332 waiver, and they are lowering rates a predicted 20 percent without more Federal money.

We heard a number of good ideas for the short term yesterday. One of the things I would like to know from you—we all would—is there anything that we could do to section 1332 specific in the next 2–3 weeks to make it easier for more States to do what Alaska and Minnesota are doing with their reinsurance program?

And let me say as a former Governor, with respect to the five Governors who are here, unless the Affordable Care Act is changed

over the next 10 years, according to the Congressional Budget Office, the Federal Government will be spending about a trillion new dollars on Medicaid expansion and about 866 billion new dollars to subsidize the individual insurance market. That number, according to CBO, comes out to about \$4,200 per subsidized individual in the individual market. And the Federal Government has a \$20 trillion debt.

The question arises, if we need to address complex health issues or reinsurance, why do the States themselves not do it? For example, Alaska came up with its own State funds to help with its plan. It is using some Federal dollars, \$48 million, it was already getting in premium subsidies and redesignating them for reinsurance. And Minnesota came up with even more money, planning to use roughly \$135 million in State Federal funds that it was already getting. Maine did it by adding a \$4 charge per health insurance policy per month. As we think about the need for more funds to deal with complex health cases, whether it is reinsurance or an invisible high-risk pool or stabilization fund, we need to think about what the States' share ought to be.

At yesterday's hearing, we also heard several suggestions for the short term on improving the 1332 waiver. These suggestions ought not to be too controversial, including reducing the 6-month waiting period, allowing a copycat application. If Montana already gets a waiver, why should Massachusetts have to go through all the same things again? That ought to speed things up. Another idea is to allow just the Governor or perhaps the insurance commissioner to apply for a waiver and not wait for the legislature to pass a law since some State legislatures only meet every 2 years.

I was intrigued by the suggestion by a Senator that we make sure that we calculate the budget neutrality requirement in a common sense way to support States' long-term plans. Then is there a way to combine the State innovation 1332 waiver, one Senator asked, with the State Medicaid 1115 waiver so that a State could share any savings it has across the two interconnected markets?

I know that New Hampshire has tried to do some things in that area, and even though the Democratic Governors and the Republican Governors support it, they are not able to do it under both the Obama and Trump administrations.

Another possibility mentioned by several Senators on both sides of the aisle would be allowing lower cost copper plans to be sold—that is already in the law—plans that are often more appealing to younger and healthier people than the insurance commissioners said we need in the markets to bring down premiums. Right now, if you are 29 or under, you can buy this plan with higher deductibles at lower costs but not if you're over 29.

That is a short list of some of the things that might make some real difference in the 23 States that have actually started the process for applying for a 1332 waiver.

I am hopeful maybe some combination of continuing cost sharing for some period of time and significant changes in flexibility for States, probably through changes to section 1332, since it is already in the Affordable Care Act—that those two things might provide a basis for action that we can take this month. Then if we act,

we will count on the House of Representatives and the President to take advantage of that, I hope as they would.

This action would not end the process. That would only be step one, and then we would go pretty quickly to step two on a long-term, strong, vibrant individual market. I hope we can begin to spend most of our time on the larger issue of health care costs.

I mentioned this yesterday, but it is worth repeating. Several of the Governors have mentioned it this morning already. For 7 years, we have been stuck in this partisan stalemate on health insurance, with most of the argument—not all of it, but most of it—about 6 percent of the insured Americans who buy their insurance on the individual market, when we really should have been spending more time on the fundamental problems with the American health care system that have caused it to grow from consuming 9 percent of the gross domestic product in 1980, about 40 years ago, to nearly 18 percent in 2015 and a predicted 20 percent in 2025. At the same time, we have the phenomenon of 5 percent of those who receive health care consuming 60 percent of the costs.

We should be doing more on those larger questions of health care costs. There is no question about it. Look at how we pay to visit the doctor, how to get a test at the hospital, what we spend on prescription drugs, how much excessive paperwork and administrative burdens increase our costs, what can be done to encourage wellness, what can be done to prevent more serious illness and disease and the high costs that come from being ill. We should be looking at the real ways to bring down the cost of health care, which is the best way to reduce the cost of health insurance.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Chairman Alexander.

As I said yesterday, after so much partisanship around the future of health care in our country, I am really glad that these hearings give us an opportunity to take a different approach and hopefully find some common ground. I appreciate your leadership in starting this conversation, and I am really grateful to all of our colleagues who are joining in on this.

Of course, I want to thank all the Governors who are here today. I notice that their names either start with B or H. Was that the requirement, or did that just happen?

[Laughter.]

It is great to have all of you here today as well.

As you know, Governors have added a really valuable perspective to the health care discussion so far. I am really glad that our committee will have the chance to get your input as we enter this next phase of working to really stabilize the markets and lower costs for our constituents in the near term.

The truth is that there is actually a lot many Democrats and Republicans agree on when it comes to the specific goal. As a starting point, even if we do not all agree on the cause, we do agree on the problem itself. Families are facing higher premiums and fewer options as a result of uncertainty in our health care system. Democrats have a number of ideas, which I will be interested in dis-

cussing with all of you today to address this problem. I want to just give a few examples.

Senator Shaheen introduced a multi-year fix to ensure out-of-pocket cost reductions under the Affordable Care Act are not cutoff. We will need a long-term stability for this program if we want insurers to stop worrying about uncertainty long enough to actually lower premiums for patients.

Senators Kaine and Carper put forward legislation to help with coverage costs for our sickest patients.

Senators McCaskill and Schatz have proposals on how we prevent their counties moving forward.

Many of us are also interested in ensuring open enrollment is as effective as possible this year, given the President's decision to slash efforts to help people get coverage. And it is not just Democrats in the Senate who are looking at a wide range of ideas to strengthen markets and lower families' health care costs in the near future. Governors Kasich and Hickenlooper, who is here with us, have put forward a plan including many policies that parallel those I have mentioned, and their plan should help inform our conversation here in Congress.

I was especially pleased, the Governors' plan would maintain protections in current law for patients like those with preexisting conditions and women seeking maternity care because as I said yesterday, this needs to be a conversation about moving our health care system forward not backward. It is certainly not an opportunity to roll back protections for patients or a chance to hand power back to the insurance companies.

I hope we can focus on areas of common ground rather than getting bogged down in ideology again that drove that Trumpcare debate. If we can do this, I believe a bipartisan agreement on health care reform is possible, not easy, but possible. I am very hopeful we will not only succeed but be able to build on the near-term steps to tackle the larger challenges families continue to face in getting the affordable care they need.

Again, I want to thank Chairman Alexander for moving us forward on this. I want to thank all of our colleagues who are here and all the Governors who are here to help us with this discussion, and I really look forward to it. Thank you.

The CHAIRMAN. Thank you, Senator Murray. I think people know the high respect I have for Senator Murray. When she gets involved and tries to get a result, we usually get one. This committee has gotten results on big issues in the past that are very complicated and very contentious, education, 21st Century CURES. We have been able to do it. We are trying to take a small step here that will lead to bigger steps.

I am going to introduce the first two witnesses, then call on Senators Warren, Bennet, and Hatch, former chairman of this committee and chairman of the Finance Committee, to introduce the other Governors.

The first witness is Governor Bill Haslam of Tennessee. He will not say it but I will say it. I think I am right. Tennessee has the lowest taxes, the lowest debt, fastest improving schools, and the No. 1 State for auto jobs. That is our story and we are sticking to it.

[Laughter.]

Governor Haslam has been indispensable in that. He has been a really terrific Governor. He is in his seventh year.

Governor Bullock is from Montana. Steve Bullock is a Democratic Governor in a State with a Republican legislature. They worked together to expand Medicaid. He has put the State's checkbook online so Montanans can see how their tax dollars are spent. Governor Bullock, we welcome you and thank you for coming all the way across the country to be with us today.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman.

I am pleased to introduce Massachusetts' Governor, Charlie Baker. Governor Baker has served as the Governor of Massachusetts since 2015, and he is currently the co-chair of the National Governors Association's Health and Human Services Committee.

There is a particular reason to have him in this hearing today, and that is that he previously served as Massachusetts Secretary of Health and Human Services, as well as Secretary of Administration and Finance, and before becoming our Governor, he served for a decade as the President and CEO of Harvard Pilgrim Health Care, which is a non-profit health care insurance company based in Wellesley, Massachusetts and serves the entire New England region.

I just want to add that Massachusetts has a long history of bipartisan cooperation on health reform, which is one of the reasons that our State's health care system has become a model for the rest of the country. The Governor and I have continued that bipartisan cooperation and tradition in recent months, and I am glad that Congress is starting to move in this direction as well.

Governor, thank you for being here and thank you for contributing your considerable expertise to this conversation.

The CHAIRMAN. Thank you, Senator Warren. And welcome, Governor Baker.

Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman. As I said yesterday, thank you for your bipartisan approach to the work that is in front of us.

There is not anybody I know who epitomizes bipartisanship more than our Governor, John Hickenlooper, my old boss. I was his chief of staff when he was mayor of the City and County of Denver. Some things I know about John is that he came to Colorado as a geologist, and he promptly lost his job during a downturn and his insurance, by the way, his health insurance.

That did not stop him. He created the first microbrewery that existed between Chicago and Los Angeles in the City and County of Denver, became a very successful businessman, became Mayor of Denver. One of the first things he did was go out and wrangle 34 mayors in the Denver metro area, many of them Republicans, to raise the sales tax to pay for what is now the newest light rail sys-

tem in the country. It covers an area the size of the State of Connecticut. When he became Governor, he continued that bipartisan work, brought environmentalists and industry together to create the first methane regulations in the United States. He has worked, as has been mentioned by the ranking member, with John Kasich from Ohio to create a bipartisan path forward that other Governors have supported.

I would close just by saying to our chairman we have the lowest unemployment rate in the United States of America, and that is our story and we are sticking to it.

[Laughter.]

The CHAIRMAN. Thank you, Senator Bennet. Welcome, Governor Hickenlooper.

Senator Hatch.

STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you, Mr. Chairman.

I am pleased to be here today to introduce my friend and colleague, Governor Gary Herbert. Governor Herbert's guidance and leadership have been tremendously important to both my staff and me on a whole variety of issues impacting the great State of Utah. Governor Herbert has been a leader in addressing opioid abuse in Utah and has truly been a trailblazer in examining how the opioid crisis addresses homeless populations. States are laboratories for transformative policies and innovations in our country, and Governors deserve our respect and appreciation for their tireless advocacy to improve daily life for their citizens.

Furthermore, under Governor Herbert's leadership, Utah has been at the forefront of providing innovative, cost-effective, high-quality health care to its constituents.

I am pleased Governor Herbert is here today to share his perspectives. Governor Herbert and I have frequently discussed the issues that plague the individual market as a result of Obamacare. He is engaged in these policies and is intricately aware of how they interact with other State efforts that aim to provide access to affordable care to all Utahans.

The Governor is also aware of the need to deregulate the individual and small group health insurance markets to put the power back in the hands of the States. This requires structural reforms to Obamacare, not just bailouts.

The committee is fortunate to have Governor Herbert here today, and I look forward to continuing to work with him to advance the health and well-being of all Utahans.

While I wish I could stay for the discussion today, I need to go and chair my Finance Committee hearing on the children's health insurance program, which also is important. That is a must-pass piece of legislation that I know each of the Governors before us today supports. I leave the commentary for Utah in the very capable hands of our beloved Governor, who I am happy to say is a very close personal friend.

I appreciate you allowing me to do this, Mr. Chairman and Madam Chairman, as well. Thanks so much.

The CHAIRMAN. Welcome, Governor Herbert.

Thank you, Senator Hatch. Just for the Governor's information, when it comes to taxes, Medicare and Medicaid, the Finance Committee under our system has the jurisdiction over that, but you are speaking to a lot of members of the Finance Committee when you speak to this committee because many are members of both committees. We thank Senator Hatch for his leadership.

Now we will go to the Governors, and we will ask each of you, starting with Governor Haslam, down the line, if you could please summarize your remarks in about 5 minutes. That will give us an opportunity to have a conversation with you between the Senators and Governors. Governor Haslam, welcome.

STATEMENT OF HON. BILL HASLAM, GOVERNOR, TENNESSEE

Governor HASLAM. Thank you and good morning to members of the committee, to Ranking Member Murray and to one of the Tennessee's all-time favorite sons, Chairman Alexander.

It is an honor to be here with this group of Governors who I consider friends and who I know to be problem solvers.

My request to this committee this morning is that you do two things: first, that you move quickly to stabilize the individual insurance marketplace; then second, that you would undertake a serious effort to work together to address the cost of health care.

As Chairman Alexander said, these are good times in Tennessee. Our unemployment rate is the lowest in history. We became the first State in the Nation to offer 2 years free of community college or technical school to all of our citizens. Our tax, as a percentage of income, and our debt per capita are among the lowest if not the lowest in the country.

The crisis of health care and the uncertainty of its future threaten our State's citizens and the State's budget. The primary difference between governing Tennessee now and when then a very young Governor Lamar Alexander led the State more than 30 years ago is the impact that the cost of health care has on everything else that we do.

Today, Tennessee finds itself with only three insurance carriers offering ACA-compliant coverage. In more than 80 percent of our counties, citizens have only one insurance option. And these limited options are provided to Tennesseans at substantial cost increases. Our experience of fewer choices at higher costs is not sustainable. We are on a path where citizens simply will not have an option to purchase from the insurance marketplace or cannot pay for the limited options that are available to them. Either way, the system fails.

Congress should take steps now to prevent the total collapse of the health insurance market by: No. 1, funding cost share reduction payments; two, creating a short-term reinsurance program; and three, providing flexibility to the States.

In Tennessee, about 60 percent of our federally facilitated marketplace participants are enrolled in CSR plans. Failure to fund CSR payments will increase premiums significantly, create even more uncertainty around the future of participating carriers, and actually increase the Federal deficit due to higher premium tax credits. Clearly, this is not a recipe for success. It is also very important to understand that our marketplace was facing collapse be-

fore this current discussion of CSR payments, and other actions and reforms will be needed to address the crisis.

Second, Congress can take additional action to stabilize markets by funding a short-term reinsurance program that would limit losses to carriers that provide coverage in the marketplace. This should produce lower premiums which, in turn, should attract new, healthier individuals to the marketplace.

A third critical way to provide more stability is to offer flexibility to States to address their unique challenges and circumstances. The waiver approval process should be expedited, and the strict guardrails currently placed upon waiver requests should be loosened in a manner that will attract younger, healthier individuals to the marketplace.

I realize that some of the things that I just outlined around stabilization costs more money, and I am asking for this at a time when many Governors, including myself, are emphasizing the skyrocketing costs of health care. The reality is that failure to address the immediate stabilization needs while Congress works on the bigger issue of cost will almost certainly result in collapse of the market. Some may say the only way to ensure legislative action on cost and realize real reform is total collapse. I do not subscribe to that line of thinking. I think every Governor here and those back at home believe that we can move to stabilize the market now while we work to take on the issue of health care costs.

Having helped to stabilize the market, it is my strong hope that this committee will then turn its sights to the cost of health care, which is crippling businesses and families and overwhelming all the other needs that should be addressed in State and Federal budgets. We must all recognize what has been missing in the argument over the Affordable Care Act. The law was supposed to solve two critical issues around health care in America. The first was the large number of people who did not have health insurance or could not afford coverage. Second, the Affordable Care Act was supposed to make health care affordable. Unfortunately, it has provided coverage or government subsidies for millions of people to have coverage at the same exorbitant costs.

One of the criticisms of the Affordable Care Act is that it took the easy part, saying that we would provide free or subsidized insurance to more people, without simultaneously addressing the hard thing, addressing costs. We should not kid ourselves. Addressing costs is difficult politically and otherwise. One of the drivers of health care costs is the misalignment of incentives that is created when we compensate providers based on the volume of care that they provide rather than on outcomes or efficiency.

In Tennessee, we are working to change the way we pay for and deliver health care so that providers are compensated based on value. And Congress should make a clear commitment to this type of payment innovation.

All of us, Republicans, Democrats, and Independents, should agree that our current path is not a sustainable one. During all of the debate about the Affordable Care Act, there has been a lot written and said about how immoral it would be to have millions of people lose health insurance coverage. I understand the argument. I am a Republican Governor who proposed a conservative plan to

increase Medicaid coverage in our State. However, can we not all acknowledge that it is just as morally questionable to cover everyone with health insurance and put the bill on a credit card to be paid by our grandchildren and not do everything we can to make health care affordable now?

Thank you again to the entire committee. As Governors, we stand ready to partner with you to secure and strengthen the individual market and our entire health care system.

[The prepared statement of Governor Haslam follows:]

PREPARED STATEMENT OF HON. BILL HASLAM

SUMMARY

INTRODUCTION

- Congress must move quickly to address market stability and then undertake a serious effort to address health care costs.
- The crisis of health care and the uncertainty of its future threaten our State's citizens and the State's budget.

STABILITY

- In more than 80 percent of Tennessee counties, citizens have only one insurance carrier option, and these limited options are provided at substantial cost increases—possibly as much as 40 percent for 2018, after increases totaling as much as 139 percent from 2014 to 2017.
- Congress should take steps now to prevent the total collapse of the health insurance market. These steps include: (1) Funding cost sharing reduction payments; (2) Creating a short-term reinsurance program; and (3) Providing flexibility to States.
- Failure to address the immediate stabilization needs while Congress works on the bigger issue of cost will almost certainly result in collapse of the market.
- Some say the only way to ensure legislative action on costs and realize real reform is total collapse, but I and Governors throughout the country don't subscribe to that line of thinking.

HEALTH CARE COSTS

- Unfortunately, the ACA has provided coverage or government subsidies for millions of people to have coverage at the same exorbitant costs, and these costs have only continued to increase at a rate that far exceeds non-medical inflation. At the State level, spiraling health care costs in recent decades have forced States to cut back on other services.
- One of the criticisms of the Affordable Care Act is that it took the easier part—saying that we would provide free or subsidized insurance to more people—without simultaneously accomplishing the hard thing—addressing costs.
- One of the drivers of health care costs is the misalignment of incentives that is created when we compensate providers based on the volume of care they provide rather than on outcomes or efficiency. In Tennessee, we are working to change the way we pay for and deliver health care so that providers are compensated based on value. Congress should make a clear commitment to this type of payment innovation.
- All of us should agree that our current path is not a sustainable one. We are a country with \$20 trillion in debt with even more staggering debt projections.
- During the debate on the future of the ACA, there has been much said about the immorality of millions of people losing health care coverage but it's just as morally questionable to cover everyone with health insurance and put the bill on a credit card to be paid by our grandchildren while not doing everything we can to make health care affordable.

CONCLUSION

- As Governors, we stand ready to partner with you to secure and strengthen the individual market and our entire health care system.

INTRODUCTION

Good morning members of the committee, Ranking Member Murray, and to one of Tennessee's all-time favorite sons, Chairman Alexander.

It is an honor to be here with this group of Governors who I consider friends and who I know to be problem solvers. My request to the committee this morning is that you do two things: first, that you move quickly to stabilize the individual insurance marketplace. Then, second, that you would undertake a serious effort to work together to address the cost of health care.

These are good times in Tennessee. Our unemployment rate is the lowest in history. Our K-12 public schools are improving at a faster rate than any State in the country, and we became the first State in the Nation to offer 2 years free of community college or technical school to all of our citizens. Our tax as a percentage of income and our debt per capita are among the very lowest in the country. The crisis of health care and the uncertainty of its future threaten our State's citizens and the State's budget. The primary difference between governing Tennessee and when then Governor Lamar Alexander led the State more than 30 years ago, is the impact that the cost of health care has on everything else we do.

STABILITY

Today, Tennessee finds itself with only three insurance carriers offering ACA-compliant coverage. In more than 80 percent of our counties, citizens have only one insurance option. These limited options are provided to Tennesseans at substantial cost increases—possibly as much 40 percent for 2018, after increases totaling as much as 139 percent for some from 2014 to 2017. Tennessee's experience of fewer choices at higher costs is not sustainable. We are on a path where citizens simply won't have an option to purchase from the insurance marketplace or can't pay for the limited options available to them. Either way, the system fails.

Congress should take steps now to prevent the total collapse of the health insurance market by: (1) Funding cost-share reduction payments; (2) Creating a short-term reinsurance program; and (3) Providing flexibility to States.

In Tennessee, about 60 percent of our federally Facilitated Marketplace participants are enrolled in CSR plans, meaning they receive assistance resulting in premium reductions. Failure to fund CSR payments will increase premiums significantly for our citizens, create even more uncertainty around the future of participating carriers and, according to the Congressional Budget Office, actually increase the Federal deficit due to higher premium tax credits. Clearly, this is not a recipe for success. It's also very important to understand that our marketplace was facing collapse before this discussion of CSR payments, and other actions and reforms will be needed to address the crisis.

Second, Congress can take additional action to stabilize markets by funding a short-term reinsurance program that would limit losses to carriers that provide coverage in the marketplace. This should produce lower premiums, which, in turn, should attract new, healthier individuals to the marketplace.

A third critical way to provide more stability is to offer flexibility to States to address their unique challenges and circumstances. The waiver approval process should be expedited, and the strict guardrails currently placed upon waiver requests should be loosened in a manner that will attract younger, healthier individuals to the marketplace. Examples of guardrail relief include more flexibility around rate bands and plan design. Simply put, without more flexibility, carriers will be left with two choices—leave the individual market or raise rates.

I realize some of the things I just outlined around stabilization cost more money and I'm asking for this at a time when many Governors, including myself, are emphasizing the skyrocketing costs of health care. In fact, I'm going to address health care costs in a moment. The reality is failure to address the immediate stabilization needs while Congress works on the bigger issue of cost will almost certainly result in collapse of the market. Some may say the only way to ensure legislative action on cost and realize real reform is total collapse. I don't subscribe to that line of thinking. I think every Governor here and those back at home believe we can move to stabilize the market now while we work to take on the issue of health care costs.

HEALTH CARE COSTS

Having helped to stabilize the market, it is my strong hope that this committee will then turn its sights to the cost of health care, which is crippling businesses and families and overwhelming all of the other needs that should be addressed in State and Federal budgets. We must all recognize what has been missing in the argument over the Affordable Care Act. The law was supposed to solve two critical issues

around health care in America. The first was the large number of people who didn't have health insurance or couldn't afford coverage. Second, the Affordable Care Act was supposed to make health care, well, affordable. Unfortunately, it has provided coverage or government subsidies for millions of people to have coverage at the same exorbitant costs.

It is past time for all of us in elected office to focus our conversation on controlling the out of control cost of health care. In the last 20 years, health care has gone from 21 percent of the Federal budget to 31 percent. At the State level, spiraling health care costs in recent decades have forced States to cut back on other services. Ever wonder why college tuition has increased so drastically? The primary factor is that as States spend more money on Medicaid, there are fewer dollars for higher education. Surely all lawmakers can agree this country has a fundamental problem as long as medical inflation is increasing at almost twice the rate of inflation of everything else. If not, as someone once quipped, "the United States government is about to become a large health insurance company with a small army attached to it."

One of the criticisms of the Affordable Care Act is that it took the easy part—saying that we would provide free or subsidized insurance to more people—without simultaneously accomplishing the hard thing—addressing costs. We shouldn't kid ourselves—addressing costs is difficult politically and otherwise. One of the drivers of health care costs is the misalignment of incentives that is created when we compensate providers based on the volume of care they provide rather than on outcomes or efficiency.

In Tennessee, we are working to change the way we pay for and deliver health care so that providers are compensated based on value. Early results from our payment reform initiative show that we are saving millions of dollars while maintaining quality of care. Congress should make a clear commitment to this type of payment innovation by encouraging coordination of Medicare, Medicaid, State employee and private value-based care initiatives and by leveraging the Federal employee plan to spur payments based on quality as opposed to quantity.

All of us—Republicans, Democrats and Independents—should agree that our current path is not a sustainable one. We are a country with \$20 trillion in debt with even more staggering debt projections. During all of the debate about the Affordable Care Act, there has been a lot written and said about how immoral it would be to have millions of people lose health insurance coverage. I understand the argument. I am a Republican Governor who proposed a conservative plan to increase Medicaid coverage in our State. However, can't we all acknowledge that it is just as morally questionable to cover everyone with health insurance and put the bill on a credit card to be paid by our grandchildren and not do everything we can to make health care affordable?

CONCLUSION

Thank you again to the entire committee. As Governors, we stand ready to partner with you to secure and strengthen the individual market and our entire health care system.

The CHAIRMAN. Thank you, Governor Haslam.
Governor Bullock, welcome.

STATEMENT OF HON. STEVE BULLOCK, GOVERNOR, MONTANA

Governor BULLOCK. Chairman Alexander, Ranking Member Murray, and members of the committee, thank you. First, thank you for inviting Governors, Democrats and Republicans, to appear before you today. Whatever comes out of Washington, DC or does not come out of it, we are on the front lines of dealing with it. And your recognizing the importance of our involvement in this discussion is significant.

Second, thank you for undertaking the hard work of working together. As we learned from the passage of the ACA, meaningful and lasting reform will be substantially hamstrung if implemented over the uniform objection of the minority party. I applaud the chair and members of the committee for doing all you can to ensure that Congress does not repeat errors of the past or even errors of the past months.

Third, we are all familiar with the old adage, the only way to eat an elephant is one bite at a time. My thanks for a singular focus on the immediate steps Congress can take to stabilize premiums and help individuals in the insurance market. Anymore, governing in DC may seem like a zero sum game, with few win-win scenarios. If you are earnest in adding greater stability to the overall health care system and the individual markets, I do believe that your efforts will reap political rewards on both sides. Some may call me a dreamer, but it might even prove to be a model for further efforts.

Following the eating the elephant analogy, it may be only one bite that this committee is taking, but it is an important one. Last time I was with Chairman Alexander again with a bipartisan group of Governors, he handed out his pocket guide to the basics of health care coverage. Sure, those on the exchanges only represent 6 percent of all those covered, 4 percent of the total insured, or the individual markets, 6 percent of all those covered by insurance. Stabilizing the individual market impacts all areas of coverage and also has a highly pronounced impact on places like where I live.

Rural Montanans like rural Americans are less likely to have that option of employer-sponsored insurance. Today 8 percent of those insured in Montana are on the individual market. Three out of four enrolled in a marketplace plan are from rural and frontier areas of our State. Eighty-four percent of all Montanans enrolled in a marketplace plan receive tax credits to make their premiums affordable, and half receive cost sharing reduction payments to reduce their out-of-pocket costs.

I do believe that we can find common ground in driving down costs and stabilizing the marketplace, and the time to do it is now.

While health care may be complex, it certainly does not take a brain surgeon to figure out how to stabilize the individual market. The effort I have been involved in, led by Governors Hickenlooper and Kasich, offer a road map and a menu of actions that this committee can take. And while the perspectives of the five Governors appearing before you this morning are certainly as diverse as the landscapes that we represent, we are uniform in insisting that cost sharing reduction payments be continued. All of us in our testimony urge you to create a temporary stability fund. We all agree that you need to make sure that both the healthy and the unhealthy continue to be covered in order to spread the risk. And we all seek the opportunity to innovate while still maintaining important consumer protections.

If this committee will work across the aisle with one another to undertake even those four measures, you will accomplish your aim of stabilizing the individual market. If you just did the CSR payments, you would take significant steps to do so.

It also does not take a brain surgeon to sabotage our current system. The inaction and the messages coming from some in DC are doing it now. In Montana, our largest insurer has proposed a rate increase for next year 10 times higher than it would be because of the uncertainty that the President and DC has created.

Finally, more important than being Governor, I am a parent, and during my first State of the State address 5 years ago, I urged pol-

icymakers to act like our kids are watching and learning from our behavior, our words, and our deeds because, indeed, they are. I implore you to do the same. In a time of seeming dysfunction, this committee and this Congress can work together to stabilize the individual market, beginning to eat that elephant one bite at a time. And who knows? We all might find that working together is not only good for Congress, but it is good for our country.

Thanks for having me and my colleagues here. I look forward to the conversation we will have over the next couple of hours.

[The prepared statement of Governor Bullock follows:]

PREPARED STATEMENT OF HON. STEVE BULLOCK

SUMMARY

I appreciate the Senate HELP Committee's attention to this important issue. It's heartening to see folks in Washington DC begin to reach across the aisle and engage in a civil, respectful dialog. And maybe even begin to listen to one another. Instead of debating proposals that would take health insurance coverage away from thousands of Montanans, and millions of Americans, focusing the discussion on how to fix the existing flaws in our health care system is the only way this country will move forward in the health care debate.

I know bipartisanship works, and on an issue as important as health care, bipartisanship is an imperative. We must come together with real solutions to stabilize the market. We need certainty and stability not just for insurance providers but also for the people in our States that need insurance. While we so often speak in terms of percentages and aggregate numbers, we cannot forget that behind the numbers are people facing a cancer diagnosis or planning to care for a sick child or parent; young people that might think they are invincible, that seek to avoid coverage, then are one accident or incident away from bankruptcy. The millions of people currently in the individual marketplace all have individual stories, and individual hopes and aspirations that this committee and Congress can help further. These people need certainty that their insurance premiums will not spike beyond what they can afford.

I appreciate the work of my fellow Governors in finding common ground on controlling costs and stabilizing the market, that will positively impact the coverage and care of millions of Americans. As Governors of both parties, both here before you today and others across this Nation, we stand ready to work with you in an open, bipartisan way to provide better insurance and health care outcomes for all Americans.

FUND THE COST SHARING REDUCTION: PREMIUM INCREASES IN MONTANA FROM FAILURE TO PAY COST SHARING REDUCTIONS

The Administration's mixed—and at times hostile—signals regarding the CSR payments and other destabilizing actions has led Montana's largest insurer to propose a rate hike for next year that's 10 times higher than it would have been under current provisions of the ACA.

CREATE A TEMPORARY STABILITY FUND

Although no longer in place, in 2014, the reinsurance program under the ACA reduced premiums in the individual marketplace by 10–15 percent.

ENCOURAGE ENROLLMENT AND ENFORCE THE INDIVIDUAL MANDATE UNTIL A CREDIBLE REPLACEMENT IS FOUND

Encouraging younger, healthier people to enroll in insurance will improve the risk pool and bring more stability and affordability to the market place. It will also protect our young adults, who are just starting their independent lives, from financial calamity if the unexpected happens.

ENCOURAGE STATE INNOVATION TO REFORM PAYMENT AND CONTROL COSTS

Strengthening primary care is critical to promoting health and reducing overall health care costs. Congress created the Center for Medicare and Medicaid Innovation (known as the Innovation Center, CMMI) to test innovative payment and delivery models that can reduce costs and improve health. Their Comprehensive Primary Care Plus model does that through a public-private partnership that bolsters pri-

mary care, provides flexibility and the right incentives to doctors, and reduces the overall cost of care.

Chairman Alexander, Ranking Member Murray, and distinguished committee members, thank you for the opportunity to appear today. Thank you for the invitation to be here and discuss some of the ways we can work together—Senators, Governors, Democrats and Republicans, to finally begin to find meaningful solutions that will increase affordability and quality of health care across America, specifically through the individual marketplace.

I appreciate the Senate HELP Committee's attention to this important issue. It's heartening to see folks in Washington DC begin to reach across the aisle and engage in a civil, respectful dialog. And maybe even begin to listen to one another. Instead of debating proposals that would take health insurance coverage away from thousands of Montanans, and millions of Americans, focusing the discussion on how to fix the existing flaws in our health care system is the only way this country will move forward in the health care debate.

Although difficult, this discussion is imperative and it is our bipartisan responsibility. Indeed, while people across the political spectrum may find flaws and shortcomings of the Affordable Care Act—and doubtless there are differing opinions concerning the substance of those shortcomings—there ought to be some agreement regarding the enduring problems caused by the manner in which the ACA was ultimately enacted. Meaningful and lasting reform in any area of policy will be substantially hamstrung if that policy is implemented over the uniform objection of the minority party. I applaud the Chairman, and members of the committee, for recognizing this to be the case, and for doing all that you can to ensure Congress doesn't repeat the mistakes of the past.

While the individual marketplace is a relatively small percentage of all Americans covered, it's instability not only impacts millions of Americans, but also has impact beyond the percentages. I believe we can find common ground in driving down costs and stabilizing the marketplace, and the time to act is now. Bipartisanship on an issue as difficult as health care can be challenging, yet it is not impossible. I know this because we've done it in Montana. And my fellow Governors appearing before you today are working hard every day to find similar common ground in their States surrounding issues like health care and other matters of significant concern.

A STRONG INDIVIDUAL MARKET IS ESSENTIAL TO A RURAL, FRONTIER STATE LIKE
MONTANA

Montana is a State of a million people spread out over 147,000 miles. The rural nature of Montana is a celebrated part of our heritage, but it does present some real challenges when it comes to access to affordable, high quality health care and emergency services. Indeed, the vitality and continuing viability of our communities, urban and rural, depend on access to quality, affordable healthcare, and the facilities that provide that care.

Until recently, far too many of our neighbors, friends, and coworkers went to work every day with the knowledge that access to health insurance—and quality, affordable health care—was beyond their reach. As a result, they were forced to avoid regular check-ups and screenings, and were often left with no choice but to access care when and where it is most expensive and most difficult to treat—the emergency room.

Montana was the last State in the country to legislatively pass Medicaid expansion and we did so with true bipartisan compromise and a uniquely Montana approach. I am grateful to my legislative colleagues on both sides of the aisle for being willing to put politics aside to improve access to health care in our State.

With passage of the Medicaid expansion and increased access to individual insurance coverage through the health insurance marketplace, Montana's rate of uninsured has dropped from a staggering 20 percent in 2013 to 7 percent in 2017. The implementation of Medicaid expansion in 2016 contributed most significantly to that drop. Growth in the individual market as a result of tax credits, as well as elimination of underwriting and pre-existing condition exclusions, were also significant factors.

It is also important to note that while today's topic focuses on the individual insurance market, the stability and affordability of the private market in States like Montana are linked to the expansion of the Medicaid population. It has been well

documented that marketplace premiums are about 7 percent lower in Medicaid expansion States than in States that have not yet expanded Medicaid.¹

The decline in uninsured and the increase in access to affordable coverage has been particularly meaningful in rural Montana. Rural Montanans, like rural Americans, are less likely to have the option of employer-sponsored health insurance. Today, three out of four Montanans who enrolled in a Marketplace plan during the last open enrollment period are from rural and frontier areas of our State. Eighty-four percent of all Montanans enrolled in a Marketplace plan receive tax credits to make their premiums affordable; half receive cost sharing reductions to reduce their out of pocket costs.

REAL IMPACTS: IMPROVING HEALTH CARE OUTCOMES IN INDIAN COUNTRY

The States that appear before this committee all present different perspectives, challenges and opportunities. One perspective that is more prevalent in the West, and worthy of this committee's understanding, is the impact on American Indians. In Montana, the lifespan of American Indians is, on average, 20 years shorter than their non-native friends and neighbors. The ACA marked the largest expansion of American Indian health care in a generation, as Medicaid expansion and the health insurance marketplace have given many American Indians access to health coverage for the first time in their lives.

Indian Health Services is an important part of upholding the Federal Government's trust responsibility to Indian peoples, but it is not comprehensive health coverage. Its chronic underfunding used to mean that IHS clinics ran out of money part way through the year, and only beneficiaries in danger of losing life or limb could get care.

The ACA, and especially Medicaid expansion, has changed that. Now, in Montana, more than 13,000 Native Americans have gotten covered through Medicaid expansion and the health insurance marketplace, which means they have access to the full spectrum of health services they need, when they need them—just like you and me.

It also means that IHS' funding lasts longer, and IHS clinics are able to make up for some of the chronic funding shortfall by billing Medicare, Medicaid and private insurance. Montana's tribal leaders have told me how important the ACA is to their people's health and future, and the Rocky Mountain Tribal Leaders Council passed resolutions supporting the ACA and Medicaid expansion.

IMMEDIATE ACTIONS TO RESTORE STABILITY TO PRIVATE INSURANCE MARKET

At the end of the day, health care is about people, not politics or posturing. It is about the well-being of our citizens, and the overall health of our communities. The ACA certainly is not without flaws and we must look for bipartisan ways to improve coverage and affordability and to ensure a stable and fair market under the law. We will not achieve these goals by pulling the rug out from under people who rely on the coverage they receive to ensure the health of themselves and their families.

We must continue working together across party lines, in public-private partnerships, and using the latest technology and best practices to ensure that patients, in all corners of our country, have access to the best care—and that their doctors and health care professionals have access to the training and support they need to provide that care.

Good health is the foundation of everything from a competitive workforce to the economic and financial security of our families.

Recently, a number of Governors sent congressional leaders some thoughts on reform, and immediate steps that could be taken to make coverage more affordable. The perspectives of the eight Governors signing that letter are as diverse as the landscapes spanning the signatory States. Doubtless, many other Governors across the country would agree with most, or at least some of the recommendations included therein. Below, I highlight a few of the areas that I hope the committee will seriously consider.

A. Fund the Cost Sharing Reduction: Premium Increases in Montana from Failure to Pay Cost Sharing Reductions

Notably, the invitation to testify before this committee wasn't to endeavor to solve all the challenges of the ACA or healthcare, but instead to present "thoughts on the

¹Office of the Assistant Secretary for Planning and Evaluation (ASPE), "The Effect of Medicaid Expansion on Marketplace Premiums," August 25, 2016, <https://aspe.hhs.gov/pdf-report/effect-Medicaid-expansion-marketplace-premiums>.

need for congressional and administrative action to stabilize premiums and help individuals in the individual insurance market for 2018.” If this committee is genuinely concerned with stabilizing the individual marketplace, the most important step it can take in the near term is ensuring funding for the cost-sharing reduction (“CSR”) payments for at least the next 2 years.

The impact of the uncertainty of whether the CSR payments will continue to be funded is exemplified by the Montana experience. Montana has three carriers offering insurance on the exchange. The Administration’s mixed—and at times hostile—signals regarding the CSR payments and other destabilizing actions has led Montana’s largest insurer to propose a rate hike for next year that’s 10 times higher than it would have been under current provisions of the ACA.

In a hearing before the Montana Insurance Commissioner, the president of that insurer testified that the uncertainty around whether the Trump administration would pay the CSR and keep current provisions of the ACA in place resulted in a requested 23 percent average rate increase. He testified that that had these uncertainties not existed; the insurer would only have requested a rate increase of 2.3 percent.² Similarly, the non-partisan Congressional Budget Office recently found that not paying the cost-sharing reductions would result in a 20–25 percent increase in premiums, and increase the Federal deficit \$194 billion over the next 10 years.³ The uncertainty surrounding whether the Trump administration will continue to make CSR payments is having a real impact on private markets, and congressional assurance that these payments will continue to occur will meaningfully impact the stability of the market—in Montana, and across the country.

B. Create a Temporary Stability Fund

Although no longer in place, in 2014, the reinsurance program under the ACA reduced premiums in the individual marketplace by 10–15 percent. With several more years of experience now behind us, it is a mechanism that will add to the stability of the market. Certainly, some States have been taking steps to do the same. However, Congress should create a reinsurance program or a fund that states can use to create reinsurance programs or similar efforts that reduce premiums and limit losses for providing coverage. This safety net will allow insurers to manage their risk and bring down premiums. As recommended in the bipartisan Governors’ letter, it should be provided for at least 2 years and that a funding source be identified to offset the cost so it does not add to the deficit.

C. Encourage Enrollment and Enforce the Individual Mandate Until a Credible Replacement is Found

Finally, encouraging younger, healthier people to enroll in insurance will improve the risk pool and bring more stability and affordability to the market place. It will also protect our young adults, who are just starting their independent lives, from financial calamity if the unexpected happens.

Education must remain a priority, and recent actions to reduce funding that would drive individuals to sign up for insurance is penny wise and pound foolish. Reducing the education budget by 90 percent and payments to navigators by 40 percent is, like the continuing threats to withhold the CSR payments, and overt attempt to sabotage the ACA. We must continue to fund efforts to educate and encourage younger people to enroll in coverage, including enrollment assistance.

Research shows young adults are less confident in their ability to choose a health insurance plan, and that most uninsured adults would like to talk with someone when signing up for health insurance. Improving young adults’ participation will lower risk and drive premium costs down. Investing in marketing campaigns that educate and appeal to this younger generation is a critical component of controlling costs.

Moreover, at this point, it remains necessary to reduce the risk that only the sickest will get insurance. Coming from a rural State like Montana that has a strong libertarian streak, I certainly understand and sympathize with those who dislike individual mandate. However this committee’s aim is near term stabilization of the individual market. The reality is that without participation of the young and the healthy we will not achieve lower premiums. We must roll up our sleeves and consider credible alternatives, but we must also have the courage to recognize that while unpopular, enforcement of the individual mandate is necessary to stabilize the

²Matt Volz, “Health law uncertainty balloons Montana insurance rates,” *Associated Press*, July 26, 2017, <https://www.usnews.com/news/best-states/montana/articles/2017-07-26/health-law-uncertainty-balloons-montana-insurance-rates>.

³Congressional Budget Office, “The Effects of Terminating Payments for Cost-Sharing Reductions,” August 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

market and prevent carriers from leaving the market place or offering premiums that price working Americans out of the private market.

LOOKING FORWARD: ENCOURAGE STATE INNOVATION TO REFORM PAYMENT AND CONTROL COSTS

In taking steps to stabilize the market for the immediate term, Congress must ensure that it doesn't stifle the innovation and efforts occurring to transform the underlying market dynamics driving the increasing cost of care; dynamics that were manifest even long before the ACA was enacted. We know that healthier Americans make for healthier businesses, families, and stable State economies. Individual health can have an enormous impact on individuals, their families, and the overall economy. We also know that, the current system of paying for repeated tests and services, not outcomes, has significant limitations. Ultimately, major transformation of how we incentivize and provide healthcare is necessary.

Strengthening primary care is critical to promoting health and reducing overall health care costs. Congress created the Center for Medicare and Medicaid Innovation (known as the Innovation Center, CMMI) to test innovative payment and delivery models that can reduce costs and improve health. Their Comprehensive Primary Care Plus model does that through a public-private partnership that bolsters primary care, provides flexibility and the right incentives to doctors, and reduces the overall cost of care.

In July of 2017, Montana Medicaid joined with the State's major insurance carriers and Medicare to launch a Comprehensive Primary Care Plus partnership in Montana that includes nearly 1/3 of Montana's covered lives. Smarter spending to support primary care and enhancing care coordination in more innovative ways is the right move. It lets us give providers the freedom to care for patients the way they think is best, and it has been proven to reduce emergency room use and costly hospitalizations.

This is good news for patients, it's good news for families, and it's good news for the patients in States like many of yours, who are joining this move away from fee for service health care system: Tennessee, Ohio and Northern Kentucky, the Greater Kansas City Area, Colorado, Philadelphia, and next year, in Louisiana.

Partnerships like this between private and public health plans, and innovations through CMMI, must continue. While the Federal Government won't always be positioned to create the partnerships or innovation, it can support and incentivize the efforts to do so.

CONCLUSION

Thank you again for inviting me and several of my colleagues. I know bipartisanship can be hard and is not without challenge. I govern in a State where almost two-thirds of those elected in both State houses serve in the Republican Party. In my experience—one that I know is shared by my fellow Governors—the challenges posed in finding bipartisan solutions to difficult issues like health care can be overcome. I worked with Democrats and Republicans to pass a unique approach to Medicaid expansion, which led to a dramatic drop in the number of people in my State without insurance. More than 80,000 Montanans have gained access to health care through expansion and folks have finally started to receive the treatment they deserve.

I know bipartisanship works, and on an issue as important as health care, bipartisanship is an imperative. We must come together with real solutions to stabilize the market. We need certainty and stability not just for insurance providers but also for the people in our States that need insurance. While we so often speak in terms of percentages and aggregate numbers, we cannot forget that behind the numbers are people facing a cancer diagnosis or planning to care for a sick child or parent; young people that might think they are invincible, that seek to avoid coverage, then are one accident or incident away from bankruptcy. The millions of people currently in the individual marketplace all have individual stories, and individual hopes and aspirations that this committee and Congress can help further. These people need certainty that their insurance premiums will not spike beyond what they can afford.

I appreciate the work of my fellow Governors in finding common ground on controlling costs and stabilizing the market, that will positively impact the coverage and care of millions of Americans. As Governors of both parties, both here before you today and others across this Nation, we stand ready to work with you in an open, bipartisan way to provide better insurance and healthcare outcomes for all Americans.

The CHAIRMAN. Thank you, Governor Bullock.

Governor Baker, welcome.

**STATEMENT OF HON. CHARLES D. BAKER, GOVERNOR,
MASSACHUSETTS**

Governor BAKER. Thank you, Chairman Alexander and Ranking Member Murray and the members of the committee. I want to thank you for this opportunity to be here today to testify on stabilizing premiums and helping individuals in the individual insurance market.

I am honored to be part of this group of Governors that are testifying today because we deal with these issues every day and we want to work with Congress and the Federal Government on health care reform.

Massachusetts has achieved near universal coverage with the highest rate of individuals with health insurance in the Nation. That is a story I am sticking to, too. And that is because we have been working and reworking it for more than 10 years. At the center of our bipartisan success is the belief that health care coverage is a shared commitment, not the singular responsibility of government.

As you consider measures to stabilize premiums and address the individual market, I would like to emphasize four key points.

First, bipartisan cooperation is essential to achieving quality, affordable health care coverage and stabilizing any market.

Second, Congress should take immediate affirmative steps to resolve the Federal cost sharing reduction payments until longer-term reforms are enacted. Carriers, providers, and employers and people all need certainty about what rates are going to be and month-to-month resuscitation of cost sharing reductions is not stabilization. They should be maintained for at least 2 years.

As future reforms are considered, a key contributor to market stability is the presence of younger and healthier people in the market. When Massachusetts passed its universal health care law in 2006, we included an individual mandate, which I support. For starters, no one really knows when they might get sick or have a tragic accident. And once it happens, they will seek care and it will be provided. And in many circumstances, they will be unable to pay for it, and that means everyone else who has insurance will be paying for the health care services rendered to those without coverage.

In addition, if people have unlimited access to purchase coverage, many will purchase health insurance only when they need it and then drop it once their care is provided, defeating the whole point behind insurance in the first place.

Continuous coverage encouraged using incentives and consequences is a critical element in ensuring that everyone is treated fairly. Different States can choose different approaches, but if we want to make insurance affordable for people that do not have access to coverage through work and do not qualify for public coverage, we need to nudge everyone into purchasing coverage and then keeping it.

Third, Congress should establish broader parameters for insurance market reforms that include greater latitude for States to meet the unique needs of their residents and health care marketplaces.

1332 waivers should be broadened for greater State flexibility. It is no secret that Massachusetts is committed to continuing to provide access to high-quality, affordable health insurance for all of our residents. An increased waiver flexibility would allow us to more effectively meet that commitment.

Three areas where changes to 1332 waivers would be a significant benefit to States are essential health benefit compliance, benefit design, and budget neutrality. Massachusetts is a strong benefit State. We support essential health benefits. However, even in our State, it was a challenge to adapt to the overly strict Federal framework of the ACA.

Fourth, Congress should take action to address health care costs, and one critical driver is rising pharmaceutical costs. Among other actions, safely expediting the FDA approval process, increasing competition by insuring generic drug availability, and creating greater opportunities for public payers to negotiate prices should be pursued.

As you consider these and other reforms to our health care system, I would ask that any legislative changes occur on a gradual timeline, ideally with State flexibility to opt out or grandfather in existing programs in order to prevent market shocks and to improve market stability.

Finally, as Governors, we are responsible for the fiscal health of our States, as well as the physical health of our residents. Reforms can place States at significant fiscal risk. Any reforms should not shift a greater financial burden onto States.

Complex legislation requires fine tuning and adjustments, and in Massachusetts, we have repeatedly revisited health care reform as we have learned from implementation and as conditions have changed. And our commonwealth is better for that. I urge Congress to commit, as we did, to returning to the table in a bipartisan fashion to review and revise any enacted reforms in the coming years.

I thank you again for this opportunity to provide testimony on this important issue, and we look forward to working with you and other Members of Congress as you consider legislation.

I submitted written testimony that goes into greater length on these and other issues and would be happy to take questions on that or anything else. Thank you.

[The prepared statement of Governor Baker follows:]

PREPARED STATEMENT OF HON. CHARLES D. BAKER

SUMMARY

My testimony will emphasize four key concepts.

First, bipartisan collaboration is essential to achieve affordable health care coverage and stabilize the insurance market. Massachusetts' success in expanding health care coverage is rooted in our ongoing bipartisan approach to problem solving that includes insurance, business, health care, political and advocacy communities.

Second, Congress should take immediate affirmative steps to stabilize the insurance market as an interim step until longer term reforms are enacted. Month to month resuscitation of cost sharing reductions is not stabilization; they should be maintained for at least 2 years. As Congress contemplates future reforms, serious consideration should be given to reintroducing a reinsurance program as a form of market stabilization.

Additionally, as the presence of younger and healthier people in the market is a key contributor to market stability, continuous coverage should be a critical element in ensuring that everyone is treated fairly and should be encouraged using incentives and consequences.

Third, Congress should establish broader parameters for insurance market reforms that include greater latitude for States to meet the unique needs of their residents. States are incubators and innovators of health care reform solutions and initiatives in both their Medicaid programs and commercial markets. For example, States should be allowed to broaden 1332 waivers for greater flexibility that will allow us to meet our commitment to quality, affordable health insurance for our residents in more effective ways.

Fourth, Congress should take action to address health care costs. As we tackle reforms to the health care system, we should bear in mind not just the implications for Federal and State budgets, but also on the people and businesses struggling to keep up with the ever-increasing costs of health care coverage and services. One critical health care cost driver that Congress should address is rising pharmaceutical costs.

I appreciate the opportunity to testify and look forward to working with you and other Members of Congress as you consider legislation.

Chairman Alexander, Ranking Member Murray and members of the committee, thank you for this opportunity to provide testimony before the Senate's Health, Education, Labor, and Pensions Committee hearing on Stabilizing Premiums and Helping Individuals in the Individual Insurance Market.

Thank you for your willingness to engage in a bipartisan way in order to find much-needed solutions. I am especially appreciative that you have convened a group of Governors to testify as we are on the front lines and are eager to work with Congress and the Federal Government on health care reform.

As a former State secretary of Health and Human Services, former CEO of a health plan and current Governor of a State justifiably proud of its excellent and robust health care system, I care deeply about access to and the affordability of health care. These are challenges that must be tackled in a bipartisan, collaborative way, between the States and the Federal Government, and with full participation from patients, employers, insurers and providers. I appreciate the opportunity to share my thoughts with you this morning.

THE MASSACHUSETTS HEALTH CARE LANDSCAPE

Massachusetts believes strongly in health care coverage for its residents. For more than 10 years, the Commonwealth has been engaged in designing and implementing health care reform solutions, first on a State level with our comprehensive, bipartisan State reform in 2006, and later with implementation of the Affordable Care Act. Working with the Federal Government, we have made considerable progress toward the goal of near universal health care coverage for our residents. Ninety-nine percent of our children and youth, and more than 96 percent of all of our residents have health care insurance, the highest percentages in the country. Today more than 257,000 individuals are covered through our State exchange, with 190,000 low to modest income residents receiving Federal and State subsidies. An additional 300,000 adults have Medicaid as a result of the expansion permitted through the Affordable Care Act. The Massachusetts State-based exchange, known as the "Connector" maintains a robust individual insurance market with 62 plans offered from 10 carriers for the current plan year.

Additionally, while health coverage is important first and foremost for its benefits to residents, health care is an economic engine for Massachusetts due to our standing as a global center of excellence in field medical research and home to some of the best treatment facilities in the world. The health care industry contributed \$19.77 billion to the State's economy in 2014, outpacing any other industry. One out of every ten workers is employed in health care related fields.

Massachusetts' success in expanding health care coverage is rooted in our ongoing bipartisan approach to problem solving that includes insurance, business, health care, political and advocacy communities and that began in the 1990s. At the center of that success is our shared belief that health care coverage is a shared commitment, not the singular responsibility of government.

As you consider legislation to stabilize premiums and address the individual insurance market, I would like to emphasize four key concepts.

BIPARTISAN COLLABORATION

First, bipartisan collaboration is going to be essential to achieve affordable health care coverage and stabilize the insurance market. The current debate in Washington about health care reform has destabilized the insurance market; carriers have responded by leaving some markets altogether or proposing to markedly increase rates

to adjust for the uncertainty. The majority of Americans support a bipartisan approach to stabilizing the market and engaging in meaningful health care reform that yields affordable health care coverage.

MARKET STABILIZATION

Second, Congress should take immediate affirmative steps to stabilize the insurance market as an interim step until longer term reforms are enacted. Carriers need certainty in order to finalize rates for plan year 2018 and begin preparing rates for plan year 2019, and providers and employers also need certainty about what those rates are going to be. Month to month resuscitation of cost sharing reductions is not stabilization; they should be maintained for at least 2 years.

I cannot stress enough how critical it is for Federal cost sharing reduction payments to be resolved affirmatively in order to maintain market stability and to constrain rate increases. It is also important to note that the Congressional Budget Office recently reported that ending the cost sharing reduction payments will actually cost the Federal Government more than making the payments, because they will be paying out more in premium tax credit subsidies.

As Congress contemplates future reforms, serious consideration should be given to reintroducing a reinsurance program as a form of market stabilization. As you know, reinsurance simply reimburses a portion of high cost claims exceeding a given attachment point.

A key contributor to market stability is the presence of younger and healthier people in the market. When Massachusetts passed its universal health care law in 2006, it included an individual mandate, which I support. I support it for two reasons. First of all, no one really knows when they might get sick or have a tragic accident, and if they do get sick or have an accident, they will seek care, it will be provided, and in many circumstances, they will be unable to pay for it. That means everyone else who has insurance will be paying for the health care services rendered to those without coverage. Second, if people have unlimited access to purchase coverage, many will purchase health insurance only when they need it, and then drop it once their care is provided, defeating the whole point behind insurance coverage.

Insurance coverage is about shared risk. We all have coverage so that together, we can pay for the care provided to the small number of people who need very expensive care. And for those who do get sick, costs can be very high. It is not unusual to have 1 percent of the population incur 30 percent of the total cost of care provided to that group. In many cases, 5 percent of the population incurs 50 percent of the cost of care received by that group.

If people do not have to carry coverage when they are healthy, and can access it only when they get sick, break a leg, need to have a procedure, or something else, then the rest of us are unfairly tagged with paying for the cost of their care.

Continuous coverage, encouraged one way or another using incentives and consequences, is a critical element in ensuring that everyone is treated fairly. A mandate is one way to encourage continuous coverage. It can also be done using financial penalties for people who do not have continuous coverage, or by establishing limited open enrollment periods. Different States can choose different approaches—or some combination—but if we want to make it easy for people to purchase insurance if they do not have access to it through work, and they don't qualify for public coverage, we need to nudge them into purchasing coverage, and keeping it.

FEDERAL/STATE PARTNERSHIPS

Third, Congress should establish broader parameters for insurance market reforms that include greater latitude for States to meet the unique needs of their residents. States are incubators and innovators of health care reform solutions and initiatives in both their Medicaid programs and commercial markets.

States should be allowed to broaden 1332 waivers for greater flexibility. These waivers are still very new tools for States to utilize as they have only been available since January 1, 2017. Massachusetts is committed to providing access to quality, affordable health insurance for our residents; rather than walking away from that commitment, we believe that increased flexibility would allow us to meet that commitment in more effective ways. In fact, this week, Massachusetts will be submitting a section 1332 waiver seeking additional flexibilities that promote market stability with a premium stabilization fund in the event that Congress does not appropriate funding of cost sharing reductions. Additionally, I will be submitting a letter to Secretary Price that seeks transitional relief regarding reviving the State's employer shared responsibility program and continuing to use specific State based rating factors. Finally, later this year, we will be submitting an additional waiver seeking permission to administer the Federal small business health care tax credit at

a State level in order to promote commercial group coverage among small businesses with lower wage workers.

I offer the following three examples where changes to 1332 waivers would be of significant benefit to States as we continue to reform our health care system. These examples concern essential health benefit compliance, benefit design and budget neutrality. Massachusetts is a strong benefit State; we support essential health benefits (EHB). However, even in our State, it was a challenge to adapt to the Federal framework. Technical improvements to the process should be allowed that support sufficient benefits that comport with best practices and market mechanisms. A prime example of one of these challenges which we still grapple with is the inclusion of pediatric dental coverage into the EHB standard. The need for dental coverage for children and youth is not in question, but addressing that need shouldn't require a rigid link between dental and health benefits within the same plan. EHB required that plans sold in the individual and small group market included pediatric dental benefits, which has not historically been included in most medical plans. There can be more than one efficient and effective way that States can ensure children covered by individual or small group plans are assured access to pediatric dental care. Even today, despite good faith efforts, most of our medical carriers still struggle to efficiently integrate dental benefits into their health plans, facing significant technical and operational barriers. All of these changes result in the carrier passing the cost down to the consumer. All the while, our dental insurance carriers had been providing dental coverage for children, adults and families with proven success and with the efficiencies that come with specialization and scale. It is critical that health plans provide coverage for the care that keeps people healthy, but Federal mandates should leverage common sense market practices and provide States with flexibility to match local requirements to local needs. Federal frameworks can balance local experimentation without sacrificing essential benefit categories.

Greater flexibility is also needed around benefit design. Value-Based Insurance Design (V-BID) approaches to benefit design seek to align patients' out-of-pocket costs, such as copayments and deductibles, with the value of services. Certain technical parameters of EHB make important kinds of benefit design innovation difficult. For example, in many areas, bronze and silver plan deductibles are extremely close to the maximum out of pocket (MOOP) limits. States may want to experiment with designing plans in which there are lower MOOP levels for high-value care (like chronic illness care) in exchange for a slightly higher MOOP overall, perhaps exceeding the existing EHB MOOP limit for relatively lower-value services. This would help make sure people who opt to buy high deductible plans don't put off care that will keep them healthy and also help make sure they don't develop an even more costly medical condition.

Finally, the current 1332 regulations require that proposals are examined on their own terms with regard to Federal deficit neutrality impact. This can greatly limit creative proposals by not allowing commercial innovations to draw from savings enabled on the Medicaid program and vice versa. Opportunities for change could range from coupling savings from 1115 and 1332 waivers that are filed together or to determine savings over the course of several years. These types of common sense adjustments along with consumer protection guardrails could widen opportunities for meaningful innovation and allow for far more comprehensive waivers that integrate the ACA, Medicaid and CHIP programs into a coherent health care insurance program at the State level.

In addition to increased flexibility and waiver authority, Massachusetts supports the development of "fast-track" waiver authority to expedite Federal processing and approvals.

HEALTH CARE COST DRIVERS

Fourth, Congress should take action to address health care costs. Having achieved near universal coverage in Massachusetts, we are now focused on health care affordability for individuals, families and employers. As we tackle reforms to the health care system, we should bear in mind not just the implications for Federal and State budgets, but also on the people and businesses struggling to keep up with the ever-increasing costs of health care coverage and services.

One critical health care cost driver that Congress should address is rising pharmaceutical costs. In 2013, Massachusetts established a health care cost growth benchmark; originally set at 3.6 percent, it was recently lowered to 3.1 percent. Although the growth in hospital and physician spending has been near or below the benchmark, drug spending is a major driver of health costs, far exceeding the State's benchmark, growing at 8 percent last year.

Unfortunately, States have limited ability to control pharmaceutical costs. Among other actions, Congress should consider safely expediting the FDA approval process, increasing competition by ensuring generic drug availability, and creating greater opportunities for public payers to negotiate prices.

MEDICAID AND OTHER REFORMS

While this hearing is focused on insurance market reforms, the prospect of reforms to the Medicaid program also looms large.

There are a number of reforms to Medicaid and the Affordable Care Act that would be welcomed by many States, including Massachusetts. I look forward to continuing to engage with Congress on those ideas. I cannot support under any circumstances any Medicaid reform resulting in a substantial loss of Federal revenue to Massachusetts and loss of health coverage for thousands of currently insured individuals. Additionally, I am opposed to Federal sanctions regarding family planning and efforts to diminish support for behavioral health and the opioid epidemic.

CLOSING

As you consider these and other reforms, I ask that Congress introduce any legislative changes on a gradual timeline, ideally with State flexibility to opt out or grandfather existing programs in order to prevent market shocks and to improve market stability.

We are making progress in our individual States, innovating with new ideas and we should avoid disrupting ongoing systems that work.

Additionally, I urge that whatever reforms are enacted, there be a bipartisan commitment to return to the table in the coming years to review and revise those reforms. Complex legislation requires fine-tuning and adjustments, no matter how perfect or well-intentioned the legislation is. In Massachusetts, we have returned to health care reform several times since 2006 as we have learned from our implementation of the law and as conditions have changed, and our Commonwealth is better for it.

Finally, as Congress takes steps to stabilize the insurance market and turn its attention to longer term reforms in Medicaid and health insurance markets, we should ensure that States have the necessary Federal fiscal support to maintain important health care services. This includes stability of funding for cost sharing reductions, the reauthorization of the Children's Health Insurance Program (CHIP), as well as the annual discretionary appropriations and Health Centers Fund and a delay in the implementation of the proposed Disproportionate Share Hospital rule.

Massachusetts currently has approximately 160,000 children on CHIP and failure to reauthorize CHIP will cause uncertainty for the families that rely on this program for health care services. Likewise, community health centers are an integral part of our health care delivery system, providing access to lower cost care in underserved locations.

For many States, including Massachusetts, this core funding provides a safety net for many of our lowest income children, adults and families which should be protected.

Thank you again for the opportunity to provide testimony on this important issue. I look forward to working with you and other Members of Congress as you consider legislation.

The CHAIRMAN. Thank you, Governor Baker.
Governor Hickenlooper, welcome.

STATEMENT OF HON. JOHN W. HICKENLOOPER, GOVERNOR, COLORADO

Governor HICKENLOOPER. Good morning. Thank you, Chairman Alexander, Ranking Member Murray, and all the members of this committee. I appreciate, as well as the others, the opportunity to testify and briefly share our bipartisan plan for stabilizing the individual health insurance market.

In 1932, Justice Louis Brandeis popularized the idea that States are the laboratories of democracy. He said, "a State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country." In other

words, States are where the rubber meets the road on the highway of the American experiment.

In Colorado, we have implemented the Affordable Care Act for 7 years, as long as I have been Governor. For many Coloradans, it has been a success. With bipartisan support, we expanded Medicaid and created a State-based marketplace. Around 600,000 Coloradans now have care because of the ACA. That is 10 percent.

Many people are angry and they have a right to be. The United States is on a lonely island among high-income nations. We spend almost twice as much for worse care. And this has been the case long before the Affordable Care Act. We need to move toward a system that compensates quality and good health, not quantity.

For the 400,000 Coloradans in the individual marketplace, many continue to struggle. Colorado has 14 counties—that is almost 25 percent of our counties—with only one insurer on the exchange. It is also home to some of the highest premiums in the country. A 60-year-old in rural Craig, CO making less than \$50,000 will pay over \$12,000 a year on premiums alone, around 25 percent of their income. That is simply unacceptable.

Even worse, our Division of Insurance is projecting premiums will increase by as much as 27 percent for 2018.

It is a big problem. Our bipartisan group of Governors, including Governor Kasich, who is not here, Governor Bullock, who is, have been working on a common sense set of solutions to help make insurance more affordable and markets more stable for this crucial 7 percent of the population.

We can do a lot at the State level, especially with congressional support.

Our plan asks you to explicitly fund the cost sharing reductions at least through 2019. Funding the CSRs for 2018 alone only will put us right back where we are now in a matter of months. It will foster uncertainty, threatening to drive up premiums and force insurers out of the market.

We also need your support by creating a stability fund that will help us set up reinsurance or similar programs.

We hope you will fully fund and strengthen Federal risk sharing programs.

We are also requesting tax incentives for insurance companies to enter counties with only one insurer, while giving Americans who live in these counties the option to buy the same insurance that Federal workers have.

Section 1332 of the ACA gives States the ability to innovate to lower costs while ensuring that certain basic guidelines are met. Existing regulations limit our ability to come up with creative solutions. That is why we are asking for a streamlined waiver submission and approval process and additional flexibility in applying the budget neutrality provisions of this section.

We believe all of this can be done in a fiscally responsible way by offsetting costs.

We need to address the underlying drivers of health care costs as well. That is why we are asking the Federal Government to empower consumers with price and quality information. We cannot stabilize the market without funding health priorities that reduce

costs like weight management, tobacco cessation, family planning, and injury prevention.

Governors and the States have proven that we can innovate. We are like startup companies. We learn from mistakes. We tweak and constantly improve. Fine is never good enough. That is part of being laboratories of democracy.

In Colorado, we are trying to stretch Federal dollars and to pinch pennies. We are reducing costs and promoting a competitive market while improving care and increasing transparency.

We have a lot to be proud of, but recent Federal action and inaction is undermining our efforts. It is time for the Federal Government to work with us not against us.

Without your help, it is like climbing one of Colorado's famous 14,000-foot mountains in winter without a parka or crampons. It cannot be done. We need immediate Federal action and responsible reforms that preserve coverage gains and control costs.

I appreciate your efforts in calling this hearing and returning to regular order in the Senate. Lasting solutions that make health insurance more affordable and markets more stable will need support from both sides of the aisle and leadership from States.

I look forward to answering your questions.

[The prepared statement of Governor Hickenlooper follows:]

PREPARED STATEMENT OF HON. JOHN W. HICKENLOOPER

SUMMARY

"In Colorado, we have implemented the Affordable Care Act . . . For many Coloradans, it has been a success. . . Around 600,000 Coloradans now have care because of the ACA. Many people are angry, and have a right to be . . . For the 400,000 Coloradans in the individual marketplace, many continue to struggle."

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"Our plan asks you to explicitly fund the cost sharing reductions at least through 2019. Funding the CSRs for 2018 only will . . . foster uncertainty surrounding these payments, threatening to drive up premiums and force insurers out of the market."

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INTRODUCTION

Good morning. Thank you Chairman Alexander, Ranking Member Murray and members of the committee. I appreciate the opportunity to testify and share with you our bipartisan plan for stabilizing the individual health insurance market.

In 1932, Justice Louis Brandeis popularized the idea that "States are the laboratories of democracy." He said "a State may, if its citizens choose, serve as a labora-

tory; and try novel social and economic experiments without risk to the rest of the country.”

In other words, States are where the rubber meets the road on the highway of the American experiment.

In Colorado, we have implemented the Affordable Care Act for 7 years—as long as I’ve been Governor. For many Coloradans, it has been a success. With bipartisan support, we expanded Medicaid and created a State based marketplace, known as Connect for Health Colorado. Around 600,000 Coloradans now have care because of the ACA.

We have dealt with its complicated provisions, benefited from its good intentions, and created a culture of innovation.

Many people are angry, and have a right to be. We need to move toward a system that compensates quality, not quantity. The United States is on a lonely island among other high-income nations: we spend almost twice as much for worse care.

For the 400,000 Coloradans in the individual marketplace, many continue to struggle. Colorado’s Western slope—which includes some of our most rural areas—has 14 counties with only one insurer on the exchange. It is also home to some of the highest premiums in the country: A 60 year old in rural Craig, CO making less than \$50,000 will pay over \$12,000 per year on premiums alone—around 25 percent of income.

That is simply unacceptable.

Even worse, our Division of Insurance is projecting premiums will increase by approximately 27 percent for 2018.

It’s a big problem, but our bipartisan group of Governors, including Governor Kasich, who is not here, and Governor Bullock, here today, has been working on common sense solutions to help make insurance more affordable and markets more stable for this crucial 8 percent of the population.

We can do a lot at the State level, especially with congressional leadership.

Our plan asks you to explicitly fund the cost sharing reductions at least through 2019. Funding the CSRs for 2018 only will put us right back where we are now in a matter of months. It will foster uncertainty surrounding these payments, threatening to drive up premiums and force insurers out of the market.

We also need your support as we work to stabilize the market by creating a stability fund, that will help us set up reinsurance or similar programs.

We hope you will fully fund and strengthen Federal risk sharing programs that will help amplify our efforts.

We’re also requesting tax incentives for insurance companies to enter counties with only one insurer on the exchange, while giving Americans who live in these counties the option to buy the same insurance that Federal workers have.

Section 1332 of the ACA gives States the ability to innovate to lower costs while ensuring that certain basic guidelines are met. Existing regulations limit our ability to come up with creative solutions. That’s why we’re asking for a streamlined waiver submission and approval process, and additional flexibility in applying the budget neutrality provisions of this section.

We believe all of this can be done in a fiscally responsible way by offsetting costs.

Bringing down health insurance premiums will require us to address the underlying drivers of health care costs. That’s why we ask the Federal Government to fully commit to paying for value over volume and empower consumers with price and quality information.

We can’t stabilize the market without funding health priorities that reduce health care costs like weight management, tobacco cessation, family planning and injury prevention, just to name a few.

Governors and States have proven we can innovate. We’re like startup companies—we learn from mistakes, fix, tweak, and constantly improve. Fine is never good enough. That’s why we’re the laboratories of democracy.

In Colorado, we are stretching Federal dollars and pinching pennies. We’re reducing costs and promoting a competitive market while improving care and increasing transparency.

We have a lot to be proud of, but recent Federal action—and inaction—is undermining our efforts. It’s time for the Federal Government to work with us, not against us.

Without your help, it’s like climbing one of Colorado’s famous 14,000 foot mountains in winter without crampons; it can’t be done.

We need immediate Federal action and responsible reforms that preserve coverage gains and control costs.

I sincerely appreciate your efforts in calling this hearing and returning to regular order in the Senate. Lasting solutions that make health insurance more affordable

and markets more stable will need support from both sides of the aisle, and leadership from States.

I look forward to answering you questions.

AUGUST 30, 2017.

Hon. PAUL D. RYAN, *Speaker of the House,*
H-232, The Capitol,
Washington, DC 20515.

Hon. MITCH MCCONNELL, *Senate Majority Leader,*
S-230, The Capitol,
 Washington, DC 20510.

Hon. NANCY PELOSI, *House Minority Leader,*
H-204, The Capitol,
Washington, DC 20515.

Hon. CHARLES E. SCHUMER, *Senate Minority Leader,*
S-221, The Capitol,
Washington, DC 20510.

DEAR MR. SPEAKER, LEADER MCCONNELL, LEADER PELOSI AND LEADER SCHUMER: As Congress considers reforms to strengthen our Nation's health insurance system, we ask you to take immediate steps to make coverage more stable and affordable. The current state of our individual market is unsustainable and we can all agree this is a problem that needs to be fixed. Governors have already made restoring stability and affordability in this market a priority, and we look forward to partnering with you in this effort.

Most Americans currently have access to a stable source of health insurance coverage through their employer, or from public programs, like Medicare and Medicaid. While rising costs are a concern throughout the system, the volatility of the individual market is the most immediate concern, threatening coverage for 22 million Americans.

Continuing uncertainty about the direction of Federal policy is driving up premiums, eliminating competition, and leaving consumers with fewer choices. Proposed premiums for the most popular exchange plans are expected to increase 18 percent in 2018 and 2.5 million residents in 1,400 counties will have only one carrier available to them on the exchange.

Despite these headwinds, States continue to try to stabilize the individual market and have developed innovative solutions to preserve coverage while making insurance more affordable.

Previously, we have written that changes to our health insurance system should be based on a set of guiding principles that include improving affordability and restoring stability to insurance markets. Reforms should not shift costs to States or fail to provide the necessary resources to ensure that the working poor or those suffering from mental illness, chronic illness or addiction can get the care they need.

Based on these guiding principles, we recommend (1) immediate Federal action to stabilize markets, (2) responsible reforms that preserve recent coverage gains and control costs, and (3) an active Federal/State partnership that is based on innovation and a shared commitment to improve overall health system performance. Just as these proposals have brought together Governors from across the political spectrum, we are confident they can attract support across party lines in both chambers of Congress.

1. Immediate Federal Action to Stabilize Markets

Congress should continue its work to identify reforms that strengthen insurance markets in the long term, but we need immediate action to ensure consumers have affordable options in the short term. Insurers have until the end of September to make final decisions about participating in the marketplaces. Congress and the Administration need to send a strong signal now that the individual market will remain viable this year, next year, and into the future.

Fund Cost Sharing Reduction Payments. The Trump Administration should commit to making cost sharing reduction (CSR) payments. The National Association of Insurance Commissioners (NAIC), National Governors Association, and United States Chamber of Commerce have identified this as an urgent necessity. The Congressional Budget Office (CBO) estimates not making these payments would drive up premiums 20–25 percent and increase the Federal deficit \$194 billion over 10 years.

Also, Congress should put to rest any uncertainty about the future of CSR payments by explicitly appropriating Federal funding for these payments at least through 2019. This guarantee would protect the assistance working Americans need to afford their insurance, give carriers the confidence they need to stay in the market, increase competition, and create more options for consumers. Because the cost of this initiative is already included in the budget baseline, the appropriation would not have budget consequences.

Create a Temporary Stability Fund. Congress should create a fund that States can use to create reinsurance programs or similar efforts that reduce premiums and limit losses for providing coverage. The House and Senate each recently proposed \$15 billion annually for States to address coverage and access disruption in the marketplace with a goal of lowering premiums and saving money on premium subsidies. We recommend funding the program for at least 2 years and fully offsetting the cost so it does not add to the deficit.

Offer Choices In Underserved Counties. Congress should foster competition and choice in counties where consumers lack options because there is only one carrier on the exchange. We ask Congress to encourage insurance companies to enter underserved counties by exempting these insurers from the Federal health insurance tax on their exchange plans in those counties. We also ask Congress to allow residents in underserved counties to buy into the Federal Employee Benefit Program, giving residents in rural counties access to the same health care as Federal workers. While these proposals may be temporary solutions, they will help provide Americans with additional choices until other policies have improved the market dynamics.

Keep The Individual Mandate For Now. Finally, to prevent a rapid exit of additional carriers from the marketplace, Congress should leave the individual mandate in place until it can devise a credible replacement. The current mandate is unpopular, but for the time being it is perhaps the most important incentive for healthy people to enroll in coverage. Until Congress comes up with a better solution—or States request waivers to implement a workable alternative—the individual mandate is necessary to keep markets stable in the short term.

2. Responsible Reforms That Preserve Coverage Gains and Control Costs

Federal action to stabilize markets is only the first step. Governors have been eager to pursue reforms that strengthen health insurance markets in our States, but uncertainty about the ACA and the status of Federal subsidies to support the individual market have made it difficult to proceed. Working alongside States, the Federal Government must make reforms that will preserve and expand gains in coverage, while controlling costs for consumers.

In efforts to augment the potential Federal actions we recommend in this letter, we attach a menu of options that individual States may consider or pursue. The options can be considered alone or assembled into a comprehensive strategy to achieve the interrelated goals of maximizing market participation, promoting appropriate enrollment, stabilizing risk pools, and reducing cost through coverage redesign. Different States will take different approaches. We all agree on and support the proposals contained in this letter, but each State will choose the State-based approaches that best fits their individual situation.

Maximize Market Participation. Approximately 22 million people now purchase coverage through the individual market, but another 27 million remain uninsured. Increasing coverage uptake among the uninsured would improve the risk pool and set in place a virtuous cycle of lower premiums leading to higher enrollment.

First and foremost, encouraging younger, healthier people to enroll in insurance and educating Americans about the importance of coverage can help improve the risk pool. The Federal Government should continue to fund outreach and enrollment efforts that encourage Americans to sign up for insurance. Many States invest in similar efforts, and all States need the Federal Government's support to maximize participation from younger, healthier people.

Also, making insurance more affordable is a key part of increasing participation in the marketplace. For example, current law includes a glitch that makes some families who can't afford insurance through their employer ineligible for tax credits on the exchange. Congress should fix the "family glitch" and give more working families access to affordable coverage.

Promote Appropriate Enrollment. Some consumers choose to enroll in a plan only when they need health care, stop paying premiums at the end of the year, or purchase exchange plans even though they are eligible for Medicare and Medicaid—all of which drives up costs in the individual market. Congress and individual States can reverse this effect, for example by shortening grace periods for non-payment of

premiums, verifying special enrollment period qualifications, and limiting exchange enrollment for those who are eligible for other programs.

Stabilize Risk Pools. The ACA created several risk sharing programs to help effectively manage the risk of the individual insurance market. However, the Federal Government has gone back on its commitment to these programs, in some cases refusing to fully fund risk sharing programs. Congress should modify and strengthen Federal risk sharing mechanisms, including risk adjustments and reinsurance. This commitment to Federal risk sharing will augment the State efforts that are supported by the stability fund.

Reduce Cost Through Coverage Redesign. States have an important but limited role in selecting essential health benefits (EHB). The Secretary of Health and Human Services (HHS) should allow States more flexibility in choosing reference plans for the 10 EHB categories than are currently allowed by regulation. HHS should give States that develop alternatives to EHBs that meet the requirements of Section 1332 of the ACA the opportunity to pursue and implement innovative approaches.

3. An Active Federal/State Partnership

States can pursue many reforms without Federal assistance. However, in some cases States are constrained by Federal law and regulation from being truly innovative. We urge Congress and Federal agencies to work with States to overcome these constraints, focusing first on improving the regulatory environment, supporting State innovation waivers, and controlling costs through payment innovation.

Improve the regulatory environment. The ACA created a greater role for the Federal Government in State health insurance markets, but retained States as the principle regulators of those markets. Recognizing the need for some common Federal standards, the Federal Government should not duplicate efforts or preempt State authority to regulate consumer services, insurance products, market conduct, financial requirements for carriers, and carrier and broker licensing in States that already effectively perform these functions. Also, Federal agencies should review the list of regulatory reforms identified by NAIC to stabilize markets.

Support State innovation waivers. Section 1332 of the ACA permits a State to request permission to waive specific provisions of the ACA, including the individual and employer mandates, as well as requirements for qualified health plans, essential health benefits, tax credits and subsidies, and exchanges. A State may not waive community rating requirements, prohibitions on preexisting condition exclusions, lifetime maximum coverage limits, preventive care mandates, or coverage for adults as dependents through age 26. To obtain a waiver, a State must demonstrate its plan would not increase the Federal deficit, would not reduce the number of people with health coverage, and would not reduce the affordability or comprehensiveness of coverage.

Many States view Section 1332 as an opportunity to strengthen health insurance markets while retaining the basic protections of the ACA. We recommend HHS streamline and coordinate the waiver submission and approval process, including an option for States to easily build on approved waivers in other States, and an option to fast-track waiver extensions. We also recommend HHS rescind its 2015 guidance on Section 1332 and clarify that States may combine waivers into a comprehensive plan and measure deficit neutrality across the life of the waiver and across Federal programs.

Control Cost Through Payment Innovation. Coverage is important, and coverage reforms can help contain costs, but eventually our Nation needs to confront the underlying market dynamics that are driving unsustainable increases in the cost of care. With the support of the Federal Government, States are resetting the basic rules of health care competition to pay providers based on the quality, not the quantity of care they give patients. This is true in our States, where we are increasing access to comprehensive primary care and reducing the incentive to overuse unnecessary services within high cost episodes of care.

Congress and the Administration should make a clear commitment to value-based health care purchasing. For example, Medicare and other Federal programs should be allowed to participate in multi-payer State Innovation Models. The Administration should align priorities for value-based purchasing across all Federal agencies, including HHS, CMS, SAMHSA, CDC, VA, AHRQ, HUD, DOL, OMB and others. Payment innovation projects should be funded through the Centers for Medicare and Medicaid Innovation and expanded to more States.

Empowering consumers with information about the cost and quality of care can help to drive competition that will lower costs. New tools should be developed to provide consumers with better information about how much health services cost or which providers offer the best quality of care. For example, the Federal Government

should work with States to promote consumer-facing websites and apps that let consumers shop for health care based on quality and cost. Many States have developed all payer claims databases to provide greater transparency for consumers, and should be allowed to include claims information from federally regulated ERISA plans in these databases.

We strongly encourage that Congress and the Administration take immediate action to stabilize the individual health insurance marketplace. If there is a clear signal to consumers and carriers that the individual market is viable, then additional State-based reforms will be more manageable and we can succeed in preserving recent coverage gains and controlling costs. As we move beyond the immediate crisis, the real challenge over time will be to confront the underlying cost drivers of health care spending, and reset incentives to reward better care for individuals, better health for populations, and lower cost.

Lasting solutions will need support from both sides of the aisle, and we applaud the bipartisan efforts that have now commenced in both the House and Senate. We ask that you support these efforts to return to regular order, allowing committees to work in an open, transparent and bipartisan manner. Governors have extensive expertise implementing changes to our health insurance system, and we stand ready to work with you and your colleagues to develop solutions that are fiscally sound and provide quality, affordable coverage for our most vulnerable citizens.

Sincerely,

John Kasich, Governor, State of Ohio; John Hickenlooper, Governor, State of Colorado; Brian Sandoval, Governor, State of Nevada; Tom Wolf, Governor, State of Pennsylvania; Bill Walker, Governor, State of Alaska; Terence R. McAuliffe, Governor, State of Virginia; John Bel Edwards, Governor, State of Louisiana; Steve Bullock, Governor, State of Montana.

A BIPARTISAN APPROACH TO STRENGTHEN OUR NATION'S INDIVIDUAL HEALTH INSURANCE MARKETS

MENU OF STATE REFORM OPTIONS TO SUPPLEMENT FEDERAL REFORMS

Maximize Carrier Participation

- Waive exchange fees for carriers who are the last remaining carrier in a county.
- Encourage participation across lines of business (Medicaid MCO, State employee, etc.).
- Streamline payor compliance (quality reporting, coverage transparency, etc.).

Maximize consumer participation

- Increase outreach to attract healthier individuals.
- Provide adequate and effective subsidies and/or premium tax credits.
- Encourage younger people to get coverage.
- Encourage continuous coverage (e.g., reward those who renew coverage every year, penalize those who stop paying premiums, require SEP enrollees to maintain coverage, and/or late enrollment penalties or waiting periods for non-continuous coverage).

Promote Appropriate Enrollment

- Verify special enrollment period (SEP) enrollment qualifications (NAIC).
- Limit individual market enrollment for those eligible for other public programs (NAIC).
- Prevent third-party payers from diverting consumers from Medicare coverage (NAIC).
- Shorten the 90-day grace period for non-payment of premiums (NAIC).

Stabilize Risk Pools

- Administer a reinsurance or similar program.
- Pursue strategies to create larger, more stable pools (e.g., consider combining individual and small group markets, or consider combining Medicaid and marketplace populations).

Reduce Cost Through Coverage Redesign and Payment Innovation

- Apply for a State Innovation Waiver to pursue innovative strategies to strengthen health insurance markets while retaining the basic protections of the ACA. Section 1332 of the ACA allows a State to request permission to waive provisions related to individual and employer mandates, qualified health plans, consumer choices and insurance competition through marketplaces, and premium tax credits and cost-

sharing reductions in the marketplace provided that State covers as many people with coverage that is as affordable and as comprehensive without adding to the Federal deficit.

- Encourage the adoption of population-based payment models that reward the effective management of total cost of care.
- Encourage the adoption of episode-based payment models that reward the effective management of specialty care.
- Enable the use of value-based insurance design and wellness incentives to tie the level of coverage for chronic care to personal responsibility for health outcomes achieved.
- Increase transparency in cost and quality (e.g., promote the use of consumer facing websites, include ERISA plan data in all payer claims databases).

The CHAIRMAN. Thank you, Governor Hickenlooper.
Governor Herbert, welcome.

STATEMENT OF HON. GARY R. HERBERT, GOVERNOR, UTAH

Governor HERBERT. Thank you, Chairman Alexander and Ranking Member Murray and members of the committee. We are all honored to be here to address you on this very important issue.

The market for individual health insurance protect, among others, the families of Utah's entrepreneurial self-employed. It would be irresponsible to allow these markets to collapse simply because of political paralysis or inaction.

Having served as Chairman of the National Governors Association, as well as the Western Governors Association, and soon to be the next President of the Council of State Governments, I have a broad appreciation for the role that States have in our Federal system. I would, therefore, urge Congress to get past the health care impasse and delegate the responsibility to find solutions to the laboratories of democracy, as Governor Hickenlooper has mentioned, our 50 States.

I would recommend allowing each State to take on the full role of regulating our health insurance markets. You can diversify the social, economic, and political risk associated with this policy change by letting the States experiment as laboratories of democracy to determine what policy works and what policy does not work.

For your information, the State of Utah has one of the lowest health care costs in the Nation. That certainly stems from our local culture and our favorable demographics, but it also comes from such practices as evidence-based measures of effectiveness, eliminating duplication of services, innovative use of managed care organizations, and empowering doctors and patients alike to make more informed choices.

I believe that if you will empower the States to determine their own health care destiny, the States will innovate and create practical solutions for the most complex health care issues of the day. We will learn from each other, and therefore we will improve.

Under current law, empowering States means greater flexibility in defining essential health benefits and simplifying the State innovation waiver process.

True self-determination goes well beyond coming to the U.S. Department of Health and Human Services with hat in hand on bended knee and with a hope for favorable treatment. True self-determination would mean a block grant of Medicaid and Affordable

Care funds with a formula that gets us to funding parity in the 50 States.

Before achieving that vision of a vibrant State-based approach, Congress needs to provide immediate certainty to the individual insurance markets.

To that end, I recommend establishing a clearly defined transition period. This would allow markets to incentivize the broadest, continuous participation in the individual insurance market. This should be done while anticipating the adjustments in a market based on greater State-level autonomy.

I personally am not a fan of cost sharing reduction payments. Nevertheless, in the near term, individual insurance markets need predictability in order to price their products adequately. The sudden demise of CSRs would destabilize Utah's individual insurance market, putting at risk some 110,000 Utahans who benefit from this program. A transition should include funding for CSRs through at least 2018 or 2019.

We should also look to market-oriented incentives to maintain and increase continuous participation in individual health insurance markets. For example, Congress could immediately reduce the cost of premiums by eliminating the health insurance tax. Insurance products could be better tailored to demand by allowing insurers to underwrite a wider array of cost-effective products, including more affordable high-deductible plans. Participation could be incentivized by greater flexibility in health savings accounts. The Federal Government should fund a temporary insurance program for high-risk pools with an option for States to operate their own risk stabilization programs.

At the bottom of all this, health insurance needs to be able to do its job of pooling risks and protecting against unforeseen health care costs instead of being used for some vehicle for social justice reform.

To get there, the excessive burden of regulatory restrictions that we have placed on insurance policies needs to be peeled back, and that needs to be done with predictability and transparency.

Frankly, most of America's consumers do not care whether or not a lot is repealed and replaced or modified and improved. Utahans want us to know that if they are prudent in their planning and budgeting, that they will be able to purchase reliable health insurance to protect them against life's unexpected health challenges. And they need to know that if they experience a medical catastrophe, that there is a safety net that will keep them from spiraling into a financial catastrophe.

The States are better able to address these issues for the unique populations and unique demographics than is the Federal Government, which is too often trapped in a one-size-fits-all mentality. I would urge you to consider a health care future that gives back to the States the lion's share of responsibility. It is something that both sides of the aisle can support, giving more authority to Governors and State houses. Returning control to the States is both prudent policy, but it is also prudent politics.

Thank you for listening.

[The prepared statement of Governor Herbert follows:]

PREPARED STATEMENT OF HON. GARY R. HERBERT

EXECUTIVE SUMMARY

Allowing our individual health insurance market to fail without providing a viable path forward would be irresponsible, but political paralysis threatens such a collapse.

Our Nation's healthcare impasse stems from principled differences about the proper role of government with regard to health insurance and healthcare. Congress can break this logjam by pushing this debate to each of the 50 States. By letting the States experiment with what works and what doesn't, Congress can diversify the social, economic and political risk associated with major policy change.

As it devolves this issue to the States, Congress needs to create a clear glide path to improved individual insurance markets. To that end, Congress should:

- create a clearly defined transition period during which Congress should continue to fund cost sharing reduction (CSR) payments;
- promote market-oriented incentives to maintain and increase continuous participation in individual health insurance markets, e.g., by expanding high deductible health plans and health savings accounts;
- help educate and financially reward individuals for taking advantage of continuous coverage (vetted outreach programs may be useful);
- reduce the cost of premiums by eliminating the Health Insurance Tax;
- fund a temporary reinsurance program for high risk pools;
- peel back the layers of regulatory restrictions that have been placed on the basic health insurance contract in a predictable, transparent way.

As Congress points the way to a more stable individual health insurance market (which in Utah would likely mean fewer market distorting taxes and subsidies) it should then foster policies that promote the breakthrough innovations in finance, education, governance and technology needed for to improve and reduce the underlying costs associated with medical care.

INTRODUCTION

Thank you Chairman Alexander, Ranking Member Murray and members of the committee for the opportunity to share my perspective on how to stabilize our individual health insurance markets.

As you know, the primary regulation of both insurance and medicine have traditionally been at the State level. It is not immediately evident that Federal intervention has helped to improve upon the States' role.

Careful observers agree that the status quo of our individual health insurance markets is unsustainable.

And most agree that allowing these markets to collapse without providing a viable path forward would be irresponsible.

And yet, because of Washington DC's political logjam, it appears that lawmakers might indeed allow this important insurance market that protects, among others, the families of Utah's entrepreneurial sole proprietors, to collapse.

This morning I want to share my thoughts about how Congress can overcome its healthcare impasse, how we can create a smooth glide path toward a broad and stable individual health insurance market with fewer market distorting taxes and subsidies, and why we should shift the national dialog about healthcare from debates about our healthcare payment system to how we can promote cost-reducing innovations medical care.

CONGRESS CAN OVERCOME ITS IMPASSE BY RETURNING GREATER CONTROL TO THE STATES

I believe the Nation's healthcare impasse stems from two deeply rooted differences of thought. The first is that lawmakers have principled differences about the proper role of government with regard to health insurance and the second is that lawmakers also have different viewpoints about which level of government—Federal or State—should be the primary regulator.

As the past chair of both the National Governor's Association and the Western Governor's Association, as the next president of the Council of State Governments, and as one who has governed in a State where productive collaboration toward shared aims is more important than ideological purity, I would urge Congress to get past your impasse on these issues by delegating the issue of government's proper role to the 50 States.

Please allow each of the States, in their various hues of blue, red and purple, to take on the primary role of regulating their health insurance markets. Instead of foisting huge social and economic experiments on the entire country—too often along narrow party-line votes—Congress has an opportunity to diversify the social, economic and political risk associated with major policy change by letting the portfolio of States experiment with what works and what doesn't.

Utah enjoys among the lowest health care costs in the Nation. Our costs may be lower because we have the youngest population in the Nation. They are also lower because of the healthy lifestyle choices of our people, many of whom regularly enjoy the unparalleled opportunities for sport and outdoor recreation in our State and many of whom religiously abstain from alcohol and tobacco.

It is not just our demographics. Utah has been able to keep our healthcare costs low because of deliberate efforts within our private healthcare system to use evidence-based measures of effectiveness, eliminate duplication of services and empower doctors and patients alike to make more informed choices. We have worked to reduce Medicaid costs low because of innovative use of managed care organizations.

If you will empower Utah to determine more fully its own healthcare destiny, I promise you that we will provide the other 49 States with proven and scalable solutions for their most complex healthcare issues. And Utah will learn from and emulate the success of others.

Under the Patient Protection and Affordable Care Act, empowering Utah would mean giving us greater flexibility in defining Essential Health Benefits. It would mean dramatically simplifying the State Innovation Waiver process under Section 1332. And it would mean expanding what could be waived under Section 1332.

Please appreciate that our vision for greater State self-determination goes well beyond coming to the U.S. Department of Health and Human Services to ask permission for how we would organize our insurance markets.

CREATING A GLIDE PATH TO IMPROVED INDIVIDUAL INSURANCE MARKETS

In order for the Nation to glide into that vision of a vibrant and innovative State-based approach, Congress needs to act today to provide immediate certainty and stability to the individual insurance market.

To that end, I recommend establishing a clearly defined transition period that allows markets to incentivize the broadest, continuous participation in the individual insurance market possible while anticipating the adjustments needed to a market with less subsidization, less taxation, and less socialization.

CONTINUE COST SHARING REDUCTION PAYMENTS IN THE NEAR TERM

I do not believe that cost sharing reduction (CSR) payments are the most transparent and effective way to assist low income individuals. Nevertheless, in the near term, our individual insurance markets need predictability in order to price their products adequately. The sudden demise of CSR support would destabilize Utah's individual insurance market. In 2016, 110,000 Utahns benefited from the CSR program, accounting for 63 percent of those receiving health care coverage through *healthcare.gov*. As a part of a transition, I recommend funding for CSRs through 2019.

INCENTIVIZE THE BROADEST, CONTINUOUS PARTICIPATION

As Congress considers the fate of the individual mandate, we should look to market-oriented incentives to maintain and increase continuous participation in individual health insurance markets. Congress can immediately reduce the cost of premiums by eliminating the Health Insurance Tax. The supply of insurance products can be better tailored to demand by allowing insurers to underwrite a wider array of cost-effective products.

For example, we would support broadening the kind of wellness incentives that can attract younger populations, the expanding high deductible health plans and health savings accounts, and providing greater flexibility within health savings accounts—such as the ability to pay for insurance premiums from an HSA. Individuals also need to be educated about and financially rewarded for taking advantage of continuous coverage. Publicly funded outreach programs may be useful, but should be evaluated for their effectiveness.

STABILIZE THROUGH REINSURANCE

The Federal Government can further stabilize the market by funding a temporary reinsurance program for high risk pools with an option for States to operate their own risk stabilization programs.

ALLOW INSURANCE TO INSURE

Insurance pools risk in order to contractually cover the costs associated with defined contingent losses. Although straightforward in concept, pooling risk in a way that is affordable to the insured and profitable to the insurer has never been easy.

If losses and costs are not contingent, in other words, if they are certain and known, then insurance premiums no longer pool probabilistic risk, but instead they socialize known costs. By forcing the coverage of pre-existing conditions, by narrowing the bands of risk, by dictating coverages and uniforming prices, government has largely robbed insurance of its risk-pooling function. And the Federal Government has further complicated matters by providing an opaque substitute for income support by instead creating public subsidies for insurance contracts.

Congress can help stabilize the individual health insurance market by allowing it to do the job of insuring against unforeseen health costs instead of using it as a vehicle for other social policies. To get there, Congress should peel back the layers of regulatory restrictions that have been placed on the basic insurance contract in a predictable, transparent way.

FOCUS ON INNOVATION

The national debate about health care has been primarily about our healthcare payment system. I believe that if States were to play a larger role in facilitating their insurance and healthcare markets that the conversation would turn to how to dramatically reduce the cost of health care. I don't believe States, for example, would choose to stunt innovation in medical technology by putting an excise tax on medical devices the way Congress has.

If we can help support robust competitive markets to operate in health care, we can turn from asking about who should be paying for medical care to questions like: How can we spur disruptive innovation in telemedicine, artificial intelligence, medical robotics and genomics? How can we continue to develop new breakthrough drugs without bankrupting those who pay for the drugs? How can we creatively increase the use of non-physician medical labor? How can we deliver more cost-effective education for nursing, health sciences, and medicine? How can we empower patients to manage better their own health with well-informed choices?

CONCLUSION

Thank you for letting me visit with you today about some aspects of our Nation's healthcare challenges.

My strong sense is that when it comes to their healthcare, the people of Utah—like most Americans—care about results rather than slogans. Whether or not a law is repealed and replaced, or modified and improved, what they need to know is that if they are prudent in their planning and budgeting, that they will be able to purchase reliable health insurance that will protect them from life's vicissitudes. And they need to know is that if they should (heaven forbid) experience a medical catastrophe, that there is a safety net that will keep it from spiraling into a financial catastrophe.

My constituents don't particularly care about the details of "cost sharing this" or "mandated that." What they would appreciate, however, is a realistic vision for an affordable, reliable, responsive, professional, and patient-focused healthcare system.

I believe that the States can do this better for their unique populations than can the Federal Government. That is why I would urge you to consider a healthcare future that gives back to the States the lion's share of responsibility. Given the impasse at the Federal level, federalism is both prudent policy and prudent politics.

As you point toward that future—which in our State would mean fewer market distorting taxes and subsidies—please provide a measured and transparent transition rather than shock therapy. And as you step back from debates about who should pay for what, please consider how to foster an environment where financial, organizational and technological innovations for improved, less-expensive medical care can thrive.

The CHAIRMAN. Thank you, Governor Herbert. And thanks to all of the Governors.

The Governors stuck to 5 minutes. I am going to ask the Senators if you will as well. And we will begin with Senator Enzi.

STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman and Ranking Member. Thank you, Governors. A lot of good suggestions there.

I am going to refer to what we are trying to do and what Senator Alexander is suggesting is biting off some pieces, but I am going to call it eating the whale one bite at a time to make it more bipartisan.

[Laughter.]

Governor BULLOCK. There was no intent on that one, sir.

Senator ENZI. And we have a whale of a problem that we have to solve, and you are kind of at the heart of the laboratories of being able to do that. I used to serve in the Wyoming legislature, and of course, naturally then have a lot of confidence in the ability of legislators.

Earlier today we talked about the section 1332s and having the possibility of, if it is approved for one, doing it for all. I would add to that—and I think that was part of the discussion—that there be a Governor opt-out of that particular thing. I would add to that—and I know that there is a difference between when the Governors that are around all the time and the legislators who are around some of the time. I have always suggested that there be an opt-out or an opt-in by the Governor provided when the legislature meets, they agree. I do not know what happens if there is not agreement. I am certain that there would be some good suggestions that would come out of that.

Yesterday, we talked with the insurance commissioners, and they talked about the need for reinsurance and the high-risk pools. And Maine has an invisible high-risk pool that I think could be useful, again provided there was an opt-out by the Governors with the approval of the legislature.

We also had a good explanation yesterday of small business health plans or association health plans and how that could help to reduce the individual market by having people be a part of a bigger group that would have more clout for doing legislating.

Let me start my questions with Governor Baker because you have explored the 1332 waiver. I think all of you have explored it. I would be interested in all of your opinions on that, where you are in the process and what suggestions you would have for changing that process for the 1332 waiver.

Governor BAKER. Thanks very much for the question.

Let me just say this. We literally are filing a 1332 waiver this week, but that is the official filing. We have actually submitted what I would call kind of a template or an outline of what it is we would like to talk about doing under 1332 previously to the folks at CMS. One of the innovations that the current administrator brought to this program was to stay instead of having you file a waiver and then have us get into a big debate about every element of it, how about you file what she called kind of a pro forma on what it is you would like to do. Let us review the game plan you

have in mind, tell you where you think have soft spots and weaknesses, and then we will help you make sure that by the time you actually submit a formal document, we have some agreement about what it is you are trying to do and where we think our opportunity to support that might be. And I thought that was administratively a terrific reform.

The one thing I would say generally about this is there are things that are program issues which I think have, for all of us, consequences in terms of how we deal with our legislature on some of this. A lot of the administrative stuff that is part of the relationship that goes on between States and the Federal Government is not particularly useful to us, and I would argue it is not particularly useful to the Federal Government either. It chews up an enormous amount of time.

If I had to pick the one thing I would say on 1332 is if you could help Washington figure out the difference between what is a debate over how you administer something and what is a debate over what a program design looks like, that would be great. There is a ton of time that is being spent on this administrative stuff that I do not think translate into much value-added for anybody.

Senator ENZI. Thank you.

Governor Herbert, would you care to quickly comment on the difference between Utah and Massachusetts?

Governor HERBERT. There are significant differences. He has a lot more people than we have for one thing. We have a younger population. We have a median age of 30. Our health care needs would be different. That is why I say we need to respect the regional differences and the demands in the marketplace for health care coverage. They are not all the same, and that is why we would encourage flexibility.

On the waiver requirements, the biggest problem really is it just takes so long. We put in a waiver ourselves this past August. That is a year ago. We still have not received an approval or denial. Streamline the process for waivers. I expect that every State would have some idea of what a waiver would look like, what they would need in their respective States. We just need to streamline the process. Once it has been approved by one State, it ought to be automatically approved by another State.

Senator ENZI. Thank you. My time has expired.

The CHAIRMAN. Thanks very much.

Senator Murray.

Senator MURRAY. Again, thank you to all of you for being here. This is really valuable.

Governor Hickenlooper, I want to start with you and thank you again for testifying today and for working with bipartisan Governors across the country to propose some solutions to stabilize the individual market. It is really my hope that we can use some of that same bipartisan approach here in this committee to come up with solutions and really appreciate your input on that.

In your proposal with the eight other Republican and Democratic Governors, you made several recommendations to immediately stabilize the market. One of those is to establish funding for reinsurance. Can you talk to us a little bit about why that will help bring premiums down?

Governor HICKENLOOPER. Yes. Thank you. As you say, especially this committee has a record of bipartisan solutions to some of the most vexing problems the country has faced. If we are going to have any committee in whose hands to put our fate, we are glad it is you guys.

We looked at the reinsurance as one of the—I would say the cost sharing is the most important thing. Reinsurance is a very close second just because so many of these pools end up being dominated by the least healthy individuals, especially people that have chronic diseases. End stage renal disease end up in dialysis all the time. These are very expensive patients. When they end up in one pool—one of our carriers has three different patients that cost more than \$5 million a year. That raises everybody's premium. What happens is if you are able to find some sort of cost sharing—it could be by disease. It could be by the cost to the patient, but some way to have a reinsurance pool, which is what happens in pretty much every other industry, then you are able to drive down the premium cost, the average cost for everyone, and dramatically increase people's participation.

I think one thing we all agree is that one of our great challenges is to make sure that we get more people participating in the system because that is what drives down premium costs. It is a reinforcing feedback loop. Reinsurance pools I think is one of the best ways to do that, and whether we do it by the Alaska model where they took existing revenues and were able to see—I think they saw a 30 percent—a 28 percent reduction in premiums costs. That is remarkable.

Senator MURRAY. I was really glad to see that you agreed that we should not roll back the guardrails that protect people with pre-existing conditions and appreciate that input as well. That was very important.

Governor Bullock, thank you for being here. Senator Tester is always talking to me about this. It is great to have a fellow Montanan here to talk about this.

This is actually our second hearing on market stabilization. And yesterday, as you know, we heard from five of our Nation's insurance commissioners about the unusual steps they are being now forced to take because they do not know whether the Trump administration is going to maintain the out-of-pocket cost reduction program, CSR.

Governor Baker noted in his testimony that almost as soon as the 2018 rates are finalized, insurers will begin preparing their premium proposals for 2019.

In the recommendations that you made with Governors Kasich and Hickenlooper, you propose Congress provide more than just 1 year of certainty for out-of-pocket cost reduction. Talk to us about why 1 year of certainty is not enough?

Governor BULLOCK. Thank you, Senator Murray. I fully recognize that Congress will continue to work on health care reform as we talk about immediate stabilization of the individual market.

In Montana, we have three insurers. All 56 counties are covered. As I said in my testimony, a 10X increase for 2018 because it is already filed because of the uncertainty of the CSR payments going forward. Those same insurers are already working on the 2019

rates, and they will be in earnest by doing it by next spring of 2018.

The only way that we are going to get some sort of certainty is if insurance companies and others feel that there will be predictability at least for a period of time while you all discuss greater reform. I do not think the cost sharing reduction payments of 1 year is sufficient for that. I would love to see 3 years. Certainly if you do overall reform in other areas, you could always trim that back. You are sending a message to the market that there is going to be some stability there, and then they can plan accordingly.

Senator MURRAY. Thank you very much.

Governor Baker, Massachusetts has a very long history with health care reform. I know your State is always looking at ways to promote stability and bring down costs. As was just talked about, you are currently applying to create a State-based premium stabilization fund to protect against the possibility that the Trump administration discontinues the out-of-pocket cost reductions. I assume that developing the premium stabilization fund proposal requires a lot of State resources. Correct?

Governor BAKER. The answer to that would be yes.

Senator MURRAY. Would you not agree that it would be better to have long-term certainty for the out-of-pocket cost reduction program rather than your State taking up these extraordinary steps?

Governor BAKER. In addition to the fact that open enrollment begins within the next 30 to 40 days, you have a lot of people who have made a lot of decisions, including people who buy insurance, based on assumptions about what products are going to be available to them and what they are going to pay for them. I think the reason the CSRs are so important at this point in time—I agree with what others have said, which is it creates stability and a sense of consistency for people at a point in time when they are literally going to be purchasing coverage for the next year.

As I said in my remarks, we basically had people price this stuff based on the assumption that the CSRs would be in place. If the CSRs are not in place, the carriers are going—and our market mostly is nonprofit carriers, too, who are local. If the CSRs are not in place, they are going to have to reprice those products, and they are probably going to go up by somewhere around 20 percent, which is going to be a real problem for the people who buy those plans. By the way, it is also going to shift a whole bunch of spending onto the advance premium tax credits to support those people who would have been buying coverage with the support of the CSRs.

Senator MURRAY. I appreciate that. I apologize to all of you. I am going to have to leave shortly. We are doing a markup on the Health, Education Committee that I am ranking member on. I really appreciate all of you being here and our committee members for being here as well. Thank you.

The CHAIRMAN. Thank you, Senator Murray. We want you to go to that other appropriation hearing because it is a good bill, and from what I have heard about it, I am looking forward to voting for it.

Senator Isakson.

STATEMENT OF SENATOR ISAKSON

Senator ISAKSON. Thank you, Senator Alexander. Thanks to you and Senator Murray for the approach that you have taken on this. You have been commended by these Governors, and that should be echoed again by us on the committee. We do have a bipartisan challenge and a bipartisan problem that is going to require a bipartisan solution. I appreciate all of you recognizing that. I appreciate Lamar and Patty's effort to make sure we do the same on the committee.

Governor Haslam, welcome. You are a great neighbor. You all were, unfortunately, a rude guest when you all beat Georgia Tech the other night as we opened up the Mercedes Dome. It was a great football game. Congratulations.

Governor HASLAM. A lot of us stayed up later than we should have.

Senator ISAKSON. As usual, when you talk about Tennessee, Governor Alexander was involved because he was also the President of the University of Tennessee before he was Governor—before or after he was Governor of Tennessee.

Governor HASLAM. After.

Senator ISAKSON. We share a lot of things together. One of them is we have a large rural area, and we have a huge problem in Georgia and I think Tennessee does too in terms of rural health care and the loss of hospitals in our State in the rural area. Are you all dealing with that in Tennessee now?

Governor HASLAM. We are. Governor Bullock referred to that in his testimony. I think that is a pretty national issue, but we definitely are. I think caught up in that you have some issues around coverage, but quite frankly, the health care industry itself is changing a lot. As they consolidate, I think all of us are afraid that the trend will be to lose more hospital beds in rural areas.

Our challenge, quite frankly, is tied to that. It is about rural economic development. It is keeping jobs and people in those areas. That is what will attract the hospital beds. Governor Bullock's point was that it is a little bit of a chicken and egg. As you lose the hospitals, it is hard to attract jobs. That is a consistent challenge, I would bet, for everybody in this group.

Senator ISAKSON. Rural areas have a higher percentage of non-insured patients coming to their doors, and that doubles and triples and exacerbates the problem.

Governor HASLAM. I do not know this, but I have been in Tennessee. Steve again showed Lamar's chart about how many people are in the individual marketplace. I bet a disproportionate share of those are rural folks in Tennessee.

Senator ISAKSON. You just used the magic phrase in terms of disproportionate share.

Are you familiar with the DISH payment?

Governor HASLAM. I am very much.

Senator ISAKSON. Those were being phased out under the Affordable Care Act under the belief that if health insurance was available to everyone and everyone was covered, then those who are indigent and could not pay and are poor, would not just go to a indigent care hospital but would go to one where they were covered be-

cause they had insurance. That did not happen. Those payments are going away, which is causing big problems in Nashville I am sure, which is one of the major health centers, and it is in Georgia.

Do you have any suggestions on this disproportionate share and what we should do in the short term?

Governor HASLAM. Ultimately I think it is part of this larger issue that we are talking about. You addressed it when the DISH payments went away, and then particularly in States like Georgia and Tennessee that did not expand, those hospitals were caught in a particularly difficult situation.

In terms of short term what we can do about that within the confines of the budget bill that you have, I do not have an answer for that right now.

Senator ISAKSON. I think Governor Baker, Governor Bullock mentioned this. Maybe others did as well. One of the key things that we have got to do is find some way to get everybody covered, get everybody participating, and getting people who are young and not at high risk for expensive diseases in their early years to help us ameliorate the cost of the senior citizens like me who are going into the hospitals at higher cost health care.

I was listening to you talk. I remember when I was in the State legislature in the 1970s and 1980s, the States faced a big crisis in terms of automobile insurance and liability insurance and finally created something called no fault. I have forgotten the first State to do it, but the States, one at a time, created no fault laws where you could not get your car tags or you could not drive your car unless you had minimum no fault insurance for liability.

Is there a comparison anybody has thought about doing in terms of health care in the States where you could have a quid pro quo where you get health insurance when you get your car or whatever it might be?

Governor BAKER. We have not gone there. In Massachusetts, basically each year when you file your State income tax, you have to demonstrate that you have coverage continually for the previous 12 months. If you do not have coverage for the previous 12 months, you pay a fee, and that fee goes into the fund that pays for uncompensated care. Generally speaking, most people choose to either take the insurance through their employer—by the way, that was the single biggest take-up when we put the individual mandate in place, which was people who had access to coverage through their employers who had not been taking it took it. That was, in fact, probably the single biggest move with respect to the number of people who are covered. We should remember here that a lot of people do have access to coverage through their employer. They just choose not to take it for a whole bunch of different reasons. When we put the mandate in place, they took it, which made a really big difference with respect to the number of people we actually had covered.

Senator ISAKSON. Which is why we put the mandate in the ACA as well.

Thank you for your leadership. I thank all of you for being here. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Isakson.
Senator Sanders.

STATEMENT OF SENATOR SANDERS

Senator SANDERS. Thank you, Mr. Chairman. Let me concur with virtually everybody by thanking you for holding these hearings. I think a lot of pain and time would have been saved perhaps if we held these hearings 6 months ago rather than going through what we went through.

I want to thank the Governors for being here. As a former mayor, I am more than aware that a whole lot of innovation comes at the local and State level and the Federal Government can learn a lot from what happens locally.

Mr. Chairman, in your opening remarks, you talked about the need to ask larger questions, and I think that is exactly right. One of the larger questions comes about—I think Governor Baker made the point that young and healthy people today may have an accident tomorrow and they will not be so healthy and they are going to run up large insurance costs. In my State and all over this country, I have talked to people who are scared to death about losing the health insurance they have if some of these Republican proposals were passed.

That raises the larger question. Why is it that in the United States of America we are the only major country on earth that does not guarantee health care to all people as a right? It is not a question of whether you are young and healthy or older and sicker. If you are an American, should you be entitled to health care as a right? Increasingly the American people believe that is the case. That is a larger question that we have got to address.

In my view the Affordable Care Act had significant successes. It also had failures. It is no small thing that 20 million more Americans have insurance who previously did not, and it is no small thing that we eliminated the obscenity of preexisting conditions and brought some other provisions.

I think, Mr. Chairman, the time has come when we as a Nation and what the polling now tells us, 60 percent of the American people now believe the Federal Government should take responsibility working with the States in guaranteeing health care to all people as a right, something that I believe.

No. 2—and Governor Hickenlooper made this point. I think you made the point that we are now spending about twice as much per capita on our health care as do the people of any other country. Mr. Chairman, I think it is great that we have the Governors here today, and we should do more of that. We might want to ask our friends from Canada or the UK or Scandinavia or Germany what they are doing, and we might ask why it is that we are spending almost \$10,000 per person on health care today, which is clearly unsustainable, while other countries are spending half of that.

I think, Governor Hickenlooper, you made the point in many ways that health care outcomes in other countries are as good or better as they are in this country. Life expectancy is longer abroad. Infant mortality is less.

Those are some of the larger questions that we have to ask.

The third larger question. We keep talking about the insurance companies. Let me break the bad news. The function of insurance companies is not to provide quality care to people. It is to make as

much money as they possibly can. Maybe insurance companies are part of the problem as to why we are spending so much money on health insurance.

In terms of some of the questions I would like to ask. All of us are aware the cost of health care is much too high and it is rising too rapidly. One of the factors for that is the high cost of prescription drugs. In that area, as everybody knows, we are spending far, far, far more than any other country on earth. The last statistics that I have seen, five major drug companies make \$50 billion in profit, while one in five Americans cannot afford the prescription drugs they need.

Governor Haslam—let us work on down the line—what do you suggest that we do to lower the outrageously high cost of prescription drugs in this country?

Governor HASLAM. I think there are a couple of things that come to mind. Having the FDA speed up the approval process for generics is one. Looking at how government as a major payer negotiates for those costs is two.

Senator SANDERS. You would have Medicare negotiate prices with the pharmaceutical—

Governor HASLAM. I would.

Senator SANDERS. Good. OK.

Governor HASLAM. No. 3, I think one of the things that the Affordable Care Act has done is it has not allowed States in their Medicaid programs to limit the number of prescriptions. In Tennessee, unfortunately we lead the Nation in prescriptions per cap or we are in the top two or three. We had a program in place that we thought was very effective providing the care that we needed that took away our right to do that.

Those are three things that come to mind.

Senator SANDERS. Thank you.

Governor Bullock.

Governor BULLOCK. There may be some unique ideas, but from the perspective of—Governor Baker spoke very eloquently on the State as a formulary and the idea of how long it takes for generics to pass through.

Allowing the State more market power, the ability to negotiate I think would be significant.

Senator SANDERS. What about reimportation of drugs?

Governor BULLOCK. I think that certainly health and safety standards need to be met. To the extent that health and safety standards are met, it is worth a discussion.

Also, it took 19 extensions to get a 6-year highway bill through. I worry in some ways—I fundamentally and philosophically agree we need to address prescription drug prices. I am a realist enough to try to say what is going to actually come out of this Congress.

Governor BAKER. I would agree with what Governor Haslam—

The CHAIRMAN. We are running out of time. If you can give a real short answer.

Governor BAKER. I think the generic piece absolutely has to get worked on.

I think giving States the ability to create formularies and programming around prescriptions generally—one part of the high cost of drugs is the high cost of individual drugs, but another part

of it is—you talk about opioids for example. We are 5 percent of the world's population. We consume 80 percent of the world's opioids. We have real issues with respect to volume.

The CHAIRMAN. We are running too far over.

Senator SANDERS. Can Governor Hickenlooper get 30 seconds?

Governor HICKENLOOPER. One sentence. I would argue for transparency of prices so that consumers can have choices, and there are apps out there that could make those choices freely available.

Governor HERBERT. Can I add my 20 seconds? If it takes 20 years and a billion dollars to get a drug approved, that is way too long. That causes the pharmaceuticals to try to recover their costs. Streamline the time, reduce the cost, we will have cheaper drugs.

The CHAIRMAN. Thank you, Senator Sanders.

Senator Collins.

STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

First, let me thank the Governors for appearing today and offering your excellent testimony.

Governor Haslam, your insurance commissioner yesterday testified about the benefits of reinsurance and said that, "it should bring premiums down remarkably." That is consistent with the experience in my State of Maine and also in Alaska. It suggests that a reinsurance pool can be successful in helping to drive down the cost of premiums.

Unfortunately, as a practical matter, many States are simply not in the position to immediately stand up their own high risk pools and to finance them. Alaska was very creative using some savings from the premium tax credits, but still put, I think it was, \$55 million into the plan.

So my question for you is, is there a need for financial assistance from the Federal Government in the short term to help set up reinsurance pools?

Governor HASLAM. I think in the short term, States will have two issues setting it up in terms of getting it through our legislature. You have got to have a legislative process, and then No. 2, where are the funds going to be? If Alaska is 55, I am not sure what Tennessee would be, but I assume it is something in that neighborhood.

Long-term, though, I definitely feel like the States should run those programs. We can run them and we will run them better.

Senator COLLINS. I agree with that. I am just worried about the short term.

Governor HASLAM. I think our Commissioner McPeak was right. I think for the first year, you are going to have to have the Federal Government help on that, but then quickly let the States do it.

Senator COLLINS. Thank you.

Governor Baker, great to see you here again. Another key to driving down premiums is broadening the number of people in the individual market. You have an individual mandate in Massachusetts, which has been in existence for many years. Obviously, the ACA has an individual mandate, which is extremely unpopular. We know that young people can stay on their parents' policies until age 26, but then they age off those policies. That is the vulnerable

group. What I hear in Maine from young people is they would rather pay the fine because it is less expensive for them, particularly if they do not qualify for a hefty subsidy. They would rather pay the fine than get insurance.

So Senator Cassidy and I at the beginning of the year introduced a bill that called for auto-enrollment of individuals with the opportunity to opt out if they wanted to. We know from the experience with 401K plans, that if you auto-enroll employees, they stay in the plan overwhelmingly. I think it is 75 percent do. Whereas, if you hand them a packet of information, they never get around to signing up.

I realize the mechanics are difficult, but if the individual mandate were to go away, which is not something you support I know, but if it were to go away, what would you think of our having an auto-enrollment system so that you could get people into insurance plans, perhaps starting with a copper plan for young people, and then allowing them the option of opting out?

Governor BAKER. I think what I would say is that—and by the way, I am glad you are thinking about this stuff this way. Maybe this is because I am a Governor and not a Senator.

I think the way you folks should think about this is there are a lot of ways for people to broaden the pool. You could do it with an auto-enroll. You could do it with an individual mandate. You could do it with a penalty for people who do not maintain continuous coverage. You could do it with access to certain kinds of plans and not others if you do not maintain continuous coverage. There is a whole bunch of different ways people could nudge people into the market and encourage them to stay in it. Frankly, you ought to leave it up to the States and let the States figure out which ways work best, as long as they pursue one.

The other thing I would say to you is you could put criteria—this would make sense financially—in there that says if you want us to play in your reinsurance pool, you have to demonstrate to us that you are doing something to encourage people to be covered because, as Governor Hickenlooper pointed out, 5 percent of the population spends 50 percent of the money, and that is in a random risk pool. You get into the individual market where typically there is a lot more people who know they are going to need the system and that is why they buy it in the first place, it is a different game.

There is definitely an opportunity here for States and Federal officials to work together to do things collectively that would broaden the risk pool, lower the premiums, encourage people to buy, and share some of the risk associated with what I think Governor Hickenlooper is talking about is the 5 percent. I really do believe you ought to make that a flexible opportunity and have States do the things that are going to work best in each State rather than trying to come up with one answer at the Federal level and then apply it across the whole 50.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.
Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman. I want to thank you and the ranking member again for holding these hearings. I found yesterday's hearing with the insurance commissioners to be informative and constructive, as is today's.

As I mentioned yesterday, Minnesota has applied for a 1332 waiver to set up a Federal-State reinsurance program. This would bring down the premiums by a whole lot, like 20 percent more. And speaking of getting more people in to get a bigger risk pool—and on the cost sharing, may I say CBO scored the cost sharing where without the cost sharing, it said the rates would go up 20 percent, and because the rates would go up and the Federal Government has to pay the subsidies, our deficit would go up. Talk about a no-brainer on the cost sharing. I agree that it should be more than 1 year and 3 better than 2.

Anyway, let us go to the Federal-State reinsurance program, which has the same kind of dynamic. If this waiver is approved—and we are hoping for news any day now. Minnesota's has not been approved yet. Our health premiums will be 20 percent lower than they would otherwise be in 2018.

During the hearing, we talked about how State and Federal reinsurance programs could be financed. In Minnesota, the State estimates that the reinsurance program will cost about \$230 million in 2018. Of this, the State will pay somewhere between \$104 million and \$132 million, with the Federal Government paying the rest. The State has authorized the program for 2 years. Even with a partial funding the State could receive from the Federal Government, if Minnesota's waiver is approved, the State's reinsurance program represents a significant financial commitment.

As documented in a letter all of our offices received from the executive directors of 12 health insurance marketplaces, other States face budget constraints that limit their ability to fund either a State-level reinsurance program or to meet the Federal matching requirements for a Federal-State reinsurance program like the one proposed in Minnesota. Given this, the letter argues for a federally funded reinsurance program that would help improve competition and stabilize the individual market over the long term. The panel of bipartisan insurance commissioners we heard from yesterday offered similar support for a federally funded insurance program.

To all the panelists, would your State be able to fund and sustain either a State-based reinsurance program or fund the State match for a State-Federal reinsurance program under a 1332 waiver?

Governor HASLAM. Again, if you would give us a year, we can run that ourselves.

Governor BULLOCK. Certainly we would have to crunch the numbers. It would be better to start at the Federal level. We also have a legislature that meets 90 days every 2 years. Also under the ACA when you had reinsurance, rates had decreased. The ability to be able to show here is what this temporary stability fund does would make it a lot easier then for the States following thereafter.

Governor BAKER. I would say it is more a question of time than anything else and figuring it out. This gets to one of those budget neutrality questions we talked about. There are Federal and State

dollars that go into a whole variety of programs here. Thinking about them in their totality so that you understand the complete picture with respect to Federal funds and we understand the complete picture with respect to State funds and how a reinsurance pool would affect what we are all spending now, it may make it possible for folks like us to apply more appropriately funds to support a reinsurance pool. It would be something we would have to figure out. I certainly believe that working collaboratively on that is something we would be very interested in doing and figuring it out.

Senator FRANKEN. Colorado.

Governor HICKENLOOPER. I would echo that. The interconnectedness of what the Federal Government spends on all these different programs emphasizes community health centers, the large network of where people have a medical home and avoid costs. It sounds like that is not a direct aspect of making sure we have reinsurance pools. Without question, the savings the reinsurance pools would create allow community health centers, which I guess you guys do not have funding jurisdiction on that, but that is coming up at the end of the month, so it is worth being aware that that is a very important thing that we get funded.

Senator FRANKEN. Senator Sanders is a big fan. I see him animated and happy.

[Laughter.]

Everybody look at that. He is happy.

[Laughter.]

Senator SANDERS. I will be happier if they are adequately funded.

Senator FRANKEN. Yes, OK. Now I got him grumpy again.

[Laughter.]

Governor HICKENLOOPER. My answer is that for any State, especially low tax States, funding those reinsurance pools would be a difficult step in a year, but we would do it, absolutely.

Governor HERBERT. The answer is yes. We had high-risk pools before the Affordable Care Act and they worked pretty well. I think the issue is transition. Again, I think the model we see in Alaska where they have identified 33 high-cost conditions that would allow them to redirect money into a reinsurance pool is something we could all look at and copy and emulate. The answer is yes.

Senator FRANKEN. Thank you. My time is up. My first question went a minute over. I will have questions for the second, third, fourth, and fifth rounds.

[Laughter.]

The CHAIRMAN. Good. I will not say anything.

[Laughter.]

Thank you, Senator Franken.

Senator Young.

STATEMENT OF SENATOR YOUNG

Senator YOUNG. Thank you, Chairman.

Thank you, Governors, for being here.

Obviously, our near-term focus here is trying to stabilize the individual markets. Governor Herbert, you mentioned in your testi-

mony that we can then turn to what I would regard as the more exciting questions. I will just kind of lay some of them out here.

How can we spur disruptive innovation in telemedicine, artificial intelligence, medical robotics, and genomics?

How can we creatively increase the use of non-physician medical labor?

How can we deliver more cost-effective education for nursing, health sciences, and medicine?

How can we empower patients to manage better their own health with well informed choices?

This is where ultimately we all want to end up because if you are not controlling the cost of health care, the cost of health insurance is going to continue to go up.

You are the chief executive officers of the laboratories of democracy, and so I would like to hear from you since innovation does, indeed, occur at the State level, in addition to the local level, the Federal level perhaps to a lesser degree than we would like, and most importantly in the private sector. I would like to hear what you have done in your States to promote innovation, to bend the cost curve down, and then touch on the Federal barriers to that State-level innovation.

We will start, since I have already invoked your name, with Governor Herbert please.

Governor HERBERT. We believe in the private sector. We are free market people in Utah and we believe that is what has made America great. Most innovation does not come from government. It comes from the private sector. We all carry around these iPhones that have more computing power now than we had during World War II on our hip. The telecommunication capability we have and access to the Internet, et cetera has come from the private sector innovation.

In Utah, we have a significant growth sector in life sciences, medical health devices. We have a number of companies that are innovating things all the time. One of the challenges we have had with this program is the tax on medical devices, which has stymied innovation and actually makes it less affordable for those who really need to have a medical device.

Senator YOUNG. Thank you so much.

Governor Hickenlooper.

Governor HICKENLOOPER. We have something called the regional care collaboratives, which are all over the State. There are 29 clinics that allow people to have a medical home, but they are basically bare bones. The focus there is to try and make sure we get ahead of chronic diseases or issues well before they become huge, cost-driven issues that they often are.

We also steal. We call it facilitated larceny among Governors, but we steal the best ideas.

I would be remiss if I did not mention New Hampshire's efforts at transparency. Transparency is going to be one of the most important things. We all talk about controlling health care costs. Knowing what you are buying when you are buying it, whether it is pharmaceuticals or getting your broken leg fixed in a hospital, knowing what it is going to cost you one place versus another in

real time and what your co-pay is going to be would go a long way. New Hampshire has that.

Senator YOUNG. Thank you, Governor. You did mention the 1332 waiver, which we discussed the need for some reforms there.

Governor Baker.

Governor BAKER. I would agree with Governor Hickenlooper about transparency. The same service, the same person, the same outcome, five different places in Massachusetts, the price can vary by 300 or 400 percent. There is a huge opportunity there. I really do believe we are getting there on that one.

I would also say that one of the things we are currently doing with our Medicaid program is contracting with health care systems on an ACO basis as opposed to a traditional fee-for-service basis and basically saying you have a big group of folks that you worry about and you take care of. You make the decisions with respect to how the best way to serve them would be and trying to get from under this volume-based approach to care delivery, which I think everybody agrees does not necessarily deliver high quality but certainly delivers high volume.

The other thing I would point out—it may be small in the grand scheme of things but it has had a big impact on prescribing—is we completely redid our prescription monitoring program and made it much more 21st century. As a result, we have five times the number of searches being done on it by doctors and other prescribers now as we saw before, and it has had a real impact on prescription writing on both opioids and on benzodiazepines and other schedule 2 and 3 drugs, which is from my point of view a good thing.

Senator YOUNG. Time is limited here. To the other Governors, my apologies.

One note is we refer to laboratories of democracy on a regular basis. I think there are some opportunities for improvement in terms of sharing best practices between laboratories. That may or may not be something that we in the Federal Government need to do, to provide clearinghouses of these best practices that result in innovative approaches, bring down costs and so forth. It may be. It may be an area where we can make some improvements. Perhaps we could work together on that.

Senator Enzi [presiding]. Senator Bennet.

Senator BENNET. Thank you, Mr. Chairman. Senator Alexander has left, but I want to call our attention to what he said at the outset of this hearing. By the way, I am so deeply grateful for his bipartisan approach to this work. That is that we need to address larger questions. He is right about that. What we are talking about today and what has consumed our politics over the last 8 years is the individual market, which covers only 6 percent of the people that are insured in this country. It is important for us to deal with it, and it is important for us to deal with it in a bipartisan way.

What we really need to grapple with—all these Governors have talked about it—is the fact that we are spending twice what any other industrialized country in the world is spending on health care and we are getting worse results, increasingly worse results. And that is not satisfactory to people in Colorado. Whether they support the Affordable Care Act or whether they do not, they are deeply

unhappy with the way they intersect with the health care system in our country.

I want to thank all the Governors for being here, and I want to thank you for your bipartisan leadership on what for people I represent is not a political issue. They realize they are having to make choices about their lives and their small businesses that no one else in the industrialized world is having to make because our system is fundamentally broken. And they know that.

I agree with Governor Hickenlooper, not surprisingly because he tells me what to believe.

[Laughter.]

That transparency is a very important part of this. There is no other market in America where you cannot know what something costs. And by the time you have finished fighting with your insurance company, you do not even know what you are being charged anymore.

We do have big issues, and I hope you will come back to deal with them.

Governor Hickenlooper, you mentioned the Colorado Accountable Care Collaborative, and I wondered whether you might be willing to talk a little more about that. Colorado was able to save over \$100 million by implementing that program which fosters integration and collaboration across providers. It has resulted for better outcomes for Coloradans in the Medicaid program and savings from the State. I wondered if you could talk a little more about that and whether it might inform the work that we are doing on the individual market.

Governor HICKENLOOPER. Sure. We started this about—it took a year and a half to kind of think it through and then a year to implement. The idea is that in each region of the State, there is a central integration of everything. It includes mental health so that now when you go to your basic care provider and you have some serious depression issues, whatever, your child is acting really bizarre—the idea was to integrate that care. We have 29 different clinics, and they are set up in seven regional care collaboratives.

These regional care collaboratives are driven by two things. One is that they cannot diminish quality. Their whole focus is to make sure quality—nothing stays the same, so quality has to improve. Second is how can they control costs. They are focused relentlessly on controlling costs. With that effort, obviously, we want—and I think have done a good job of expanding coverage and making sure more people have a medical home. The notion that we can get to people that have potentially crippling diseases, that we can get to them sooner and make sure that they get the care that will mitigate and in many cases can avoid those really drastic conditions has been a huge part of saving that \$100 million.

Senator BENNET. Thank you for that. I hope we pay attention to it as we go forward.

I also wanted to ask you one additional question. As you mentioned, 600,000 Coloradans have been covered as a result of the Affordable Care Act. We are now at a record low of 6.7 percent uninsured people, but we still have a lot more to do especially in our rural areas where there is often only one hospital. Fourteen of our counties only have one insurer. It is especially difficult—Governor

Baker mentioned this—for families that are facing this opioid crisis that we have.

You mentioned in one of your bipartisan proposals with Governor Kasich the idea that people in such counties might be able to buy into the Federal employee health benefit plan. I wonder if you could talk about that a little bit and how you came to that proposal.

Governor HICKENLOOPER. We have 14 counties, almost a quarter—we have 64 counties in Colorado—that have only one insurance company that provides coverage. We wanted to, A, provide incentives for other companies to come into that market and they would avoid all taxes, a number of different tax incentives to encourage that competition. We also wanted to make sure that the Federal employee benefits program—that people could then choose to be a participant in that plan as well. Again, another choice. For many people, not necessarily the right choice, but for some it would be exactly the right choice, but again, expanding those choices. I think the goal there is to make sure that the Federal Employee Health Benefit Plan is available in those States where we have the greatest challenge—in those counties.

Senator BENNET. I would say, Mr. Chair—I know I am out of time—that another possibility here that I have heard of might be for people to be able to buy into the State employee plans as well. These are all interesting.

Governor HICKENLOOPER. We agree with that, and we did want to speak for all the other States. There was some resistance among other Governors.

Senator ENZI. Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Gentlemen, thank you all. You have all thought deeply about health care. I have had the privilege to speak with some of you. Thank you all for being here.

I apologize I came late. You may have already addressed this.

Each of you—I walked in just as you all were speaking I think you, Governor Baker, or maybe you, Governor Haslam, about the need for flexibility, implying that if you have flexibility, frankly you do a little bit better job, more bang for the buck, if you will, than right now what we do from Washington, DC.

That said, we have a CPIM, a rate of inflation which is higher than the normal rate of inflation, and in some areas of health care, it is a little bit higher than that. There is some stuff in there you cannot control. I think, Governor Baker, in your testimony you say States cannot do much about the cost of pharmaceuticals. We stipulate that. With flexibility, do you think that you could bring down the rate of inflation of health care in your State? With flexibility, you get a lump sum of money. You can combine risk pools. You can do reinsurance programs. You can—you name it. You can work with that.

Governor HASLAM. I will make a couple of comments. I think Senator Young has talked about innovation. There is nothing that makes you innovate quite as much as having to balance your budget. All of these Governors, I guarantee you somewhere during the year we say we balanced however many budgets for however many

years you have been in office. The truth is most of our constitutions make us do that. That causes us to think innovatively.

Governor Herbert is right. The market thinks of innovative ways to change products. That is not our job. Our job is to think of creative ways we can address that.

Senator CASSIDY. The simple answer, it sounds as if you think as you could.

The question is, though, because critics would say if the Federal Government is not telling you what to do, then coverage will suffer. You will have folks with a fig leaf of coverage but in reality Governors do not care enough to make sure that they have adequate coverage.

Governor HASLAM. Right. The question particularly for folks will be, well, will you care about the least of these if we give you that control. I would argue this committee just went through an exercise last year where you really passed an unprecedented amount of control not just to States but to local governments through schools. I think you are going to see that process work.

Senator CASSIDY. Governor Bullock.

Governor BULLOCK. I think the ability to innovate certainly when there are consumer protection safeguards on such, we can do a lot with. One of the things that the Affordable Care Act did is provided some essential health benefits that did not exist certainly prior in so many areas.

Senator CASSIDY. Let me ask. Let me interrupt because I have limited time.

The CHIP program gives you an essential health benefit package essentially. You are all familiar with CHIP. I do not have to define it. What about the CHIP as a vehicle that would give you that safeguard but perhaps a little bit more flexibility than the ACA?

Governor BULLOCK. I think flexibility can be helpful. If the funding is not there, it is fairly meaningless. In some of the proposals that I have seen, talking long-term, if I lose a third of my Medicaid funding, I am not going to be able to do what I am currently doing.

Senator CASSIDY. Got it. If funding is adequate, then you would feel like you can do something a little bit more cost-effective than maybe what you are required to do.

Governor BULLOCK. Adequacy defined by the terms of a Senator or a Governor may be two different things.

Senator CASSIDY. My daughter and me. We have different definitions of adequate funding.

[Laughter.]

Governor BULLOCK. The distinction is there that, we are providing the coverage, and if it all gets shifted to the States, it is going to substantially change what can be done I think no matter how much flexibility we are given.

Senator CASSIDY. Let me just shift gears.

One thing I have noted under the ACA, the expansion is generous, obviously, but in 2020 States will be required to put up 10 percent in order to draw that down. For the expansion State Governors, frankly my State will be about \$310 million. And if we are frank, financing gimmicks will make up some of that, but it is still a lot of money.

For the expansion State Governors, is that going to be problematic or do you think, oh, no, we can handle the 10 percent, no big deal, and send it on?

Governor BAKER. Massachusetts started covering more people through a variety of 1115 waivers back in the 1990s. We negotiated literally the fifth Federal waiver that we have negotiated over the course of the past 20 years and signed it last fall, just about a year ago now. That waiver has certain parameters on the Federal side and on the State side that we have to live with for 5 years. Our assumption is we are going to deliver on our share of the puzzle on that one, and we expect the feds to deliver on theirs. There are all kinds of shared responsibility and accountability in that.

Senator CASSIDY. Yes, but again, that 10 percent on the ACA 2020 Medicaid expansion, that is a chunk of change for States that typically are paying more for their Medicaid expansion population than their traditional Medicaid and they have enrolled a lot of people.

Governor BAKER. Yes. No, I know. My point here is that we have a 5-year expansion. We signed the waiver. We expect to live up to our end of the bargain.

Senator CASSIDY. It may not be easy, but you are going to do it.

Governor Baker. Yes.

Senator CASSIDY. Sounds good.

Anyone else?

Governor BULLOCK. It is real money, but I can also say uncompensated care has dropped by 25 percent. My overall uninsurance rate has dropped from 20 percent in 2013 to 7 percent today. And for a rural State, if I do not have health care in those smaller communities, I lose those communities. Is it a big chunk of money? Yes. Is it an investment in Montanans that we will be asking the legislature to make? Yes.

Senator CASSIDY. Thank you. I yield back.

Senator ENZI. Senator Whitehouse.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thank you very much. I know that both the chairman and the ranking member had to go on to other things. It is a very busy time here as you all know very well from all the many issues you have in other committees here in the Senate, as well as ours.

I want to join my colleagues in expressing my appreciation for both the bipartisan nature of the committee's work that Senator Alexander and Senator Murray have led and particularly Senator Alexander's stated commitment this morning that he wishes to move on to address other issues, cost-related issues, in the system.

What I would like to spend my time doing with our distinguished Governors here this morning is to ask for you to take a look at a couple of questions and then get back to us because I am going to make a bet that we will, in fact, move on to those other topics once we get through the market stabilization. I am not sure we are going to get you back before we move on. I want to take advantage of you while you are here. These are questions that I will ask for the record so that you have a chance to have your staffs get back to us here, but I really think it would be helpful for us as we move

on into that next area to get your views on some of the specifics in those areas.

I have a number of them. The first has to do with patient safety and medical errors. It strikes me that hospitals who give their patients hospital-acquired infections are a good bipartisan topic. I do not think there are Democratic or Republican hospital-acquired infections. There have been a lot of studies that show there is significant cost to patient safety problems and medical errors with hospital-acquired infections being one example among many, perhaps the most watched example. I would like to get your thoughts on whether you think that ought to be an area of focus for us.

A second somewhat related topic is the wild variations in care and in outcomes that we see in different States and for different conditions. It seems to me that the areas where people are showing really good results ought to be leadership areas and other States ought to be induced to move toward those results and we should try to encourage that kind of behavior in whatever way we can. That is the second point is what you can give us by way of advice in trying to move the bad performers where there are wide variations in care and outcomes more toward the higher performers.

The third is in the area of administrative overhead and dispute. There are lots of areas under that general category, but the one that most readily comes to mind to me is the continuing bureaucratic warfare between insurance companies and providers over getting paid. Insurance companies have built an enormous stable of staff who are dedicated to telling providers no, we are not going to pay you for that. Providers in return have had to staff up with an armamentarium of their own to fight through that insurance industry blockade, and the entire exercise back and forth contributes exactly zero health care value by my judgment anyway. There are ways that we can reduce those burdens.

I know that years ago when I visited our Cranston community health center, they told me that they had more bodies on the payroll devoted to trying to get paid than they had on the payroll—boy, do I see a lot of heads nodding when I said that—devoted to actually delivering health care services to their clients and customers.

Fourth is trying to support—and Wisconsin has been particularly good in this—making sure that what a patient wants as he or she nears the end of life is what that patient gets. There is a combination of bad preparation for that inevitability and bad Medicare and other billing rules around that predicament that very often lead families to get trapped into a machinery of hospital—the grind that they cannot get out of in time for their loved one to actually have their wishes honored at home. There is no Democratic or Republican way to have a family's wishes honored.

The last thing I will mention is payment reform. We can do a lot more to encourage health care as opposed to just treatment when people get sick. My time is up, but let me just brag on Coastal Medical, a primary care practice in Rhode Island, and Rhode Island Primary Care Physicians, another big primary care practice in Rhode Island, both of whom have demonstrated that they are driving down costs year over year on an average annual patient basis while seeing the service to their patients and the happiness and

satisfaction of their patients soar because they are getting better treatment. Better treatment in this area actually has the happy benefit often of reducing cost.

If you could look at those specific things, together with any particular local things that I have not mentioned that you would like to flag for us, that would be a very useful thing for us to put to work in later hearings.

I thank the chairman for indulging me in the extra minute, and I thank all of you for your cooperation in this effort.

The CHAIRMAN [presiding]. Thank you, Senator Whitehouse.

I apologize. I had to step away and vote. I am glad I did because for the third consecutive year, we recommended to the Senate a \$2 billion increase in appropriations for the National Institutes of Health. That does not make many headlines, but it is very important.

[Applause.]

That was good. That does not happen much.

[Laughter.]

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman. I am glad you are calling on me next because I want to get down there to cast that same vote. We have two committees meeting, overlapping.

I want to reiterate what I said yesterday about how pleased I am that we are at this point of bipartisan hearings, and your work together with our ranking member is so important. It is great to have this excellent panel of Governors representing both parties in diverse States.

We are focused predominantly on market stabilization issues that we hope to expeditiously see move through the Senate and hopefully the entire Congress. I know that there have been a number of elements of that legislation that we have heard reflected in our chairman and ranking member's opening remarks and in all of your statements to this committee. Those areas of growing consensus relate to the cost sharing reduction payments, the State flexibility issues with 1332 waivers, and some of the areas emerging around reinsurance and risk management tools.

Most of you also mentioned the incredible importance of the participation of young and healthy people in the markets in your States. Prior to the passage of the Affordable Care Act, young people in particular were one of the most uninsured age demographic in our country often because graduating from high school, an entry level job that does not provide insurance or going to school where the insurance offerings might be lacking, all sorts of barriers for young people.

We have been talking about the growing consensus. At the same time that Congress is working together, we have an Administration that has announced recently some changes in spending plans, if you will, and other administrative policies that may work against that or will work against that. There is a 90 percent cut in the out-reach expenditures for this next open enrollment period, shrinkage of the actual time for that open enrollment period, cuts to programs like The Navigator program, and last, I think a question mark

around enforcement of the individual mandate. It might be called an individual aspiration rather than an individual expectation of seeking coverage.

I guess in terms of stabilizing the markets in your States, how important is it that we focus on addressing these administrative changes? And if you could answer sort of quickly about the aggregate impact of those, that would be helpful because I would love to get one more question in. Governor Haslam?

Governor HASLAM. I do not know if there is a quick answer to what you said, so I will do my very best.

Obviously, the individual mandate is not working. We have a lot of folks that it is intended to sign up who have just said I am still not going to do it. On the other end, the sick people are sicker than we anticipated, and that is why we are in the situation we are in. I will let some other folks have a minute to talk about that.

Governor BULLOCK. Quickly— I referred to this in my written testimony—we need to make sure we have a risk pool. The idea that we will cut 90 percent of the education dollars and 40 percent of The Navigator dollars, when what we need to do is draw these people in, does not make sense. In Montana, we are a Libertarian State. We do not like the government telling us what to do. By the same token, we need to make sure people are in that risk pool. Until a credible alternative, either incentives or other things, are created that we need to continue to have that mandate. In some respects, it is like the no fault insurance that Senator Enzi had referenced at the start. It made everybody get insurance, and we got to make sure of ways to do that if we are going to hold down costs in the individual market to ensure that we have a decent risk pool.

Senator BALDWIN. Governor Baker.

Governor BAKER. We are in a slightly different spot because we run our own exchange, and if you run your own exchange, you are required under the Federal law to actually have a Navigator and an outreach program, which we do. We run it and we pay for it ourselves in Massachusetts.

What I would say about that is it is at least important what you are doing as it is how much you spend on it. We made a lot of changes to the way we do outreach over the course of the past couple years and have tried to do things that actually seem to move the needle with respect to enrollment and have stopped doing things that were not moving it at all. I would say this is a good example of Senator Young's comment about States could learn from each other about this. I am telling you there is some stuff that you and we pay for that does not get us anything with respect to enrollment, and there is some stuff we do that does and we should be talking more about the how on that one.

Senator BALDWIN. Great.

Governor HICKENLOOPER. Without repeating anything anyone else said, we started using social media for the first time. We are getting rock and roll bands and musicians. You have to look at who your target is and then how you get to them. The notion of using trusted advisors, trying to do outdoor recreation opportunities to get people to sign up, all those are different ways—and cutting back the revenues by which when you're finally figuring out how to make it work is probably bad timing.

Governor HERBERT. Let me just say that talking to Senator Franken earlier, we debate over how we pronounce “insurance.” We actually are debating what insurance is. And the challenge of having a pool created, whether it is by mandate or by incentive—we have kind of violated the program. We have said we have a lot of young people that do not want to be involved. In Utah, our uninsurance rate was 11 percent before the ACA. The national average was 13. Of those 11 percent, half of them could afford it but chose not to. A lot of it was the young invincibles. If we are reinventing the definition of what insurance really is, recognize that we have some of these problems. Should we have a mandate or should we have incentives to create that proper pool? And that is part of the debate we have overall that undergirds this whole thing.

The CHAIRMAN. Thank you, Senator Baldwin.
Senator Murkowski.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman. We are all kind of popping in and out of other meetings, but it was important for me to come back.

I personally wanted to thank each of you for being here, each of you for your leadership on these issues. Governor Hickenlooper, what you have done in leading a bipartisan group of Governors to come forward with some suggestions for us—I think this is exactly what many of us had been hoping that we would have an opportunity to do is this level of engagement. We can do a lot up here in the capital here in Washington, DC, but you all have to translate it on the ground. The fact that we have not had this open dialog to this point in time on this particular issue area is I think part of what has taken us so long to get here. I just thank you for that.

It has been described that we got to figure out how we approach this, and I appreciate the chairman’s leadership in focusing on a very discrete area in terms of how we stabilize the individual market. Whether we are eating the elephant one bite at a time or Senator Enzi’s analogy, which was eating the whale, I will tell you that I actually know how to eat the whale.

[Laughter.]

It is a very prescribed way that you cut the whale so that it is shared according to tradition.

I am not going to suggest that I have all the answers with health care, but I do think that Alaska has provided a little bit of some guidance here as an extremely high-cost State in a very remote and rural area with a very small population. Everyone is now looking at what we have done in leading on 1332. It is not perfect, but it does provide an example.

I want to recognize that with the approach that the chairman and the ranking member have taken, that we are going to look specifically to how we can stabilize the individual market, there are some very clear areas of consensus whether you are Republican or Democrat, rural or urban.

First is dealing with the CSRs, and whether it is a 1-year, 2-year, or perhaps longer, we can figure that out. It is about the predictability. I think that that has to be key.

The flexibility given to the States. Again, there is uniformity there.

The fact that it has to be bipartisan. This cannot be the Republican solution to health care, just as just having a Democrat solution to health care was not the answer for us either.

Getting us to where we are today—the process is better when it is open like this, and I appreciate your input here.

The question that Senator Baldwin had just posed about how we deal with ensuring that we have significant numbers that are enrolled. Yesterday, there was discussion about the cuts to The Navigator program. It was very interesting because the insurance commissioner from Oklahoma said we have insurance agents on every corner. In Alaska, I can tell you we do not. Recognizing that we might need to look at different approaches given the demographics of the respective States I think is important for us.

One thing that came up in a letter that you had led, Governor Hickenlooper, was the opportunity for some creative solutions in underserved markets. Alaska is clearly an underserved market. The proposal that was out there was that you might be able to buy into FEHBP, the Federal Employee Health Benefit Plan. That might not be the answer, but it is intriguing to me. In Alaska, we have 18,000 people on the individual market. That is it. Why are we creating a new system for 18,000 people?

Can you speak a little bit more to the discussions that you had amongst Governors on some of these proposals for how we deal with those in underserved markets?

Governor HICKENLOOPER. Sure. And thank you for your leadership on health care as well. Obviously, you do represent a different part of the United States.

It is worth saying that all these Governors—Governor Kasich and I talked to over 20 Governors to try and collect information around this. One of the hard parts was figuring out how do you distill that down into a set of recommendations that can have a real material bearing on something like those individual markets in certain parts of the world where it almost does not make sense.

Obviously, I think the Federal plan is a viable solution. When you look at it, for a lot of individual markets, it is too expensive. They get things they do not necessarily want. It is not a perfect solution. Also trying to provide incentives for basic health insurance plans and companies to go into these markets and give it at least a fighting chance to make a sliver of profit out of it is probably the most important thing.

Governor Kasich and I—we disagree about an awful lot of this stuff. Ohio has a big rural population. We have a big rural population. Everybody up here has a big rural population. That is a consistent effort that I think if we had more bipartisan support and I would say more work with the Governors as well, we would make more progress.

Senator MURKOWSKI. I want to do that.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Warren.

Senator WARREN. Thank you, Mr. Chairman.

I also apologize for having to be in and out. We are doing a hearing on North Korean sanctions, another easy issue.

As Governor Baker has already emphasized, in Massachusetts making sure that everyone has high-quality, affordable health insurance has not been a partisan issue. Democrats and Republicans work together to make sure everyone has access to health care.

Governor Baker, I want to ask you a question about costs. If President Trump follows through on his threat and refuses to pay the cost sharing reduction subsidies that help keep insurance premiums down, Massachusetts would lose about \$146 million in 2018 alone. Does that mean that the Federal Government will save \$146 million in Massachusetts expenditures?

Actually no. This is one of the things we talked about with respect to the fact that there is a whole bunch of places where Federal money is involved in health care. According to the CBO—we have talked about this a little bit—you would end up at the Federal level paying more in advanced premium tax credits if you did not have the CSRs. And net-net, it would be a negative for the Federal Government over the course of the next 10 years.

Senator WARREN. In fact, I think it is about \$194 billion nationwide.

Let me ask the question the other way then. If insurance companies and people in Massachusetts are going to get Federal money either way, then why do you care whether or not President Trump makes the cuts to these cost sharing programs?

Governor BAKER. The big part about the cost sharing piece and the uncertainty associated with it is what it does to the behavior of people in the market. Whether you are health insurance plans or you are individuals or you are providers, you are all basically trying to figure out what are the rules of the game and what is the Federal Government's role going to be in participating.

Part of the reason why we have talked about the fact that you probably need to put this in place for 2 years and then figure out what some of the larger issues we have been talking about this morning should be about is because you need to create some certainty here for the individuals and the families who buy in the individual market, who participate in the exchanges, and send the same message to the carriers and to the provider community.

Senator WARREN. If the President's threat to cut cost sharing makes no sense financially either for the Federal Government or for the States or for the families, can you think of any policy justification for threatening to blow up the health insurance marketplaces in Massachusetts and around the country by deliberately driving up costs in this way?

Governor BAKER. Having listened to my colleagues here talk about what the impact of the elimination of the CSR program would be in their States and knowing that it would probably represent a 20 percent increase in the cost of insurance for individuals and small businesses, which is really who we are talking about here in Massachusetts, and the fact that I do not think the Federal Government would save money, I said before I think it would be a bad idea. I really appreciate the fact that you all are having a conversation about how to make sure that we continue to provide

stabilization or create stabilization in a market that clearly needs it.

Senator WARREN. I think failure to stabilize is reckless and preventing that should be our No. 1 priority here.

I want to ask a question about market stability. Some people are asserting that in order to improve the ACA's insurance markets, we need to let States reduce the quality of coverage that people are allowed to buy, garbage plans, you know, weaker and weaker plans or plans with much higher out-of-pocket costs. Governor Baker, in order to stabilize its market, does Massachusetts let insurers offer garbage plans, plans that toss out coverage for things like maternity care or addiction treatment, or let insurance companies offer plans that have such high deductibles that people will go bankrupt even though they have health insurance when they get sick?

Governor BAKER. We have a fairly robust exchange. We have 10 carriers. We have 60 plans. And by the way, depending upon—within the essential benefits framework which we support, you can buy a different level of cost sharing. You buy a bronze plan, a silver plan, a gold plan, depending upon what your particular interests are.

Massachusetts pays—people think of us as a high-cost State, but actually families and individuals in Massachusetts pay less as a percent of their income in health insurance than the national average. People in Massachusetts have lower out-of-pocket expenses as a percent of their personal income than people do at the national average level. And the total cost of coverage in Massachusetts, even with the fact that we have pretty robust plan designs, is plus or minus about 5 or 6 percent higher than the U.S. average but nowhere near as a lot of people think it is. We do not think the path to success with regard to market stability is reducing in draconian ways the options that are available to people.

What I do believe—and I said this earlier—is our ability to create stability in that market over the course of 10 years to get a lot of people into it and to encourage people to participate. As I said, I support—the mandate has been a much more effective way for us to manage costs.

The other thing I would say—and this gets back to the question that was asked earlier about risk sharing and reinsurance—we do support with State funding on the premium side because we think that is a good idea with respect to making sure people have access to plans they can afford. That is part of what would become the conversation in Massachusetts if we headed down the road of trying to play to support a reinsurance model as well.

Senator WARREN. Thank you very much. I think Massachusetts is the example of showing that we can stick with strong insurance plans that protect families and at the same time have market stability and that ultimately that works for everyone. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

I do not usually do this—and I will give Senator Warren time if she wants to say anything else. I do not disagree with what she said about the President and the cost sharing thing except one other fact is the United States District Court for the District of Columbia ordered the President to stop paying the cost sharing reduc-

tion payments because he is not authorized to do that under the Constitution because we, the Congress, authorized the payments but did not appropriate the money.

What we would like to do is clear that up—I would like to do is clear that up by appropriating the money for a period of time. Then if the President did not do it, that would be another question.

Senator WARREN. Mr. Chairman, I need no rebuttal. If this Congress moves forward and authorizes the money and gives our States the ability to stabilize their markets under the Affordable Care Act, I am all in.

The CHAIRMAN. Good. Thanks very much. You and I agree on that. Thank you, Senator Warren.

Senator Hassan.

STATEMENT OF SENATOR HASSAN

Senator HASSAN. Thank you, Mr. Chair. And my thanks to you and Ranking Member Murray for these hearings.

To our very distinguished panel, thank you for being here. As a former Governor, you are some of my favorite people. Welcome.

Thank you for offering the different perspectives of your States. As I said yesterday, I think one of the things that is so useful about these hearings—yesterday we heard from insurance commissioners. Today we are hearing from you. You all actually are on the front lines making things work, and I think sometimes when we move out of our ideological debates and into problem solving, we actually can find a way forward.

To that end too, a shout out to Governor Hickenlooper and Governor Kasich and all of you who have come together on the bipartisan proposal from the Nation's Governors because it has really helped us focus on problem solving and I appreciate it very much.

We have talked a lot about two issues that seem to be everybody's focus in terms of the task of immediately stabilizing our markets, reinsurance and the cost sharing reductions.

I want to ask quickly about the discussion we have been having here about whether the Federal Government should fund at least a temporary reinsurance option for States, whether the States have the wherewithal to do it all themselves. I sat here today thinking that if I were still in the Governor's seat, I would be making the argument that at least some of the seed money should come from the feds because the feds are going to save money if we put in place a reinsurance program and premiums go down.

Is that an assumption or a belief you all share too, that there are savings both on the State side and on the Federal side, if the Federal Government could put up the seed money and get the reinsurance program up and running at least temporarily? Any one of you.

Governor BAKER. I certainly look at the funding you spend on the advance premium tax credits and the money you spend on the CSR program and the money you spend on Medicaid generally. And I would say yes. If you reduce the cost of coverage, then that is going to impact all the other things that the Federal Government puts money into to pay for the cost of coverage.

Senator HASSAN. Thank you.

Anyone else?

Governor HERBERT. Let me just add. Senator, I think we all want to have a cost-to-benefit analysis. Whatever the cost is, there ought to be a benefit. If there is a better way of doing things and spend the money in a better way, let us do it. We want stability in the marketplace. We want predictability. We know that is what the marketplace wants.

We find, though—and Governor Haslam kind of mentioned this—that States kind of have to govern under a different set of rules than you do here in Congress. We really do have to balance the budget. We have to live within our means. When you say provide seed money, if you have that in the budget to provide seed money or any other kind of whatever you want to call the money, if we could find a cost-to-benefit where we have a reduction of the overall deficit being spent here in Congress, that is probably a good thing. If it just adds to the deficit, I think the concern that many have in this country is where is the end going to be. If we are approaching \$20 trillion, how much more can you generate.

Senator HASSAN. If we are talking about the actual program that we have up and running, the advance premium tax credits that we would have to pay as opposed to using that money as seed money for reinsurance and bringing down the overall cost I think weighs to the benefit side of the cost-benefit analysis.

Governor HERBERT. I agree, and I think we need to think in terms of short term, but you also need to be thinking in terms of long term.

Senator HASSAN. Thank you.

I know that others may want to chime in, but I wanted to move on to at least one other point. Governor Baker, I will start with you because as neighboring States, we have worked together on combating the heroin and opioid/fentanyl crisis in our States. It is an epidemic that impacts States around the country. I wonder if you could comment on the importance of having predictability, participation in the insurance coverage market, and essential health benefits to the capacity to stand up treatment and recovery services in your State.

Governor BAKER. Certainly the fact that we already had sort of virtually universal coverage made it much easier for us to expand our recovery and treatment capability in Massachusetts, which we have done over the course of the past couple years. We have probably increased our support for that by about 50 percent.

The other thing—and I mentioned this earlier—that really made a difference was being able to work collaboratively with our colleagues across the New England region on prescription monitoring, which because the system is now a lot more 21st century and a lot more user friendly, we have far more prescribers using it and they are using it a lot more often. The data that they are getting from it not just in terms of the person that is in front of them, but also in terms of sort of best practice standard and where they sit relative to their peers, has had a big impact on prescribing patterns. For the first time in 15 years, in the first 6 months of 2017 over the first 6 months of 2016, the number of people who died in Massachusetts went down. We still have a long way to go. That number had gone up year over year every single quarter for literally 15 years. I do think that having a system where for the most part cov-

erage was not the first question that people had to deal with with respect to accessing treatment made a big difference.

Senator HASSAN. Thank you.

Mr. Chair, I see my time is up. I will submit maybe a question. We have talked about transparency of cost, which is something that New Hampshire has led in. We also need to be talking in transparency of outcomes because my experience has been that people think that if we are talking about lowering the cost of their care, we must be talking about giving them lower quality care. In fact, the inverse is often true. I think combining those metrics is really important. I will include a question to the record about that.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Casey.

STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thanks. I want to reiterate our thanks to you and Ranking Member Murray for these bipartisan hearings. Good news for the country when they see these hearings playing out.

We are grateful and certainly grateful to the Governors who are here. You have very difficult jobs every day, and the time you are spending here not only here today to give testimony and answer questions, but both your advocacy and the way you convey a sense of urgency about these short-term issues, especially CSR payments, and other issues we hope to get consensus on, we are particularly grateful.

I was just running back and forth literally across one hallway to the Finance Committee. We are dealing with yet another matter of urgency which is the Children's Health Insurance Program deadline on September 30th. Lots to do on two major health care issues.

The one part about this discussion today that is encouraging—and it has been evident now for a couple of weeks at least, if not longer—is that there is consensus about the need to make the cost sharing payments and to legislate, as Chairman Alexander has indicated to us, and to also get to some other issues like 1332.

One thing I wanted to ask about is—because there was discussion I think today that I may have missed but certainly yesterday as well about the 1332 waiver but also the 1115 waivers. Governor Baker, I wanted to start with you.

On the thinking to combine savings from both waivers, one concern raised with regard to that by combining those savings from those waivers, the intent would be to help folks in the marketplace. Would there be a cost or an adverse impact on Medicaid or Medicaid beneficiaries? Anything you can tell us about that or any concern you have about that.

Governor BAKER. That is a big part of why we appreciate the opportunity to think about this stuff holistically in our conversations with folks at CMS and at the Federal level. The number of different revenue streams and the number of different programs that the feds finance different parts of the health care community, when you are talking about the population that is sort of somewhere between, call it, 100 percent of poverty and 300 percent of poverty, working people for the most part, folks who do not typically have access to coverage as directly as folks who are either automatically

qualified for Medicaid sort of across all 50 States because of their status and their age and they are disabled or they are very poor and the folks who just have access to coverage because they have been working for 20 years and they make enough where it does not really affect their ability to access employer-based coverage—that whole area in there, which represents a lot of people, has with it a lot of different sources of State and Federal money. One of the things we believe would be helpful to you and to us is to make sure that we account for all of that when we try and figure out what the best way, as Governor Herbert said before, to deliver the highest benefit and the most appropriate level of cost across what we at the commonwealth put in but also what you at the Federal level put in as well.

Senator CASEY. I appreciate that. I know I will be short on time, but if we can do it by way of written response to an additional question.

Governor Hickenlooper, I want to thank you for the work you have done in a bipartisan fashion with Governor Kasich, including Governor Wolf of Pennsylvania working with you as well. I know that others at the table are equally engaged. Because you have some Pennsylvania roots, I will direct this question to you.

With regard to the age rating limit, some States have proposed balancing the risk pool, which is obviously of great significance and priority, but some States have proposed balancing that risk pool in a way that potentially could negatively impact seniors. Is there anything that you would want to say about that with regard to both the age rating limits or otherwise? Any concern you have there?

Governor HICKENLOOPER. Yes, of course, I think we all have a lot of concern on that, and I will be brief.

Expanding the calculations by which older people end up paying even more than they have been seems unconscionable. Certainly there are other ways to approach some of those discrepancies. The real issue here is how do you get more young people to join up. This is probably the wrong way. If you talk to AARP or any of the advocates for older Americans, they get very agitated when they hear this. It is unfortunate to take that direction when there are other choices.

Senator CASEY. Governor, thanks very much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Casey.

Senator Kaine.

STATEMENT OF SENATOR KAINE

Senator KAINE. Thank you, Mr. Chair. To the chair and ranking, these are great hearings.

The chair mentioned in his opening comments just yesterday in Virginia, there was an announcement that a major company that was thinking about going into markets that Anthem had pulled out of—individual markets—that Optima, which was thinking about doing it, had decided not to do it. Virginia is going to grapple with what so many States are, a real now division between urban, suburban, and rural communities. The Optima decision, the Anthem decision is going to hit rural Virginia the hardest. Virginia did not

expand Medicaid. That has hit rural Virginia the hardest. One of the issues we have to grapple with—and I think many of your States are facing this too—is we do not want to become two nations separated between rural America and the rest of the country.

I thank all the Governors. I really admire what you do. You are on the front line. And you are before a committee that is uniquely situated to do this job. This is a committee that has Governors, mayors, doctors, insurance commissioners, State auditors, small business owners, professional humor therapists.

[Laughter.]

We have the bases covered. We can do good work.

I am struck by both yesterday and today the commonality in testimony between the insurance commissioners and Governors around a number of concepts: stability and hopefully 2 years of stability and predictability around the CSRs, what we can do to get more young people in, a variety of strategies on that flexibility to States under 1332, and the viability of reinsurance, whether it is a Federal program or Federal funding for State reinsurance programs. These are bipartisan ideas.

One thought that has been ventured by critics of some of these approaches—and these are not the people on this committee, by the way, but they are some people in Congress and elsewhere—is things like CSR and reinsurance is, “bailing out insurance companies.” You are elected Governors of your States. I assume that you are not here with the primary purpose of bailing out insurance companies. That is a rhetorical question. I know that is not why you are here. It is interesting that is sort of a critic that some would level about CSR and reinsurance in particular.

As I understand the CSR payments, they are basically payments to help individuals deal with out-of-pocket costs, deductibles and co-pays.

You have done a very good job, each of you. As you have collectively described the benefits of reinsurance, you can lower premiums. By lowering premiums, you can bring in more young, healthy people and other people who just find affordability more attractive, obviously. By lowering premiums, you reduce the advance premium tax credit, the subsidy call on the Federal budget. You can protect high-risk people, and you can also send a signal of stability to insurers that there will be a backstop against high-cost claims keeping them in the market.

The strategies that we are talking about here and that have been validated by yesterday and today, two groups of bipartisan leaders at the State level, are anything but a bailout for anyone. They are really designed to help people and to provide at least some temporary stability with a predictability that will enable us to find bigger picture items.

I am going to ask a general question kind of along the line of Senator Whitehouse since there is such consensus around the basic points. When we get to the longer-term discussion, if you could start Governor Haslam, and come across the table, what would be the one thing you would most want us to focus on if we get to step two, we take the stabilization steps?

Governor HASLAM. I think we have to begin to align incentives. Some of you have talked about payment reform and doing that on

the provider side. Quite frankly, you have to do something on the user side as well to incentivize better behavioral choices. Today, I tell people all the time health care is like going to the grocery store. The assistant manager meets you when you walk in the door. You walk up and down the aisles. You get to the cash register and they say thank you very much. You can see why we have gotten to where we are. We all know the history. Aligning incentives would be where I would start.

Governor BULLOCK. I largely agree with Governor Haslam. We need to move from paying for just repeated services and tests to paying for value.

It is also important through all of this too—I think Tennessee has done it. Montana has done comprehensive primary care plus reform. We did it through the Center for Innovation. As you go forward, do not mess with things like that because we are trying to do some good work already in payment reform and starting to look at care coordination, which did not always exist.

Senator KAINE. Governor Baker.

Governor BAKER. To build on what my colleagues have already said, I would add to that the transparency issue that has been discussed before. There is a lot of variation—let us leave it at that—not just in the way care gets delivered but also how much we pay for basically the same kinds of things.

I also think, as Senator Whitehouse brought up, this whole issue around variation in both approach to providing care in certain situations and circumstances and outcomes. There is a lot of research on that, and not a lot of it finds its way into daily practice. That would be a great place I think for, frankly, the Federal Government to actually take the lead. You have a lot of resources and a lot of knowledge and a lot of opportunity there.

Senator KAINE. Mr. Chair, I am over time, but could I allow Governors Hickenlooper and Herbert to answer? Thank you.

Governor HICKENLOOPER. I would just reemphasize transparency. I think that is going to be the next big opportunity. Just go into a Walmart or any big—you know, Target, and they have hundreds of thousands of SKUs, all different colors, every little thing you can buy, and yet hospitals come and tell us or other care providers tell us, well, there is too much complexity. We cannot predict what something might cost. Ultimately we have got to be able to have some system by which people know and can easily through their handheld device or whatever get a sense of what it is going to cost them to get their broken leg fixed or stitches in their arm or maybe a serious medical procedure and know what that is going to cost and what their co-pay is going to be and what the quality is going to be at, let us say, the five different places that are within a 5-minute drive of where they live.

Senator KAINE. Governor Herbert.

Governor HERBERT. Let me say I agree with what has been said. I think we learn from each other. If Massachusetts has a great plan and the people of Utah like it, we will probably adopt it. It should not be mandated to us. We should be able to choose what we think is best in our own respective areas of responsibility.

I do believe we need to move the conversation, once we get through the stabilization here, but there has got to be a discussion

about the cost of health care. The undergirding cause of the rise of premiums and insurance. What are we doing? Why are we not putting more doctors in the marketplace? Why are we not incenting people to go into the field of medicine? How about tort reform? What about more information and consumer choice where they can pick and choose and be informed in their choice on their medical issues? Those things will help us drive the cost down for the cost of health care and drive down the cost of insurance.

Senator KAINE. Thanks, Mr. Chair.

The CHAIRMAN. Thank you.

Senator Murphy is here and he has not asked questions. The Governors have been very generous with their time this morning, including the hour they spent with about 30 other Senators. After Senator Murphy, I am going to move to wrap up the hearing unless Senators have other—Senator Franken and Senator Whitehouse, you may have other comments.

Senator FRANKEN. I do.

The CHAIRMAN. OK. Then we will make time for that. Then I am going to give the Governors a minute or 2 each in case there is one more thing you would like to say to us. Then we will wrap it up after that.

Senator MURPHY. If Senator Franken has a question, he can go ahead.

Senator FRANKEN. Is that OK, Mr. Chairman?

The CHAIRMAN. Sure.

Senator FRANKEN. Yesterday we briefly discussed the Graham-Cassidy proposal. I want to say that I have a great deal of respect for both Senators Graham and Cassidy. Though if Cassidy were here, I would say more for Graham.

[Laughter.]

He is not here.

I have grave concerns with this proposal, and I want to ask our panel about the plan's potential implications. Although the plan's specifics have changed over time and reportedly will change again, what we know from earlier versions of the Graham-Cassidy plan and from recent news reports is that it could eliminate funding for premium subsidies, eliminate the cost sharing reduction payments, and eliminate the enhanced Federal funding for the Medicaid expansion. Instead, starting in 2020, the Federal Government would return some but not all of this funding back to States in the form of a block grant. This means that States will be receiving less money under these block grants than they would be projected to receive under the ACA.

Not only that, but the proposal significantly redistributes funding across States such that States that have been more proactive in enrolling individuals in the Medicaid expansion and marketplace coverage like, Governor Baker, yours and my State, will see billions in losses, while other more sparsely populated States and those that have not expanded Medicaid coverage could see funding increases at least in the initial years.

After 2026, all the State funding would be eliminated, which means States would be on the hook for all costs associated with Medicaid expansion, premium subsidies, and other cost sharing reduction payments after that point.

Earlier versions of the Graham-Cassidy plan also included a proposal to cap and cut Medicaid funding just like the proposal that was included in the Republican bill to repeal the ACA, which failed to pass the Senate a few weeks ago.

Governor Baker, based on what we know about the Graham-Cassidy proposal, is this a reform that you could support for Massachusetts?

Governor BAKER. I am also a big fan of Senator Graham and Senator Cassidy, but no. The proposal would dramatically negatively affect the Commonwealth of Mass. We are talking billions and billions of dollars over the course of the next 4 or 5 years. That is not to say that there are not plenty of programs where the Federal Government block grants money to States that work. A lot of our child welfare money comes through a block grant. We get money for substance abuse services and mental health services through block grants. We get money for—I would argue some of the transportation money we get looks a lot like a block grant. This particular proposal, in part because of the way it is designed, has major consequences for a State like Massachusetts.

I would also argue when we talk about Medicaid generally—and I know this is not supposed to be about Medicaid—your income level as a State, your wage as a State is calibrated into what you get from the feds. We are a 50 percent match State. I am pretty sure you are a 50 percent match rate. Governor Herbert is a 70 percent Federal match rate. Governor Bullock I think is a 65 percent match rate, and I think Governor Haslam is a 65 percent match rate. I have no problem with that. Higher income States should get a lower share of reimbursement from the feds than lower income States. I completely understand that. That formula is framed in a way that is deemed to be sort of equitable based on that.

The problem I have with the Graham-Cassidy piece, especially for a State like us, is it assumes that the cost of health care across the country should be the same everywhere. We are a high wage State, as I just pointed out. Because we are a high wage State, wages make up about 70–75 percent of the cost of health care at the provision level in most States, which is why we get paid less on the Medicaid match than some other States. To promote the idea you could build a block grant model around the idea that the cost of care that is higher in Massachusetts than it might be in Florida because somehow Florida is just smarter and better, that is not accurate. The simple truth is we have higher wages than they do in Florida, and that has a lot to do with why our health care costs are higher.

Senator FRANKEN. I am out of my time. I would note that 99 percent of children are covered in Massachusetts, and more than 96 percent of all Massachusetts residents have health care. These are the highest rates in the country, and with a bipartisan effort, Massachusetts developed a system of health coverage that works. I know that this Graham-Cassidy plan would be not beneficial to States like yours and like mine—

Governor BAKER. Correct.

Senator FRANKEN [continuing]. That do cover—I think we may be second in the country.

Governor BAKER. You just need to know my mom is a Democrat from Rochester, MN.

Senator FRANKEN. I so love you.

[Laughter.]

The CHAIRMAN. With that, we will thank Senator Franken and go to Senator Murphy. Then we will conclude the hearing.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you, Mr. Chairman.

You all have been so fantastic for giving us so much of your time.

I wanted to just probe this question of guardrails a little bit more, and maybe I am going to pose this question to Governor Hickenlooper.

I understand the need to allow for States to be laboratories of experimentation. Lord knows, we still need more experimentation to figure out what works and what does not work in health care. We also do exist in a national economy with a decent amount of fluidity between people and businesses. There is an argument that having some floor on what insurance plans cover protects States and actually creates stability in the overall economy.

You have all recommended giving States more flexibility, but where is the natural end of that? Because I think there is some benefit to knowing that no matter what State you go to, you are going to be able to have folks that are sick or have higher levels of medical acuity be insured. There is probably some benefit to know that there is some relatively uniform standard of benefit, maybe not exactly what is in the ACA today, but at least some modicum of regularity.

Talk to me a little bit about whether you see some benefit in having some floor of benefits or protections and how far you would go in taking down the guardrails.

Governor HICKENLOOPER. We discussed this at great length in trying to come to consensus with Republicans and Democrats. In the end, we support the concept of essential health benefits and what those guardrails are, as they are now. In other words, we do not address that.

What we really focused on was how do you make the bureaucracy easier so you can get these various waivers that pretty much all of us agree offer not only cost savings, but in many cases will improve the actual outcomes of health care delivery. At some point, that will get discussed and debated, and that is a longer issue than we have here. We were very specific to make sure that those essential health benefits, those guardrails, should be maintained.

Within that, there are all kinds of places where maintaining those health benefits can be done less expensively. Governor Baker talked about the alignment of medical, you know, dental benefits. Rather than having your basic insurance company set up whole new systems to provide dental benefits, you have companies that do that already, and they were not permissible under the Affordable Care Act. Those kinds of waivers I think are the driving force of a lot of the change we are going to see in the short term, and if one State has already qualified, other States should qualify as well.

Governor HASLAM. Senator Murphy, can I jump in on that real quick?

Senator MURPHY. Sure.

Governor HASLAM. Undoubtedly you are right. I will say this. It is way out of whack now. The balance is—back to Governor Herbert, it is the States going to the Federal Government hat in hand, and there is an assumption from the Federal Government—and it is a little offensive, to be honest with you—that says you will not care for the least of these unless we tell you exactly how to do it. You trust us with education. You trust us with so many other things. And there is a sense in which like you are saying we do not trust you to care for the least of these. I know Governors of all types, and we get it. We understand that is part of our deal. We are just so caught up in the bureaucracy that we know there are a lot of dollars being wasted.

Senator MURPHY. I want to ask you one other question on another topic. Governor Baker, I want to talk to you about the individual mandate because as part of the President's executive order at the beginning of the year, he required that the IRS start to unroll the enforcement of the individual mandate. And they actually declared on February 14th that they would scrap plans to reject tax returns that do not include information on coverage status. And at least one actuarial firm suggested that this order, this uncertainty around whether the individual mandate is going to be enforced, is contributing to about 10 percent of the premium rise.

You were sort of first out of the box as a State to understand the importance of the individual mandate. Can you just talk a little bit more about your experience with the mandate and what it potentially does to rates if there is at the very least great uncertainty from the perspective of insurers as to whether anybody is going to bear consequences if they do not abide by it?

Governor BAKER. I was an insurer once. I am not anymore. I am not going to try and speak for them today.

What I would say is that the mandate, at least in Massachusetts, did three things. The first thing was it encouraged people who had access to coverage through their employer to take it, and that actually represented a huge part of the increase in covered lives after the mandate took effect, which was not something anybody was anticipating or appreciated, I do not think, before we put the mandate in place. We were thinking about it mostly as a way to make sure that everybody was in the game, including folks who historically had just chosen not to buy.

The second thing I would say is that we have been at it for 10 years now, and it does create a certain level of sort of shared responsibility and a cultural understanding that there is a reason why you buy insurance because you do not know necessarily if there might be some point in time when you are going to need to use it. We are also a mandatory auto insurance State. I think people for the most part get that, and I think it has helped stabilize the market in some respects.

I really do believe that the CSR issue is a much bigger issue for the carriers than what shows up on your income tax return. This is me being the Governor as opposed to a Senator. I would push you folks to think about encouraging States to come up with ways,

especially if you are going to create reinsurance pools in conjunction with them, that create some semblance of a reasonable market. There are a lot of ways people could encourage folks to buy insurance and to keep insurance other than a mandate. I happen to like the mandate because it is what we have been using. It is what people are familiar with, and people understand it in Massachusetts. I do think this is one thing where States, which are a lot closer to people and have a lot more engagement with them day in and day out, could pursue a whole variety of different options. You need to find out that some work better than others, and that would end up being useful and appropriate, especially if you decide you want to get into the business of doing shared reinsurance pools.

Senator MURPHY. Thank you.

The CHAIRMAN. Thank you, Senator Murphy.

Governors, thank you. I want to give you the last word in just a minute to ask you to take a minute or 2 for anything you would like us to have for the record or you would like to emphasize.

First, let me ask you. There has been a good deal of talk about attracting younger people into the individual market. A couple of Senators on both sides of the aisle actually have suggested that with what is now the copper plan in the Affordable Care Act, which is essentially a low premium, high deductible alternative—you could call it a catastrophic plan in a sense. Its goal is to keep, as I think one of you described, a medical catastrophe from turning into a financial catastrophe. In the Affordable Care Act, you can only buy that if you are 29 or younger. The suggestion was to take off the age cap and allow anybody of any age to buy the copper plan.

Do any of you have an opinion about that? Let me put it this way. If it were part of a bipartisan package that included extension of the CSR and other things, what are the pros and cons of that?

Governor HASLAM. I do not know enough actuarially to know how big a difference that is going to make. I do not know.

Governor BULLOCK. I think when you are actually hearing some real consensus on what needs to be done to stabilize it, if Charlie Baker does not know what it is going to do, chances are none of the Senators will. I think that it goes a little further than where we ought to be talking about if we are really looking at immediate stabilization.

Governor BAKER. Going back to when we did health care reform in Massachusetts 10 years ago, we did set up plans that you could buy if you were under the age of 29. This was before the Federal law that said you could carry your parents' coverage until you are 26. We were really thinking about a particular market there. And that was designed to encourage young, healthy people to purchase insurance, many of whom are thinking differently about this than other people are.

I agree with Governor Haslam. I do not know what the actuarial impact of applying that more broadly across the whole marketplace would be. Obviously, my answer to that would be it would be good to have somebody do the analysis and let you know what they think.

In Massachusetts, it was designed to serve a very particular purpose, and that purpose only. It was not made available to the whole

market for a reason, and the reason was we wanted to make sure that the market overall maintained some degree of actuarial soundness within the folks who were buying who were sort of over the age of 30.

The CHAIRMAN. Anybody else?

Governor HICKENLOOPER. I would agree that we do not have actuarial information, but there was a huge process of discussion that went into that decision to put the age limit on there. If you were going to change it—it is not impossible to imagine changing it incrementally, in other words, just do not abolish it but look at what you might add or take away from the plan and then how you might adjust the age in some way.

The CHAIRMAN. It is a thought. Thank you.

Governor HERBERT. Let me add that I do not know that we know the impact actuarially, but I do believe that more choice is better than less choice. I think government puts barriers in place that draw lines and it probably distorts the market. If there is a demand out there for lower cost, high deductibles, we ought to allow that to happen and see, in fact, what the market will, in fact, result in.

The CHAIRMAN. Thank you for your answers. This is the kind of thing that you deal with in your States with your legislatures. I am looking for a way to get a result, and it is pretty easy to be for extended cost sharing payments. That is just more money, and we can argue about how long it should be and that is one thing. We will have no chance of getting that unless we have, in addition to that, some restructuring of the market, part of which could be with making section 1332 work better. That is an opportunity to do that, and the reason I am emphasizing that, I think there is generally consensus about that. It is already in the law. It is easier for people to accept on the Democratic side who approved the law. If we are fixing it, that is easier for them to do.

To get a Republican President and a Republican House and a Republican Senate just to vote for more money will not happen in the next 2 or 3 weeks unless there is some restructuring. A different policy, which is already in the law for people under the age of 29, is some restructuring and would be welcomed by, I think, a number of the Senators, which is why I asked that.

I have two questions to ask you. And a number of you have your staff and insurance commissioners here. It would help us if you could give us specifically the things you would like to see us change in flexibility on 1332, and you can add 1215 if you want—those two waivers—very specific. For example, the waiting period, the me-too plan, the things you have mentioned. If you could give them to us in the next 3 or 4 days. We have written down what you have said, but this train may move through the station, and this is a chance to change those things. If you want to tell us exactly what those are and we got it by the middle of next week, we could use it and it would help us get a result.

The same would be true if you can think of anything that would help States do what Alaska and Minnesota have done, if any change in the law is helpful to that because many of you have talked about reinsurance. Reinsurance is one way to deal with individuals with complex care. Stabilization funds is another, a variety

of ways. Creating a brand new Federal reinsurance pool in the next 10 days is not going to happen. There is just not any way to do that. What we see in Alaska and Minnesota is you are using dollars that are already there in a way that does not cost any more and you are actually reducing premiums without more Federal dollars. If there is any impediment in the law to any other State doing that, it would be very helpful to know it.

Another thought, something we might be able to do in the short term, is pilot programs for a good idea. Senator Heitkamp suggested that. She suggested, for example, association plans, which we go back and forth about, but she suggested before this hearing, let us try a pilot program for a few States who have ideas about association plans. If that idea were appealing, that would be helpful. Or if you want to suggest another kind of a pilot program that we might include in our short-term plan. I am trying to be very specific with you because all of you are Governors. You do this all the time. This is what you do every day. You try to get a result right out of competing points of view.

We have, just to put it bluntly, Democrats who have no trouble voting for more money for the Affordable Care Act because they wrote the act, they passed it, and they like to fund it. You have Republicans who have 7 years of opposing more funding for the Affordable Care Act. Republicans want more flexibility.

Those are the two things that will help us get a result to help stabilize the individual market in 2018.

All the other ideas are very welcomed. Anything that has to do with taxes—for example, the health care tax was mentioned. That is \$145 billion over 10 years. There is no way we are going to find a way to get \$145 billion in the next 10 days. Plus, all those things are the jurisdiction of the Finance Committee and it would be more complicated.

I am trying to keep it very simple. We know how to do big issues. Senator Murphy is here. He and Senator Cassidy solved a big complicated problem on mental health, and we know how to do that. I think we have been so much at a stalemate on this that any small step that helps stabilize the market in 2018 will, A, keep the premiums down and that step would include some extension of the CSRs. As Governor Bullock pointed out, it would be a signal to the country and to the markets that we know what we are doing and a second and third step may be coming down the road.

I was going to ask this question, but I will not. I will just state it. I am intrigued with the fact that Maine set up its own reinsurance program. You can pay for these. I think there is general consensus among Republicans and Democrats that an individual market that is small, has people that do not fit into all the other markets, some very sick people, that any long-term solution is going to have to address especially some amount of people with complex cases, some of the sickest people. And that takes money. There are different places the money can come from. It could come from Federal dollars or savings from Federal dollars. It could come from State tax dollars. I pointed out in my statement your budgets are balanced and we are \$20 trillion in debt. We are spending a trillion on Medicaid expansion in the next 10 years, another trillion on subsidies—866 on subsidies, so a little money problem here. Or

what Maine did was they just tacked \$4 on every policy and created a fund, and it worked pretty well for them.

As we think about reinsurance as one way to deal with complex cases, I think there is a State role in this as we go along.

Finally, thank you so much for coming. I know how busy you are. You have busy schedules every day. You have come a long way. You have given us an enormous amount of time. You have been very specific and helpful. I hope we can come to some sort of result this month. I would like to give you the last word going down the line, and then we will conclude the hearing.

Governor HASLAM. I would just say I think you have a group of people who are willing to help. When you walk through the political situation, we get that. We deal with it every day and we want to help.

I also need to beg your forgiveness. I have to jump out. Thank you very much for hosting us.

Governor BULLOCK. I would say ditto to my colleague, Governor Haslam. It was striking to me, as I read the testimony of the five of us, how much similarity there was. I think we all know what we need to do. I think Congress knows what we need to do in the immediate term under your charge. I do fundamentally and philosophically believe if this committee and this Congress can take this step, that it also sends a much more significant message as far as the opportunities for reform going forward.

Governor BAKER. Ditto my colleagues to my right here.

I would also just add there are a number of other things that would be interesting to incorporate into a bill that would involve reform on the 1332 piece. One is section 125 plans. We used to have those. Pre-tax basis, individuals could buy coverage if they did not qualify for coverage available at their employers. That is another thing that the ACA just wiped away. And there are a lot of people who used to play in the section 125 space, and it is a good solution for a lot of people. It is unfortunate that it is gone.

The family glitch, which we talked about earlier—that is a total winner. Republicans and Democrats should be all in on that one.

States that have established rating factor models that have worked for years and years—and they are a small group in their individual market, which again was just wiped away by the Federal reform.

I frankly do not understand why we should be running rating factors for individual and small group insurance in 50 States out of Washington, DC. It just does not make any sense to me.

We will put all these on a list, but I think there is a bunch of things we can offer up with respect to that.

The CHAIRMAN. It would be very helpful. The more specific, the better.

Governor BAKER. The final thing I just want to say is I really appreciate your leadership on this, and I have always appreciated the tone and the civic-minded approach you have taken to everything you have done in public life. Thank you.

Governor HICKENLOOPER. I want to echo that too.

I will echo also the gratitude. It is refreshing not just for us but for all the Governors and I think for a lot of people around the country to see this work being done on a bipartisan basis. Actually

Governors being the people that have to implement these laws and these sets of regulations—we find it very important for us to be involved in the process and obviously recognize the work you have to do is not easy and it has got a long way to go.

I want to emphasize—I was going to emphasize the family glitch, but Governor Baker did that already.

I do want to reemphasize community health centers and making sure that people have a medical home at the least possible cost with the highest possible quality, which is what community health centers stand for.

I also just want to frame the question because this gets into the partisanship, but at least from my perspective, the Republican inclination is more focused around individual freedom, individual responsibility; Democrats around the power of collaborative efforts. Democrats care just as much about that self-responsibility and that individual freedom, and Republicans care just as much about that collaborative effort.

When I was in business, I spent 15 years renovating old buildings and building restaurants—aligning self-interests where you can get both sides to see that they can get a benefit from a possible compromise is the single reliable way to make progress through really difficult issues. And I think this case is a classic case in point that we all have self-interests, the Republicans, the Democrats, and then all the different players. We talked about the pharmaceutical companies. We talked about the care providers. We can go right down the list. There is a way, by having them at the table, that we could thread that needle I think and really begin to control costs, for the first time maybe in the last 50 years at the same time that we are improving quality and expanding access.

The CHAIRMAN. You have the very last word, Governor Herbert.

Governor HERBERT. Very appropriate too. Thank you.

[Laughter.]

Let me say amen to what my colleagues have said. I think it is an opportunity for us in fact to address you and to give you some what we think is a common sense approach to things, which Governors have to do, and I know as a former Governor, you understand that.

I wrote down three things I learned here today, maybe reemphasized.

One, there are philosophical differences. We have some that argue that health care is in fact a right, while others think it maybe is not a right.

We have the same kind of goals. We differ on process. That is the debate you have around here all the time. We want to make sure everybody has health care, access to good quality health care at affordable prices. How we get there is where we in fact have disagreement.

We also emphasized—and you mentioned it in your remarks, Mr. Chairman—that we have different rules. We balance our budgets. We have to do that. They do not do that here in Washington, and you are approaching \$20 trillion in debt and rising. The question is how much is too much and what do we do about it. I think you are going to have to finally decide how much money are you going to spend, how much are you going to commit on health care. That

is a decision that is yet to be made. Again, I think that is one that you are going to have to look at.

I would also say we cannot let perfect be the enemy of good. You have heard that before. There are some great solutions and opportunities here, but sometimes they get stymied. If we look at just our immigration debate forever, and yet we cannot seem to get anything done because we have perfect being the enemy of good.

And last but not least, there is clearly a lack of trust exhibited in my opinion by Congress toward the States. That is why they feel like they have to put out every jot and tittle of what we need to follow. Nobody cares more about Utahans than Utahans and those who have also been elected to represent them. Please give us the confidence that we will find a way. Let the States be the laboratories of democracy on all of these issues, and we will find a better solution. If in fact Massachusetts has a better way, Utah will be the first in line to try to copy and emulate. If we think that is good or bad or we will modify and improve, we will do what we need to do in the Utah way. I would say the same thing for all the States. Give us that opportunity and we will solve the problem much more effectively, much more efficiently with lower cost to the taxpayers and getting better outcomes.

The CHAIRMAN. Thank you, Governor Herbert. Thanks to all of you.

I noticed that Senator Carper, former chairman of the National Governors Association, has been sitting there in the front row for most of today. Governor King, Senator King, was here as well.

On September 12th, our committee will meet again to hear about the State flexibility and advance many of the topics mentioned today.

The record will be open for 10 days for comments and questions.

Thank you again for being here.

The committee will stand adjourned.

[Additional Material follows.]

ADDITIONAL MATERIAL

OFFICE OF THE GOVERNOR,
HELENA, MONTANA 59620.

Hon. LAMAR ALEXANDER, *Chairman*,
Hon. PATTY MURRAY, *Ranking Member*,
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC 20510.

DEAR CHAIRMAN ALEXANDER and RANKING MEMBER MURRAY: Thank you again for the opportunity to appear before your committee to discuss stabilization of the individual market. I hope the committee will act quickly and introduce legislation to stabilize the individual market. As outlined at the hearing, ongoing funding for the cost sharing reduction is a critical first step.

This letter responds to the follow-up questions submitted by the committee. Those questions ask for thoughts on how to improve transparency and address costs and improve quality outcomes in our healthcare system. My answers are provided below.

IMPROVING TRANSPARENCY & ADDRESSING COSTS

Fragmented health information is a major barrier to understanding and improving the true value of health care services being delivered to all patients in all care settings. While many ideas have been proposed to correct the ills of the health care system, it's clear that there is no one single solution.

Instead, a collection of improvements need to be made to the health care delivery and payment systems to lower costs while improving the quality of care that individuals receive.

The electronic exchange of health information is integral to any health care transformation, both because of its potential to prevent medical errors and improve costs, efficiency, and quality and as a tool for monitoring system performance. Without the right data to demonstrate accountability, funding that should go to patient care goes to insurers and providers to build new buildings, pay executive teams millions of dollars in wages and executive perks, maintain incredibly wasteful and costly systems and operations with no proof of impact, and otherwise avoid transparency and accountability for actions that diminish and impair access to care for patients.

Montana Data Infrastructure Pilot

Montana has established a stakeholder group to explore the feasibility of establishing a State Health Information Exchange (HIE), built on a successful pilot underway in the State's largest community of Billings. Success of this initiative is based on performance that delivers a great experience, high care quality outcomes, optimal utilization of services, and ultimately curbs costs. Comprehensive Primary Care Plus (CPC+) elevates the bar for a provider or health system's need to demonstrate and be accountable for the level of value of their services. All of this requires interconnected, reliable information. A Montana HIE solution will create significant opportunities throughout Montana not only in health care, but in the health of Montanans by:

- Informing decisionmaking at all levels including consumers, healthcare providers, payers, healthcare associations, policymakers, and State leadership;
- Promoting and helping fulfill regulatory compliance for healthcare providers and payors more efficiently;
- Illuminating healthcare utilization trends, and individual and population health risks and needs; Connecting emerging delivery models like home and community based services; And improving understanding of value-based performance of healthcare delivery and payor systems.

For such an effort to be successful, Congress should hold HIT vendors accountable to strong interoperable data infrastructure standards necessary to support a sophisticated network of care coordination partnerships. The result will be a higher-performing health system, with measurably better outcomes and value.

IMPROVING HEALTH OUTCOMES

Integrated Behavioral Health and Access to Behavioral Health Services

The American health care system should better address social determinants of health, which underlie management of chronic disease and utilization of healthcare resources. Integrated behavioral health services not only demonstrate positive impact for high risk patients, but also positive impact on productivity and sustain-

ability for practices using these services. If we are going to look to develop a high-performing health care system that deals with the totality of medical costs, ignoring mental health and substance use as drivers of costs will not work. Primary care providers are already on the front lines of this fight, as they prescribe 70 percent of the anti-depressants in the United States.

This year, Montana launched the first public-private partnership to fund a project ECHO clinic to help integrate behavioral and physical health care. Montana Medicaid is partnering with commercial carriers to use tele-health technology to provide psychiatric expertise and consultation to remote collaborative care teams at primary care practices across the State. These integrated behavioral health collaborative care tele-clinics are the result of a public-private partnership between Montana Medicaid, the Montana Mental Health Trust, Blue Cross Blue Shield of Montana, and PacificSource Health Plans. The initiative launched this year and already serves 16 primary care practices across Montana.

The care teams work on topics that include:

- Basic and advanced psychopharmacology
- Suicide and substance use screenings
- Unipolar and bipolar depression
- Anxiety disorders
- Child and adolescent psychiatric disorders

If you have additional questions, please contact the Governor's Senior Health Policy Advisor, Jess Rhoades, at *Jrhoadesmt.gov*. or 406-444-5503.

Sincerely,

STEVE BULLOCK,
Governor.

RESPONSE BY CHARLES BAKER TO QUESTIONS OF SENATOR WHITEHOUSE
AND SENATOR HASSAN

SENATOR WHITEHOUSE

Question. Following the HELP Committee's work to stabilize the individual market, I hope the committee will move on to other efforts to address cost and improve quality in our health care system.

I believe the following areas are ripe for bipartisan collaboration:

- a. Improving patient safety by preventing medical errors and healthcare-acquired infections;
- b. Addressing the dramatic variations in care quality and outcomes across States;
- c. Identifying ways to reduce administrative overhead and dispute, specifically the bureaucratic warfare between insurance companies and providers over reimbursement;
- d. Ensuring that a patient's wishes are honored at the end of his or her life; and
- e. Advancing payment reform to encourage prevention and primary care.

Which of these areas should be a priority for the HELP Committee going forward? What strategies would you suggest to lower costs and improve quality in these areas? Is there innovative work in your States and communities that you would like to highlight?

Answer. Thank you again for the opportunity to address the HELP Committee on stabilization of the individual market. Stabilizing the market is necessary in order to address the underlying issues of health care affordability and costs. States are incubators and innovators of health care reform solutions and initiatives, and I continue to advocate for increased flexibility within the 1332 waiver process to allow States to innovate in meeting the unique health care needs of their States, while also maintaining the coverage gains we've achieved. Below please find my responses to the questions submitted for the record. I am available should the committee have any further questions.

I believe addressing cost and quality in our health care system with bipartisan solutions is an important undertaking. Having achieved near universal coverage in Massachusetts, we are now focused on health care affordability for individuals, families and employers.

I suggest the HELP Committee prioritize policies that advance payment reform and encourage preventative and primary care. Massachusetts has been advancing payment reform on various fronts, most notably in our Medicaid program (known as MassHealth). Through the State's innovative 1115 Medicaid waiver, Massachusetts is implementing a nation-leading model of Accountable Care Organizations (ACOs). Under the new model, networks of physicians, hospitals and other commu-

nity based health care providers will be financially accountable for cost, quality, and member experience for over 850,000 MassHealth members.

Historically, MassHealth has operated under a fee-for-service model that has resulted in the inefficient delivery of care. Under the ACO model, health care providers will be paid to improve the care coordination and health outcomes for MassHealth members. Notably, the ACO program will allow for investment in primary care providers and innovative ways of addressing social determinants of health. As of August of this year 2017 health care organizations across the State have executed agreements to participate in the program, which is set to go live March 1, 2018.

Administrative simplification and reducing overhead for payers and providers are equally important policies to pursue. In Massachusetts, we have undertaken several initiatives to address burdens cited by our own health care market participants. Examples of such initiatives include:

- the establishment of a quality measurement taskforce comprised of government and industry representatives to develop a standardized, multi-payer quality measurement set; and
- the establishment of a cross-agency working group to identify and reduce State reporting requirements on payers and providers.

SENATOR HASSAN

Question. During the September 7th HELP Committee hearing, many of you mentioned curbing rising health care costs as an important part of stabilizing premiums in the individual market. In this effort, I believe we should consider not only health care cost transparency, but also transparency in health care outcomes. Lowering health care costs should not mean that patients experience worse outcomes; instead, we should take steps to incentivize value-based care—we should give patients the tools they need to choose quality health care providers, and reward providers for lowering costs while simultaneously improving outcomes. I am interested to know your thoughts related to not only cost transparency but also on transparency of outcomes—and how we can combine these metrics to improve our health care system. Are your States engaged on this front, and if so, how?

Answer. In Massachusetts, we believe that transparency around costs and quality is fundamental to curbing costs and improving our health care system. It also allows consumers to be better informed about their health care options and the decisions they make. We are actively engaged in several transparency initiatives:

- Consumer Website—One of our State's quasi-public agencies, the Center for Health Information and Analysis (CHIA), will be launching a consumer transparency website later this fall. The first phase of the site, largely modeled off of New Hampshire's health care cost website, will contain a pricing tool that allows consumers to look up the price of certain procedures based on their zip code and insurance plan using data from the Massachusetts' All Payer Claims Database. Initially, the website will include existing quality data, with the goal of eventually layering in more sophisticated quality measurements.

- Quality Measure Alignment—Massachusetts has also established a quality measurement taskforce, comprised of government and industry representatives to develop a standardized, multi-payer quality measure set. Standardized metrics will allow for meaningful quality comparison across providers and plans, thereby increasing the utility of such quality information by health care consumers and policy-makers.

[Whereupon, at 12:10 p.m., the hearing was adjourned.]

