

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

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
STATE FLEXIBILITY

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SEPTEMBER 12, 2017
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(II)

C O N T E N T S

STATEMENTS

TUESDAY, SEPTEMBER 12, 2017

Page

COMMITTEE MEMBERS

Alexander, Hon. Lamar, Chairman, Committee on Health, Education, Labor, and Pensions, opening statement	1
Murray, Hon. Patty, a U.S. Senator from the State of Washington, opening statement	4
Franken, Hon. Al, a U.S. Senator from the State of Minnesota	7
Enzi, Hon. Michael B., a U.S. Senator from the State of Wyoming	35
Collins, Hon. Susan M., a U.S. Senator from the State of Maine	39
Young, Hon. Todd, a U.S. Senator from the State of Indiana	43
Bennet, Hon. Michael F., a U.S. Senator from the State of Colorado	45
Murkowski, Hon. Lisa, a U.S. Senator from the State of Alaska	47
Whitehouse, Hon. Sheldon, a U.S. Senator from the State of Rhode Island	49
Cassidy, Hon. Bill, M.D., a U.S. Senator from the State of Louisiana	51
Baldwin, Hon. Tammy, a U.S. Senator from the State of Wisconsin	53
Murphy, Hon. Christopher S., a U.S. Senator from the State of Connecticut	55
Warren, Hon. Elizabeth, a U.S. Senator from the State of Massachusetts	56
Kaine, Hon. Tim, a U.S. Senator from the State of Virginia	59
Hassan, Hon. Margaret Wood, a U.S. Senator from the State of New Hampshire	58

WITNESSES

Leavitt, Michael O., Former Secretary of Health and Human Services, Salt Lake City, UT	7
Prepared statement	9
O'Toole, Allison Leigh, Chief Executive Officer, MNsure, St. Paul, MN	12
Prepared statement	13
Bragdon, Tarren, Chief Executive Officer, Foundation for Government Accountability, Naples, FL	16
Prepared statement	17
Tyson, Bernard J., Chairman and Chief Executive Officer, Kaiser Foundation, Hospitals and Health Plan, Inc., Pleasanton, CA	22
Prepared statement	24
Tomczyk, Tammy, FSA, FCA, MAAA, Senior Principal and Consulting Actuary, Oliver Wyman, Milwaukee, WI	29
Prepared statement	30

ADDITIONAL MATERIAL

Statements, articles, publications, letters, etc.	
Response by Allison Leigh O'Toole to questions of Senator Whitehouse	65

(III)

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

TUESDAY, SEPTEMBER 12, 2017

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

The committee met, pursuant to notice, at 10:05 a.m. in room SD-430, Dirksen Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Murray, Enzi, Collins, Cassidy, Young, Murkowski, 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 third of four hearings on stabilizing the cost of premiums and ensuring that Americans are able to purchase insurance in the individual health insurance market in 2018.

This is the market where 6 percent of insured Americans, that is 18 million people, buy their insurance; those who do not get insurance from the Government through Medicare, or Medicaid, or on the job.

For the past few years, the cost of premiums in the individual market, co-pays and deductibles, have been skyrocketing in many States. Half of these 18 million Americans have Government subsidies to help cushion the blow of the rising prices. Many of those who find themselves in the other half are being priced out of the insurance market; they simply cannot afford it.

That is why these hearings have a narrow objective. What can Congress and the President do between now and the end of the month to help limit premium increases in 2018 and begin to lower premiums after that?

We heard in our hearings last week that there also is a danger, if we do not act, Americans in some counties, literally, will have no insurance to buy because insurance companies will pull out of collapsing markets.

The other reason we have a limited objective is while this committee has been able to resolve contentious differences on a great many issues, we have been stuck in a partisan political stalemate

for 7 years on health insurance. A small bipartisan step would break this stalemate and, hopefully, lead to some other steps.

This morning, we will hear from experts, who work in or with States, as they develop plans to stabilize their individual market or implement other, broader health care reforms.

Senator Murray and I will each have an opening statement, and then we will introduce our five witnesses. After their testimony, senators will each have an opportunity to ask the witnesses 5 minutes of questions.

I want to thank Senator Murray for, as she always does, working so well with the committee to agree on the witnesses, to make these hearings bipartisan, and aim toward a result rather than just an opportunity for us to make speeches about our various points of view.

The focus of today's hearing is this, as I said, how can we give States more flexibility in approving health insurance policies as one way of creating better coverage, more choices, and lower prices?

Despite our partisan differences, our two hearings last week demonstrated a real hunger by many senators on both sides of the aisle to come to a result.

Between the meetings held before last week's two hearings, and the hearings themselves, for two consecutive days half of the members of the U.S. Senate attended. We had a good number of senators who came by to meet the witnesses today before this hearing who are not members of our committee.

I had expected there would be two themes in our work, but during those hearings, three themes emerged that, I would suggest, represent a working consensus for stabilizing premiums in the individual market in 2018.

The first theme is congressional approval of continued funding of the cost sharing payments that reduce co-pays and deductibles for many low-income Americans on the exchanges. I have recommended that we continue those payments through 2018.

That theme is promising because Cost Sharing Reductions were created by the Affordable Care Act, and because temporary cost sharing payments were a part of both the Senate and the House republican bills to repeal and replace the Affordable Care Act.

The second theme, senators from both sides of the aisle suggested expanding the so-called "Copper Plan" already in the law so anyone, not just those 29 or under, could purchase a lower premium, higher deductible plan that keeps a medical catastrophe from turning into a financial catastrophe.

By providing a choice for lower cost plans to everyone, the State insurance commissioners suggested that we would give young and healthy people more options to buy insurance.

The third theme—advocated by State insurance commissioners, Governors, and senators from both sides of the aisle—is to give States more flexibility in the approval of coverage, choices, and prices for health insurance. That third piece is what we are discussing today.

Most of the discussion about flexibility is centered on giving States greater flexibility by amending Section 1332, the State Innovation Waiver, that is already in the Affordable Care Act.

We heard from virtually every witness last week that an application for a Section 1332 is too cumbersome, inflexible, and expensive. Some 23 States have taken steps to start the process. So far, two have succeeded.

There was no shortage of suggestions about how to make Section 1332 work better, but they basically come down to this. Let us ease the process of applying so that more States can do what Alaska has done, but faster; and let us give States actual flexibility in their approaches, like Massachusetts requested.

What Alaska has done, and what Minnesota, Iowa, and Maine are considering doing, is to use the Section 1332 Waiver as a way to take care of higher cost individuals and lower premiums without using additional Federal funds. This might include reinsurance, stability funds, or invisible high risk pools to help individuals with complex and chronic conditions.

To help States do this, the recommendations from witnesses last week included, reduce the 6-month application review period. Allow a copycat application. If Senator Murray's State gets something approved, why can't Tennessee not come along and say, "We want to do what Washington State did with one change?"

Allow the Governor to apply for a waiver and not wait for the legislature to have to pass a law, since some State legislatures only meet every 2 years.

Extend the waiver length; fast track process for emergency waivers; define budget neutrality as over the entire term of the waiver rather than a single year; eliminate the so-called "firewall" between the Section 1115 Waivers and the Section 1332 Waiver; eliminate the 2012 regulation and 2015 guidance, which will make these process suggestions work better.

We also heard from several witnesses, including the Governor of Massachusetts, that the current rules on what types of health insurance can be offered under Section 1332 Waivers are so rigid that a State essentially cannot offer anything but an existing Affordable Care Act exchange plan.

Real State flexibility means giving States more authority to offer a larger variety of health insurance plans with a larger variety of benefits and payment rules.

This type of approach to insurance allows individuals the opportunity to have a more personalized health insurance plan. It is an approach that can benefit healthy individuals, as well as with complex and chronic medical conditions.

For example, as Governor Baker of Massachusetts testified, "Greater flexibility is also needed around benefit design. Value-Based Insurance Design approaches to benefit design seek to align patients' out-of-pocket costs, such as copayments and deductibles, with the value of services."

"Massachusetts is committed," he said, "To providing access to quality, affordable health insurance for our residents. Rather than walking away from that commitment, we believe increased flexibility would allow us to meet that commitment in more effective ways."

While there was much consensus last week, I would caution members that there still are significant differences to deal with. A true compromise requires democrats to accept something repub-

licans want: more flexibility for States; and republicans to accept something democrats want: continued funding for cost sharing payments in the Affordable Care Act. Both sides have been supportive of the so-called "Copper Plan."

As an example, the chairman of the Finance Committee, Senator Hatch, a former chairman of this committee, on Friday questioned continuing cost sharing without significant structural reforms in the Affordable Care Act.

On the other hand, several democratic members have insisted that what they call guardrails in the law not be changed.

As for guardrails, I want to be clear that I am not in any way proposing that we change the patient protection guardrails already written into Section 1332, including that nobody can be charged more if they have a preexisting condition; the requirement that everyone is guaranteed to be sold insurance; the requirement that your insurance policy cannot be rescinded; that those under 26 may remain on their parents' insurance; and that there may be no annual or lifetime limits on your health benefits.

As for the Essential Health Benefits, States already may waive those under the express provisions of Section 1332 in the Affordable Care Act.

The guardrails that need examinations are the severe restrictions on benefit design that Governor Baker was talking about that affect the result that would be achieved when the U.S. Department of Health and Human Services approves a State waiver application under Section 1332. That is where we need to have further discussion.

We had a good deal of discussion among senators. Senator Franken and others discussed that with our witnesses earlier today and I hope we will hear more about that. You could help us a great deal if you can help us resolve this part of the problem.

Under the Section 1332 Waiver rules, the result achieved under a waiver has to be a plan that is "as comprehensive" in benefits, actuarial value, and out-of-pocket cost as an Affordable Care Act exchange plan, cover a comparable number of individuals, at roughly the same cost to individuals, and at no increased cost to the Federal Government.

This essentially means that no other type of benefit design for health insurance plans is allowed.

That would be like a restaurant menu with only one item, or a travel agency with only one destination, or if Dr. Seuss had written a book entitled, "Oh, The Place You Can Go."

Today's witnesses have extensive experience in helping States design policies of approving insurance and we look forward to your advice of how to give States real flexibility in ways that increase coverage, choices, and lower prices.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you, Chairman Alexander.

Thank you to our witnesses for being here as well today.

Before I begin, I want to say a few words on the ongoing situation in the Gulf and Atlantic Coasts, and in the wildfires in the West.

As a Nation, our hearts continue to be with the families who have lost loved ones and all those whose lives have been upended by Irma and Harvey.

On behalf of many of us, I just want to say we extend our deepest appreciation to the countless first responders, and public servants, and neighbors, and volunteers who have inspired us all through their bravery and self-sacrifice.

I, like everyone, commit to working with all of us in the coming weeks and months to make sure these people have the Federal resources and partners they need. I am sure all of our committee joins me in saying that.

I am eager today to continue our conversation on bipartisan steps we can take to restore certainty to the individual insurance market for patients and families across the country who are worried about being able to afford the care they need next year and beyond.

So far, we have had focused, substantive discussions in our first two hearings—and in our many conversations off the committee—on areas of significant common ground around those goals.

That is due, in large part, to the members of this committee. I want to thank all our colleagues, on both sides, for their efforts.

I would also note, as Chairman Alexander has mentioned, our steps to open up this process to members off the committee. We committed to opening up this process at the very beginning of our talks, and I know I speak for many of us when I say, Mr. Chairman, those morning coffees have been extremely helpful.

As I said last week, and I will repeat today, even if we do not agree exactly on the cause, we do agree on the challenge facing this committee: families will see higher premiums and fewer options as a result of uncertainty in our health care system.

We also agree that we need to act very quickly, and everyone here understands we have a very narrow window to do so.

Last week we heard some valuable recommendations in our conversations. First of all, Governors and State insurance commissioners, from all corners of our country, republicans and democrats, agreed that we need multi-year certainty for out-of-pocket cost reductions.

As discussed, many insurers are already making their plans and setting premiums well beyond 2018.

If we want to provide the kind of certainty actually needed to lower costs for patients and families, doing the bare minimum here is simply unacceptable.

Second, there is consensus that, along with guaranteeing out-of-pocket cost reductions, we should consider additional ideas to make health care work better for patients and families.

One idea is establishing a reinsurance program to help offset costs associated with covering the sickest enrollees. That is something that has come up consistently throughout our hearings, as have other options.

Third—and democrats have been very focused on this from the start—there is agreement the damage being done by this Administration on open enrollment and consumer outreach is having a real impact and could potentially undermine our efforts to restore sta-

bility to the markets. Like my colleagues, I strongly believe we need to address that issue.

Of course, those are just a few examples, and there are many more areas where we have seen agreement.

Today's hearing, on specific steps we can take to provide some flexibility to States and communities, is an important discussion.

I have to say, among the many measures cited as pressing priorities by our witnesses so far, State flexibility is not something they said they absolutely need to stabilize the market in the short term.

We have heard a lot of interesting proposals, I do worry that many suggestions could wind up increasing out of pocket costs for patients and families when our principle goal in these hearings, and in our bipartisan negotiations, is making care more affordable, not less.

I commit on my end—and I know my democratic colleagues do as well—to seriously listening and considering the ideas presented here today. I hope we can stay focused on the common goal of lowering costs for patients by stabilizing our markets as soon as possible.

Let me underscore what I have said many times. This has to be a conversation about moving forward, not backward, when it comes to affordability, coverage, and quality of care.

I want to emphasize that because democrats will reject any effort to this discussion if it erodes the guardrails and protections that so many patients and families rely on. This is going to be a difficult needle to thread, I admit, but it is clearly possible.

As we know, Governors Kasich and Hickenlooper, in consultation with nearly 20 other Governors nationwide, put forth a market stabilization plan, which maintain protections in current law for patients like those with preexisting conditions and women seeking maternity care.

Let me be clear. Like any worthwhile compromise, I know we will not agree on everything at the outset. If we can keep today's discussion focused, work through these issues in a specific and balanced manner, while keeping our larger goals in mind, I do believe we can get a result, as Chairman Alexander would say.

Last, I have to admit, I do just want to say publicly, I am disappointed there are still some senators trying to push us down a partisan path on health care.

Again, republicans and democrats are finally working together here, and it is refreshing and needed, and we have made critical progress. It would be deeply disappointing if another partisan debate over Trumpcare erupted and derailed our efforts here.

I hope those senators will join these bipartisan conversations, instead of doubling down on harmful repeal efforts again that people across the country have rejected.

With that, I want to say, Mr. Chairman, again how much I appreciate all your work on this, everybody participating, and I look forward to today's discussion.

The CHAIRMAN. Thank you, Senator Murray.

We will now ask each of our witnesses, if they will, to summarize their statements in 5 minutes. We have a lot of senators who would like to ask questions and I will briefly introduce them.

Governor Mike Leavitt is the former Governor of Utah, the former chairman of the National Governors Association, and the Republican Governors Association, and the head of the Department of Health and Human Services. He brings lots of experience to this. He is now in the private sector.

Allison Leigh O'Toole. Senator Franken, would you like to introduce her?

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Absolutely.

It is a pleasure to introduce Allison O'Toole today.

As perhaps some of you know, when it came to insurance exchange rollouts, MNsure, the Minnesota Health Exchange, like many other exchanges, had a pretty rocky one. After that, what I would like to call the "Minnesota Effect," kicked in. MNsure got better and is now one of the highest performing exchanges in the Nation.

Minnesota now has a 96 percent insurance rate. That is a State record and it is the second highest in the United States. Of course, the Minnesota Effect does not happen by itself. Leadership matters and under Allison O'Toole's leadership, MNsure has experienced 2 years of record breaking enrollment, increase system stability, and better customer service. It has led the Nation in the last 2 years in a row in the percentage of new enrollees.

Ms. O'Toole, thank you for your work helping Minnesotans find health coverage. I am happy to see you here and welcome today to the committee.

The CHAIRMAN. Thank you, Senator Franken.

Our third witness is Tarren Bragdon. He is the CEO of the Foundation for Government Accountability. He has testified several times before committees in Congress. He has worked with several States on innovative models to stabilize and reform insurance markets.

Bernard Tyson is here. Thank you, Mr. Tyson, for coming. He is the CEO of Kaiser Foundation Health Plan, one of America's leading integrated health care providers and not for profit health plan that serves nearly 12 million members.

Tammy Tomczyk, is a Principal at Oliver Wyman Actuarial Consulting specializing in health insurance.

I cannot tell you how many times the senators have been sitting around coming up with ideas that somebody would say, "Where is an actuary so we can find out what this will actually do?" We are glad you are here today.

Governor Leavitt.

STATEMENT OF HON. MICHAEL O. LEAVITT, FORMER SECRETARY OF HEALTH AND HUMAN SERVICES, SALT LAKE CITY, UT

Mr. LEAVITT. Good morning to Senator Alexander, Senator Murray, and all the rest of the committee.

This committee hearing appears very much to me to be about the age-old dilemma of how to divide the responsibility for governing between State governments and the Federal Government.

Having served as Governor, and also as a member of a cabinet, I have come to understand that there is a role for both, but States and the Federal Government see the word “flexibility” with some difference.

I have often joked to Governors that flexibility means just leave the money on a stump in the woods at night and we will take care of everything else. I have come to understand as a cabinet member that this partnership does require some degree of flexibility.

In my cabinet roles at EPA and at HHS, I dealt with these issues over and over because both of those departments or agencies were dependent on a partnership with the States.

I developed in my own mind a basic strategy and I would commend that to you as you wrestle with this dilemma, and it can be expressed in four words, National Standards, State Solutions.

I found over and over again if the Federal Government would focus on developing what you have referred to as guardrails or standards, and then allow States the flexibility to operate within their own circumstances, that better outcomes result.

It is not unique just to health care. Senator Murray’s poignant remarks on the hurricane victims, I recall very clearly during Katrina that as we deployed into the area affected, HHS had a substantial amount of responsibility after people had been rescued or had escaped.

Our assets actually were not Federal assets. Our assets were State assets that had been aggregated.

I saw that again when we were dealing with pandemic influenza. The assets were not Federal assets; they were State assets. The Federal responsibility was to coordinate, to establish national standards, but allow the States to perform solutions.

In 2007, when we rolled out the Medicare Part D to 43 million people, that was a national program, but it was a requirement that we have the flexibility inside States to be able to deploy according to their own set of values and circumstances. Again, National Standards, State Solutions. I saw that at EPA as well.

There is a very real reason for that and it is that logistically, it is just not possible for a national government to respond in just the innumerable ways in which that flexibility has to be applied.

I would also like to make clear that while I was not a profound supporter of ACA, I have seen insurance exchanges as a very important part of the solution. Despite my skepticism on certain parts of ACA, I have been a booster, a supporter, and an advocate.

I suggested that States needed to be the place that these were administered for the reasons that I have suggested. For certain reasons, many of them political, some States chose not to do that.

I would like to be clearly on record that I believe insurance exchanges and marketplaces are about the only real solution to the individual marketplace in a way that we can aggregate capital and create risk pools that work. It is very important we get this right.

I do have a series of suggestions that I would like to make that will be part of our discussion. You have mentioned the 1332 Waiver.

My first suggestion; earlier, we talked about Katrina, was that during the Katrina period, HHS and specifically CMS, was re-

quired to make a lot of decisions quickly and to grant authority to States.

Rather than have waivers worked through one at a time, we created standard waivers that States could call upon, similar to what Senator Alexander suggested, that if one State has been approved that other States could count on having it approved. That is a solution that would work here too.

In fact, I believe that HHS could create a menu of waivers that States could call upon and rely upon, particularly when we get into the area of reinsurance, which we will speak of later.

My second suggestion is to clarify the interdependence of waivers. This is not independent of this. We are not dealing today in this hearing with Medicaid. Medicaid waivers fall under Section 1115, but they often have a bearing on the way 1332 Waivers are to be dealt with because they are interdependent.

Right now, they cannot be dealt with together. With a tweak of the law, you could make that possible.

My third suggestion is that it is important that you reevaluate the current budget neutrality requirements under the 1332 Waiver. Currently, they have to show neutrality in every year.

Members of this committee know full well in the Federal budget process, it is a virtual impossibility to show budget neutrality in every State when you are dealing with a long-term investment. You should fix that and allow States to achieve overall budget neutrality, but to do it in the context of the overall waiver period not simply every year as they stand.

Mr. Chairman and Madam Vice Chair, I look forward to, or ranking member, I look forward to this conversation and participating.

[The prepared statement of Mr. Leavitt follows:]

PREPARED STATEMENT OF HON. MICHAEL O. LEAVITT

SUMMARY

We are here today to consider the best way to divide responsibility between State governments and the Federal Government for stabilizing the individual insurance market to ensure citizens in every State have access to health insurance. The question that always seems to create tension is, "how much flexibility should the States have."

Having served as a Governor and a Cabinet Officer I have come to understand that both the State and Federal Government view flexibility differently.

The overarching strategy can be stated in four words: "National Standards, State Solutions."

On matters related to health, the Federal Government excels at two things: Setting expectations and the collection and distribution of money. As a practical matter, the Federal Government is challenged to execute uniformly across the entirety of this large diverse Nation, and thus roles should be assigned with care. With those limitations, the Federal Government is highly dependent on States for execution of expectations.

I am a republican. Long before the ACA, I was a strong and vocal advocate of insurance exchanges in the individual insurance market. I did so because they represent a market solution. I think exchange marketplaces are a fundamental tool to facilitate increased competition and consumer choice in a private insurance market. The failure of insurance marketplaces will inevitably generate momentum toward the expansion of Federal Government coverage for this population.

Though I was not a supporter of the ACA, after it passed, I advocated forcefully for States to take responsibility to operate the exchanges. Why? Because of my belief in the notion of "National Standards, State Solutions." I know in the long run States execute better than the Federal Government. States can find solutions that deal with the diverse culture, values and circumstances of their communities. Time has and will prove that to be correct.

The ACA provides a vehicle to adopt a National Standard, State Solutions strategy. The 1332 waiver process is part of the law already and provides a framework of national standards and a vehicle to give States the flexibility required to allow State solutions.

- I recommend that CMS work with States to create a series of model 1332 waivers that States can choose from to accelerate solutions.
- My second suggestion is for the Federal Government to clarify that interdependent waivers (for instance, 1115 waivers and 1332 waivers) can be evaluated based on the merit of their singular proposal.
- Finally, may I suggest a re-evaluation of the current budget neutrality requirements of the 1332 waiver that would permit States to show budget neutrality over a longer timeframe.
- Likewise, certainty is required on CSR payments. Congressional appropriations need to signal that the market can count on these at least until 2018 or 2019.

Good Morning Senators Alexander and Murray. Thank you for holding this hearing—and the hearings you convened last week on this important topic. Stabilizing the Individual Insurance Market is the first step we can take to ensure citizens in every State have access to health insurance.

It is my perception that members of this committee, in general terms, share an aspiration for citizens of the United States to have access to affordable and high-quality health insurance. I sense there is agreement that both the States and the Federal Government have a role in that effort. The age-old dilemma of how to divide responsibility between State government and the Federal Government seems to be very much at play here. The question that always seems to create tension is, “how much flexibility should the States have.”

Having served as a Governor and a Cabinet Officer I have come to understand that both the State and Federal Government view flexibility differently. For a Governor, flexibility means a preference for the Federal Government leaving money on a stump in the woods at night. However, as a Federal official, I came to clearly understand that State partnerships require accountability. I dealt with this dilemma constantly because both the Department of Health and Human Services and the EPA were heavily dependent on State partnerships to carry out their mission.

Based on that experience, I want to recommend an overarching strategy and three specific policy suggestions.

The overarching strategy can be stated in four words: “National Standards, State Solutions.”

On matters related to health, the Federal Government excels at two things: Setting expectations and the collection and distribution of money. As a practical matter, the Federal Government is challenged to execute uniformly across the entirety of this large diverse Nation, and thus roles should be assigned with care. With those limitations, the Federal Government is highly dependent on States for execution of expectations.

Twelve years and 19 days ago, Hurricane Katrina struck, creating a devastation similar to what is faced this morning by communities caught in the paths of Hurricanes Harvey and Irma. I was U.S. Secretary of Health and Human Services at the time. Our Department’s role was to aid victims after their evacuation or rescue. I quickly came to understand that the emergency response system of the Federal Government is in large measure an aggregation of the State emergency response capacity operating under Federal coordination. Emergency response was done differently in Arkansas than in Texas, or Florida. In their own way, the States got it done. If we had insisted on absolute uniformity, the effort would have failed. National Standards, State Solutions.

Shortly after Katrina, we were required to prepare the Nation for a potential pandemic influenza. Once again, it became evident that the Nation’s public health capacity was the aggregation of State and local public health organizations, acting with Federal coordination. Each State aligned their assets. Were some better than others? Yes. The Federal Government simply does not and should not have sufficient capacity to deploy everywhere. National Standards, State Solutions.

On January 1, 2007 HHS rolled out Medicare Part D, the prescription drug benefit to 43 million people. Even though it was a Federal program, our only way to execute on the mission was to harness the collective capacity of States, and the community assets they engaged. There were significant differences in the ways States and their local communities approached this. There had to be. They had different assets, cultures and traditions. There was flexibility built into the program to allow for those variations. It has been a profound success. National Standards, State Solutions.

I came to understand that the Environmental Protection Agency is at heart, a health organization. Once again, the Federal Government establishes expectations that span the United States, and help with funding. When it comes to executing those priorities, the EPA is highly dependent on States. The standards with the most compliance are those where flexibility is provided to accommodate differences in approach. National Standards, State Solutions.

The purpose of this hearing is to discuss how to assure Americans under age 65 have access to affordable insurance policies in situations where coverage is not available through an employer. I am a republican. Long before the ACA, I was a strong and vocal advocate of insurance exchanges in the individual insurance market. I did so because they represent a market solution. I think exchange marketplaces are a fundamental tool to facilitate increased competition and consumer choice in a private insurance market. The failure of insurance marketplaces will inevitably generate momentum toward the expansion of Federal Government coverage for this population.

Though I was not a supporter of the ACA, after it passed, I advocated forcefully for States to take responsibility to operate the exchanges. Why? Because of my belief in the notion of "National Standards, State Solutions." I know in the long run States execute better than the Federal Government. States can find solutions that deal with the diverse culture, values and circumstances of their communities. Time has and will prove that to be correct.

Many States choose to let the Federal Government operate the exchanges. In large part, those decisions were affected by political controversy and uncertainty. The execution in rolling them out was predictably flawed. While the mechanisms are still clunky and unstable, it has improved with time.

Insurance marketplaces are very fragile right now, and the window for fixing them is closing. At this point, no one is well served by their collapse.

The ACA provides a vehicle to adopt a National Standard, State Solutions strategy. The 1332 waiver process is part of the law already and provides a framework of national standards and a vehicle to give States the flexibility required to allow State solutions.

Alaska's 1332 waiver is a great example of this principle in action—Alaska's State-established reinsurance program is a success story in reducing costs and increasing access to insurance for Alaska's resident. It is an approach other States could and should copy and improve.

My first specific suggestion is consistent with what you have heard in last week's hearings with Governors. Earlier I mentioned Hurricane Katrina. While I was Secretary of HHS, we recognized a need for consistency and speed in permitting States that adopted displaced residents to apply for Medicaid coverage for those residents. To meet this need, the Agency issued model waivers that consisted of a series of Medicaid templates to ease the burden of the application process for the affected States and to provide them with greater certainty of the expectations and outcome for approval. I recommend that CMS work with States to create a series of model 1332 waivers that States can choose from to accelerate solutions. By doing so, the Federal Government creates national standards, but allows States to develop State solutions. There could be a set of standard waivers related to risk stabilization programs, re-defining marketplace products or benefits, or alternative private exchange portals. This fosters collaboration and investment in the waiver process—as well as to expedite the application process.

My second suggestion is for the Federal Government to clarify that interdependent waivers (for instance, 1115 waivers and 1332 waivers) can be evaluated based on the merit of their singular proposal. The need for transformative changes in insurance marketplaces in coordination with other Federal programs, like Medicaid is undeniably logical. What isn't defensible is forcing separate processes that consume time and money, and which foreclose the opportunity of States to accrue joint savings from a flexible arrangement in both programs. Often the authorities sought under these programs are interdependent. A lag on one defers critical progress on both.

Finally, may I suggest a re-evaluation of the current budget neutrality requirements of the 1332 waiver that would permit States to show budget neutrality over a longer timeframe. The current requirement for budget neutrality in each year of the waiver demonstration restricts up-front investment and State flexibility. From the budget process in Congress, it is not always realistic to recapture value from an investment in 1 year. Moving to a budget neutrality requirement over a longer time horizon will support innovation and State control—under a reasonable national standard.

Likewise, certainty is required on CSR payments. Congressional appropriations need to signal that the market can count on these at least until 2018 or 2019. Given

the business cycle requirements under which plans operate, this is a requirement, in my judgment. States are offering differing guidance to plans for how to account for the availability of CSR funding in rate setting. This unpredictability causes insurers to be unable to accurately predict the regulatory environment. It has been noted, but bears repeating, that in fact funding CSRs will prevent premium rates from rising even higher, creating an increase in Federal spending through the increase in the amounts of the Advanced Premium Tax Credits (APTCs).

I will conclude as I began. The key principle is “National Standards, State Solutions.”

Thank you for the opportunity to testify today.

The CHAIRMAN. Thank you, Governor Leavitt.

Ms. O’Toole, welcome.

STATEMENT OF ALLISON LEIGH O’TOOLE, CHIEF EXECUTIVE OFFICER, MNsure, ST. PAUL, MN

Ms. O’TOOLE. Thank you.

Good morning, Chairman Alexander, and Ranking Member Murray, and committee members.

I would like to thank you, Senator Franken, for that kind introduction. As you know, I work with a great team and I am really proud of the progress we have made.

As CEO of Minnesota’s State based exchange, MNsure, it is my job to work with the on the ground realities of getting Minnesotans enrolled into coverage.

I have seen firsthand the value of State flexibility in responding to turbulent market conditions, and the effectiveness of State level policy initiatives that have improved conditions over the years.

Like many States, Minnesota has seen a great deal of volatility in its individual market, and while that market has shrunk in the last few years, MNsure’s enrollment has continued to increase. This past open enrollment season, we had a record number of Minnesotans enrolling through the exchange.

As Senator Franken mentioned, we now have 96 percent of Minnesotans covered. That is the highest rate in State history and the second highest in the country, and we are really proud of that.

The flexibility of a State-based exchange is a large part of our success. We have full control over our outreach programs and we are able to tailor activities to meet the needs of Minnesotans.

We partner with trusted, local organizations and brokers with strong ties to communities to help consumers. Over the past year, these partners enrolled more than 125,000 Minnesotans into coverage. Our locally organized Assister Network is a big reason MNsure has led the Nation 2 years in the highest percentage of new enrollees.

Being a State-based exchange also gives us flexibility to call special enrollment periods when Minnesota-specific situations call for them.

For example, in February of this year, we were able to give Minnesotans an extra week to enroll because our legislature passed a premium relief bill late in the open enrollment period.

While MNsure performed well this past year, the individual market as a whole saw significant challenges. State action on premium relief and a reinsurance program have mitigated some of those increases for consumers, but premiums remain too high and provider networks too narrow for many Minnesota families.

These State actions are short-term fixes and we share the widespread recognition that action at the Federal level is needed to add certainty, stability, and strength to individual markets across the country.

Among our top priorities that we believe would help stabilize and strengthen markets are the following, and there are four of them.

First, permanent funding of Cost Sharing Reduction payments; States and issuers require certainty on future funding of those payments.

Second, a long-term Federal reinsurance program; a long-term, comprehensive, federally funded reinsurance program is necessary to ensure consumers have access to affordable coverage as the individual market is inherently less stable than group coverage.

Minnesota has seen that reinsurance can work, reducing premiums by as much as 20 percent. A State-only funded program is unsustainable in the long run.

Let me add an important caveat here. The lower prices I mentioned are dependent on the Administration granting Minnesota a budget neutral Federal waiver to implement our reinsurance law.

If our waiver is not granted in the next few days, Minnesotans will be paying substantially higher premiums next year. That is not speculation. That is fact. We are hopeful that the waiver is forthcoming, but I want you to know that that waiver has not yet been granted.

Third, continue flexibility over the use of 1332 Waivers. State innovation and experimentation will be key to identifying creative solutions that can maximize affordable coverage and manage health costs and quality. We encourage additional flexibility for States while also maintaining important consumer protections.

Last, continued enrollment outreach and marketing efforts. In Minnesota, we found that the older and sicker folks sign up first. If we are to have a robust and diverse risk pool, we must put in the extra effort to bring younger and healthier Minnesotans into the pool.

Defunding or eliminating enrollment outreach efforts undermines the goal of creating strong risk pools across the country that leads to more affordable prices. I would like to underscore that point because it is critical for stability.

Thank you, again, Chairman Alexander and Ranking Member Murray for your time today and for holding these hearings. I am really happy to be part of this important conversation.

[The prepared statement of Ms. O'Toole follows:]

PREPARED STATEMENT OF ALLISON LEIGH O'TOOLE

SUMMARY

As the CEO of Minnesota's State-based exchange, MNsure, it's my job to work with the on-the-ground realities of getting Minnesotans enrolled in health coverage. I have seen first-hand the value of State flexibility in responding to turbulent market conditions and the effectiveness of State-level policy initiatives that have improved conditions over the last year.

Like many States, Minnesota has seen a great deal of volatility in its individual market. Over the last few years Minnesota's individual market has shrunk. Last year premiums in Minnesota rose by an average of more than 50 percent and one of the State's major carriers pulled out of market.

Despite that challenging environment MNSure's enrollment has continued to increase year over year. This past open enrollment season, a record number of Minnesotans purchased coverage through the exchange.

Ninety-six percent of Minnesotans are covered. That's the highest rate in State history and the second highest in the country.

The flexibility of a State-based exchange is a large part of our success. This year marked the second year in a row MNSure beat its enrollment and revenue projections, and our budget is self-sustaining, balanced and conservative.

While MNSure performed well this past year, the individual market as a whole saw significant challenges. State action on premium relief and a reinsurance program have mitigated some of the premium increases for Minnesotans, but premiums and out-of-pocket costs remain too high and provider networks too narrow for many Minnesota families.

These State actions are short-term fixes, and we share the widespread recognition that action at the Federal level is needed to add certainty, stability and strength to individual markets across the country.

Among our top priorities that we believe would stabilize and strengthen markets are:

- One: Permanent funding of cost-sharing reduction (CSR) payments
- Two: A long-term, Federal reinsurance program
- Third: Continued flexibility over the use of 1332 waivers
- Fourth: Maintain flexibility for State-based exchanges
- Lastly: Continued enrollment outreach and marketing efforts

Thank you, Chairman Alexander and Ranking Member Murray for holding these hearings. I'm honored to be part of this important conversation.

Good morning Chairman Alexander, Ranking Member Murray and committee members.

As the CEO of Minnesota's State-based exchange, MNSure, it's my job to work with the on-the-ground realities of getting Minnesotans enrolled in health coverage. I have seen first-hand the value of State flexibility in responding to turbulent market conditions and the effectiveness of State-level policy initiatives that have improved conditions over the last year.

Like many States, Minnesota has seen a great deal of volatility in its individual market. For example, last year one of the State's major carriers pulled out of market, and premiums for those insurers that remained increased more than 50 percent. Because of these changes and others, Minnesota's individual market shrunk.

Despite that challenging environment, MNSure's enrollment has continued to increase year over year. This past open enrollment season, a record number of Minnesotans purchased coverage through the exchange, with 33 percent more Minnesotans purchasing private health insurance through the exchange than the previous year.

Ninety-six percent of Minnesotans are covered. That's the highest rate in State history and the second highest in the country.

The flexibility of a State-based exchange is a large part of our success. This year marked the second year in a row MNSure beat its enrollment and revenue projections, and our budget is self-sustaining, balanced and conservative.

MNSure has full control over our outreach programs, which means we are able to tailor activities to meet the needs of Minnesotans. We partner with trusted local organizations and brokers with strong ties to the communities that they serve to help consumers. Over the past year, these partners enrolled more than 125,000 Minnesotans into health coverage. Our locally organized assister network is a big reason MNSure has led the Nation 2 years in a row in the percentage of new enrollees.

Being a State-based exchange also gives us the flexibility to call special enrollment periods when Minnesota-specific situations call for them. For example, in February we were able to give Minnesotans an extra week to purchase coverage after our legislature passed a premium relief bill late in the open enrollment period. This extra week enabled 4,000 more Minnesotans to enroll in coverage.

The premium relief bill, which was proposed by our Democratic Governor and passed by our Republican legislature, provides a 25 percent automatic discount on premiums to consumers on the individual market who do not receive tax credits in 2017. It is a 1-year program that will be effectively replaced by a State reinsurance program for 2018 and 2019, if Minnesota receives approval for our 1332 waiver application that is currently under review by CMS. Without quick Federal approval, Minnesota will not be able to implement the reinsurance program, which will have a devastating impact on our overall market, and more importantly Minnesotans.

While MNsure performed well this past year, the individual market as a whole saw significant challenges. Bipartisan action by the State on premium relief and a reinsurance program have mitigated some of the premium increases for Minnesotans, but premiums and out-of-pocket costs remain too high and provider networks too narrow for many Minnesota families.

These State actions are short-term fixes, and we share the widespread recognition that action at the Federal level is needed to add certainty, stability, and strength to individual markets across the country.

Among our top priorities that we believe would stabilize and strengthen markets are:

- **One: Permanent funding of cost-sharing reduction (CSR) payments.**

States and issuers require certainty over the future of CSR payments. Elimination of this program will compromise the affordability of coverage and services for millions of Americans and further destabilize these markets, driving up premium prices for consumers. In Minnesota the vast majority of our CSR dollars go to fund our Basic Health Plan, MinnesotaCare. These funds are worth over \$100 million dollars a year to our State budget.

- **Two: A long-term, Federal reinsurance program.**

A long-term, comprehensive, federally funded reinsurance program is necessary to ensure consumers have access to affordable coverage as the individual market is inherently less stable than group coverage. In our proposed rates for 2018, Minnesota has seen that reinsurance can work, reducing premiums by as much as 20 percent. In order to finance the reinsurance program the State proposed under the 1332 waiver, Minnesota was forced to tap State funds and cost shift from other health care programs. This is not something the State can sustain for a longer period of time.

- **Third: Continued flexibility over the use of 1332 waivers.**

State innovation and experimentation will be key to identifying creative solutions that can maximize affordable coverage and manage health costs and quality. We encourage additional flexibility for States, while also ensuring that all consumers can continue to receive comprehensive and affordable coverage and protection for pre-existing conditions. Some specific areas where the waiver process could be improved are:

- Expedite review: the current waiver process can take up to seven and a half months. That is too long for States needing to take rapid action. Minnesota's experience here is apropos, given that our Department of Commerce needs to finalize our rates and we are still waiting for approval from CMS.
- Allow States to submit waivers prior to receiving final legislative approval.
- Provide model waivers from CMS for States to follow.
- Allow States to concurrently complete multiple steps in the approval process; for example, allow the completeness review and Federal public comment periods to run simultaneously.
- Allow deficit neutrality across the life of the waiver, rather than year by year.

- **Fourth: Maintain flexibility for State-based exchanges.**

Maintaining flexibility for State-based exchanges to tailor certain Federal rules to the unique conditions of its State will help them better manage the dynamic and volatile conditions of the individual market. Minnesota greatly appreciated the flexibility offered by CMS in its final rule on market stabilization issued in March. This flexibility allowed MNsure to respond to concerns from stakeholders and supplement the upcoming open enrollment with a special enrollment period giving Minnesotans more time to shop for coverage. This flexibility also allows States to:

- React to State specific situations and demands; for example, providing necessary Special Enrollment Periods in response to local legislation.
- Control their own marketing and enrollment outreach.
- Collaborate with other public health agencies to increase efficiency gains.
- Have additional oversight and accountability at the State level.
- Provide customer service to better address local needs.

There may be opportunities to extend some of these advantages to States on the Federal exchange as well, such as controlling their marketing and outreach efforts.

- **Last: Continued enrollment outreach and marketing efforts.**

In Minnesota, we've found that older and sicker individuals are the first to sign up, and if we are to have a robust and diverse risk pool to ensure affordable prices, we must put in the extra effort to bring in younger and healthier Minnesotans. Defunding or eliminating enrollment outreach efforts undermines the goal of creating strong risk pools across the country that lead to more affordable prices.

Thank you, Chairman Alexander and Ranking Member Murray for holding these bipartisan hearings. I'm honored to be part of this important conversation.

In Minnesota, we are fortunate to have a long history of bipartisan cooperation and innovation on health care. While our debates can certainly be as messy as anywhere else, our results over the last 25 years show what can be accomplished when both parties work together.

Whether it was the founding of the Nation-leading MinnesotaCare program 25 years ago that provides health coverage to low-income working Minnesotans, or leveraging Federal programs to develop smarter payment models for lower cost and better care, Minnesota has benefited from a recognition on both sides of the aisle that when more people have health care coverage our economy is stronger and our State healthier. Thank you again for this opportunity.

The CHAIRMAN. Thank you, Ms. O'Toole.
Mr. Bragdon, welcome.

STATEMENT OF TARREN BRAGDON, CHIEF EXECUTIVE OFFICER, FOUNDATION FOR GOVERNMENT ACCOUNTABILITY, NAPLES, FL

Mr. BRAGDON. Thank you, Chairman Alexander, Ranking Member Murray, and members of the committee.

Thank you for the privilege of testifying.

I am Tarren Bragdon, CEO of the Foundation for Government Accountability.

We work at the State and Federal level to advance policy reforms to free more Americans to experience the power of work and to reduce the biggest payroll deduction for most Americans, the cost of health coverage. Our model reforms were introduced in 41 States this year and have passed in 29 States over the last 3 years.

As this committee leads with bipartisan ways to improve costs and coverage, I offer three recommendations.

First, Americans with preexisting conditions need premium relief, as well as access to insurance, without being segregated to plans with fewer benefits or higher premiums than those available to everyone else.

This can be achieved with invisible risk sharing, an approach that is invisible to those who are sick, but that successfully reduces premiums for everyone, as well as reduces the number of uninsured.

In 2012, with invisible risk sharing, Maine offered new plans in the individual market with much lower premiums, up to 70 percent lower with similar deductibles, and increased enrollment with the sole active carrier in that market, up 13 percent in 18 months.

When combined with expanded age rating, this approach lowered annual premium costs by up to \$5,000 for someone in their twenties, and up to \$7,000 for an individual in their sixties. Maine at the time was more restrictive with its age rating of 1.5:1, moving to 3:1.

Individuals could keep their current plans and only transition to new plans if they chose to do so. My written testimony highlights a chart that shows the premium impact of Maine's invisible risk sharing meant that premiums in Maine, going from red to green, were the same or lower as premiums for a healthy, nonsmoker in neighboring New Hampshire where they had a traditional high risk pool at the time.

Actuarial firm Milliman estimated the impact of Maine's model nationally, and they found that invisible risk sharing would lower

individual premiums by up to 31 percent in the individual market for those buying outside the exchange without any reduction in benefits or any increases in cost sharing.

These lower premiums would mean up to 2 million more Americans would voluntarily buy coverage. Milliman estimated that the cost of this approach nationally, this targeted reinsurance, would be between \$3 and \$5 billion excluding premium contributions from insurers.

We would recommend that the Federal Government jumpstart the invisible risk sharing program initially and then transition after two or 3 years to the States.

Second, States need real policy flexibility allowing a greater continuum of health coverage, particularly for those buying insurance on their own with a clearly defined, and reasonable process, and timeline for 1332 Waivers.

Section 1332 could be of more interest to States and more benefit to consumers if there was a clearer guide path toward timely approval and more policy flexibility. Practical and process concerns demand a simplified set of statutory guardrails, a clearer and fixed timeline for approval, and more policy flexibility for States.

Evidence both from actuaries, as well as from families, show that if more lower cost plans are allowed then more individuals will buy one that has the protection they want at a price that they are able or willing to pay.

Only one in three of those with individual insurance today are eligible for both CSR's and tax credits. That means two out of three in the individual market face the full brunt of higher deductibles and some, if not all, of the premium increases under the ACA.

Third, bipartisan reforms that reduce the cost of health care should carefully be considered under any bipartisan reform effort as ultimately the cost of coverage is reflective of the cost of care.

This year, a divided legislature in Maine passed into law with unanimous, bipartisan support a reform that lowers the cost of care by expanding transparency as well as access.

This reform grants patients the right to shop for the best value care regardless of the network status of a provider. This is not any willing provider, as the patient can only leave the insurer network if the actual cost out-of-network is below the average in-network. It is like in any competitive provider patient right.

It is time for Congress to send a lifeboat to patients and lower health care costs with the right to shop, which combines true price transparency with access to all high value providers.

Thank you. I encourage the committee to consider these three recommendations.

[The prepared statement of Mr. Bragdon follows:]

PREPARED STATEMENT OF TARRIN BRAGDON

SUMMARY

Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for the privilege of testifying. I am Tarren Bragdon, the Founder and CEO of the Foundation for Government Accountability (FGA). FGA works at the State and Federal level to advance policy reforms to free more Americans to experience the power of work and reduce the biggest payroll deduction for most Americans, the cost of health coverage. Our model reforms were introduced in 41 States this year and have passed in 29 States over the past 3 years.

As this committee leads with bipartisan ways to improve cost and coverage, I offer three recommendations:

First, Americans with pre-existing conditions need premium relief as well as access to insurance, without being segregated to plans with fewer benefits or higher premiums than those available to everyone else. This can be achieved with invisible risk sharing, a proven strategy that successfully reduces premiums and reduces the number of uninsured.

In 2012, with invisible risk sharing, Maine dramatically lowered premiums in the individual market (by up to 70 percent) and increased voluntary enrollment with the sole active carrier (up 13 percent in 18 months). When combined with expanded age rating, this approach lowered annual premium costs by up to \$5,000 for someone in their twenties and up to \$7,000 for someone in their sixties (Maine was more restrictive than the ACA with 1.5:1 age bands and moved to 3:1.) Individuals could keep their current plans and only transitioned to new plans if they chose to do so.

Actuarial firm Milliman estimated the impact of the Maine model nationally. They found invisible risk sharing would lower individual premiums by up to 31 percent in the individual market for those buying outside of the exchange, without any reduction in benefits or increases in cost-sharing. These lower premiums would mean up to 2 million more Americans would voluntarily buy individual insurance on their own, without subsidies. Milliman estimated that the cost of this approach nationally would be between \$3–5 billion annually, excluding premium contributions from insurers.

Second, States need real policy flexibility allowing a greater continuum of health coverage, particularly for those buying insurance on their own, with a clearly defined and reasonable process and timeline for 1332 waivers.

Section 1332 could be of more interest to States and benefits to consumers if there was a clearer glide path toward timely approval of waiver applications and more policy flexibility. Practical and process concerns demand a simplified set of statutory guardrails, a clearer and fixed timeline path for approval, and more policy flexibility for States. Evidence from actuaries and families shows that if more affordable range of plans are allowed, then more individuals will buy one that gives them the protection they want at a price they can and will pay.

Third, bipartisan reforms that reduce the cost of health care should be carefully considered under any bipartisan reform effort, as ultimately the cost of coverage reflects the cost of care.

This year, the divided legislature in Maine passed into law—with unanimous bipartisan support—PL 232, “An Act to Encourage Maine Consumers to Comparison-shop for Certain Health Care Procedures and to Lower Health Care Costs.” This reform grants patients the right to shop for the best value care regardless of the network status of a provider. This is not “any willing provider,” as the patient can only leave an insurer network if the actual cost out of network is below the average in-network price. This is like an “any competitive provider” patient right. It is time Congress sends a life boat to patients and lower health costs with the right to shop—true price transparency and access to all high-value providers.

With bipartisan leadership and the three recommendations outlined above, this committee and this Congress can lower premiums for those with pre-existing conditions and everyone else, create a more affordable continuum of health coverage, and actually lower the cost of health care.

Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for the privilege of testifying. I am Tarren Bragdon, the Founder and CEO of the Foundation for Government Accountability (FGA). FGA works at the State and Federal level to advance policy reforms to free more Americans to experience the power of work and reduce the biggest payroll deduction for most Americans, the cost of health coverage. Our model reforms were introduced in 41 States this year and have passed in 29 States over the past 3 years.

As this committee leads with bipartisan ways to improve cost and coverage, I offer three recommendations for your consideration:

First, Americans with pre-existing conditions need premium relief as well as access to individual insurance, without being segregated to plans with fewer benefits or higher premiums than those available to everyone else. This can be achieved by employing proven strategies that have successfully brought down premiums and reduced the number of uninsured.

Second, States need real policy flexibility to allow a greater continuum of health coverage, particularly for those buying their own insurance on the individual market, with a clearly defined and reasonable process and timeline.

Third, bipartisan reforms that reduce the cost of health care should be carefully considered under any bipartisan reform effort, as ultimately the cost of coverage reflects the cost of care.

1. LOWERING THE COST OF COVERAGE FOR THOSE WITH PRE-EXISTING CONDITIONS AND EVERYONE ELSE WITH INVISIBLE RISK SHARING

As my fellow panelist from Oliver Wyman and, separately, actuarial firm Milliman¹ have noted, the guaranteed issue mandate is the main driver of individual insurance premium increases under the ACA (up to 45 percent premium increase on average, according to Milliman). Congress must embrace a reform with a record of success to both lower premiums and maintain access for everyone buying insurance on their own.

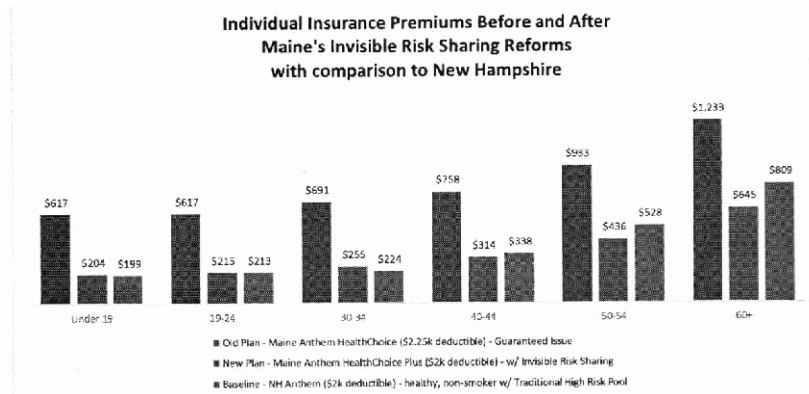
Prior to the ACA, most States segregated those with pre-existing conditions to high risk pools, which sometimes meant higher premiums or fewer benefits for enrollees. However, both Idaho (first) and Maine (later) pioneered a better and more sophisticated approach that lowered premiums without forcing those with pre-existing conditions to buy different plans. It is far more effective than an open-ended reinsurance program that costs more and is not as effective at reducing premiums.

Guarantee issue is a driver of higher premiums because of the open-ended risk and the higher costs it creates for insurers and, ultimately, policyholders by requiring insurers to accept all applicants.

Maine used an invisible risk sharing approach to both limit the risk and cap the cost for those individuals with pre-existing conditions, but did so with no negative impact on those same individuals. With this approach, those with pre-existing conditions are treated the same as everyone else while still having access to the same plans and benefits and most importantly, lower premiums.

In 2012 with invisible risk sharing, Maine dramatically lowered premiums in the individual market (by up to 70 percent) and increased voluntary enrollment with the active carrier (up 13 percent in 18 months). When combined with expanded age rating, this approach lowered annual premium costs by up to \$5,000 for someone in their twenties and up to \$7,000 for someone in their sixties (Maine was more restrictive than the ACA with 1.5:1 age bands and moved to 3:1.) Individuals could keep their current plans, and only transitioned to new plans if they chose to do so.²

As the chart below shows, the premium impact of Maine's invisible risk sharing meant that those who were healthy or had pre-existing conditions in Maine had the same or lower premiums as healthy, non-smokers in neighboring New Hampshire (which had a traditional high-risk pool at the time).



Source: Anthem rate filings in Maine and New Hampshire (Maine Bureau of Insurance, New Hampshire Insurance Department).

¹James O'Conner, "Comprehensive Assessment of ACA Factors that will Affect Individual Market Premiums in 2014," Milliman, prepared for America's Health Insurance Plans (April 2013), <http://www.iss4all.com/MillimanACAPremiumReport4252013.pdf>.

²Joel Allumbaugh, Tarren Bragdon, and Josh Archambault, "Invisible High-Risk Pools: How Congress Can Lower Premiums And Deal With Pre-Existing Conditions," Health Affairs (April 2017), <http://healthaffairs.org/blog/2017/03/02/invisible-high-risk-pools-how-congress-can-lower-premiums-and-deal-with-pre-existing-conditions/>

We contracted with Milliman to produce an independent actuarial study to show the impact nationally of using invisible risk sharing under a similar structure. That independent study in its entirety is attached to my testimony. Under this model, insurers paid claims for only those individuals with pre-existing conditions which are identified upon application, and insurers cover the first \$10,000 of claims per person per year. Insurers contribute 90 percent of premiums collected for those eligible for this risk sharing arrangement, which dramatically lowers the cost of the program (covering 40 percent of costs) and prevents gaming by insurers (dumping more individuals into risk sharing).

Combined with expansion of age brackets, invisible risk sharing would lower individual premiums by up to 31 percent in the individual market for those buying outside of the exchange, without any reduction in benefits or increases in cost-sharing. In addition, these lower premiums would mean up to 2 million more Americans would voluntarily buy individual insurance on their own, without any increase in subsidies. Milliman estimated that the cost of this approach nationally would be between \$3–5 billion annually, excluding premium contributions from insurers.³

Furthermore, invisible risk sharing money is only spent to reimburse the actual claims of those with pre-existing conditions or those in the risk sharing program. It is not a general reinsurance subsidy with an unspecific impact on premiums. A good contrast is how Alaska's 1332 reinsurance program reduced a projected premium increase from 42 percent to just a 7 percent increase⁴ whereas the Maine invisible risk sharing alone *reduced* premiums from the baseline by 20 percent or more. In other words, invisible risk sharing gets us a far better bang for our buck, because far fewer resources are needed to reduce premiums even more than under traditional reinsurance or a traditional high-risk pool.

Invisible risk sharing works because, at time of application, it caps the claim costs for insurers to cover those individuals with known pre-existing conditions, removing both the open-ended risk as well as limiting the high claims costs of these individuals. Premiums spike with guarantee issue because of this risk and the high claims costs it creates. Invisible risk sharing mitigates both, with a targeted approach. Effectively, one can receive the benefit of guarantee issue without experiencing the premium increases guarantee issue would normally create.

We would recommend that the Federal Government jumpstart the invisible risk sharing program initially and then, after 2 to 3 years, transition to the States. This would allow for the fastest and greatest amount of premium relief, while allowing States to customize their approaches over time. Maine started its program just 13 months after the legislation was passed and signed into law. A Federal program could begin during 2018, say next fall, and create a special enrollment period for new applicants so that they could immediately reap the benefits of lower premiums, should they choose to do so.

2. REAL POLICY FLEXIBILITY FOR STATES AND PATIENTS WITH EXPANDED 1332 WAIVERS

FGA's work in numerous States has revealed bipartisan hesitations about Section 1332 of the Affordable Care Act. As evidence of this, only 8 States even introduced 1332 authorizing legislation this year. There is hesitation due to the cost of the planning process, the higher barriers States must clear before an application will be considered, and the unclear timeframe of waiver approvals as well as the unclear coverage and premium benefits to individuals and families.

Put another way, with the current entry barriers and the structure of 1332s, the legislative "squeeze" necessary to get it done in a State is not worth the policy "juice" produced.

But the individual market is in crisis. There has been a 20 percent drop in those with unsubsidized ACA individual insurance this year, as healthy people drop high cost coverage they determine is not worth it.⁵ That unsubsidized individual market is now at least 2 million people smaller than it was pre-ACA.⁶ To put this in per-

³Kathleen Ely, Thomas Murawski and William Thompson, "The Federal Invisible Risk Pool," Milliman, prepared for the Foundation for Government Accountability (April 2017), <https://thefga.org/wp-content/uploads/2017/04/The-Federal-Invisible-High-Risk-Pool.pdf> with summary available at: <https://thefga.org/wp-content/uploads/2017/04/FIRSP-One-Page-2.pdf>.

⁴Virgil Dickson, "CMS Approves Alaska Waiver Aimed at Stabilizing Individual Market," Modern Healthcare (July 2017), <http://www.modernhealthcare.com/article/20170711/NEWS/170719975>.

⁵Associated Press, "Frustration Mounts Over Premiums for Individual Health Plans," New York Times (Sept 2017), <https://www.nytimes.com/aponline/2017/09/03/us/politics/ap-us-health-overhaul-paying-full-freight.html>.

⁶Kurt Giesa and Peter Kaczmarek, "Stabilizing the Individual Health Insurance Market," Oliver Wyman (August 2017), http://www.oliverwyman.com/content/dam/oliver-wyman/v2/publications/2017/aug/Market%20Stabilization_Final%20Version.pdf.

spective, only 4 million IRS returns this year paid the individual mandate penalty.⁷ In addition, since 2013, the number of individuals covered through small businesses has dropped 24 percent, showing that individuals are not simply migrating to group coverage as the economy improves.⁸

Only 1 in 3 of those with individual insurance are eligible for both Cost Sharing Reductions (CSR) and tax credits. That means 2 in 3 in the individual market face the full brunt of higher deductibles and some, if not all, of the premium increases under the ACA. For the majority of people in the individual market, the battle over CSRs is of little consequence. This does not minimize the CSR impact on those with low incomes, but simply shows that premium relief and flexibility through expanded 1332 waivers would impact vastly more Americans.

To be clear, I do not believe that changes to the current Federal guidance is sufficient. Legislative changes are needed in both the entry barriers for States and what policy flexibility States can achieve with a 1332 waiver. The four current statutory entry barriers are too high, and almost mutually exclusive, to allow a State to even apply without that State committing millions or billions of additional taxpayer dollars. Keeping the guardrail of Federal budget neutrality makes sense, but reforming the other three is vital.

Section 1332 could also be of more interest to States if there was a clearer glide path toward timely approval of waiver applications and more policy flexibility. As FGA has noted in Health Affairs, the likely process is cumbersome as Section 1115 waivers, with decades of precedent, take an average of 323 days to win approval. Section 1332 waivers require bilateral approval by Treasury and the Department of Health and Human Services. If States are to change the ACA subsidy structure, the IRS has advised that States may need to waive certain tax provisions altogether and replace them with State-administered tax programs, something almost impossible for the seven States with no State income tax and extremely costly for all other States to do.⁹

These practical and process concerns demand a simplified set of statutory guardrails, a clearer and fixed timeline path for approval, and more policy flexibility for States.

For those concerned about the types of coverage offered at the State level under a revised 1332 waiver, it is important to remember that States have more than 2,200 mandated provider and coverage benefits on the books.¹⁰

In short, State policymakers need a greater continuum of individual insurance plans to be allowed if premium relief is going to flow to the vast majority of the individual market and if more individuals and families are going to voluntarily buy insurance outside their employer without new or increased subsidies. The way to empower States to create this more affordable continuum is to give them more policy flexibility in how individual insurance plans are regulated under a revised and expanded 1332 framework. No one should be shut out of the individual market due to health. But evidence from actuaries and families shows that if more affordable range of plans are allowed, then more individuals will buy one that gives them the protection they want at a price they can pay. Policy flexibility for States through a revised 1332 structure is needed to accomplish this.

3. REDUCING THE COST OF HEALTH CARE THROUGH TRANSPARENCY AND EMPOWERING PATIENTS

To finish, I want to focus on the root cause of so much of the heart burn and controversy about costly efforts to increase coverage—the underlying cost of health care. There is bipartisan support for greater transparency and consumer protection in health care. This year, the divided legislature in Maine passed into law—with **unanimous bipartisan support**—PL 232, “An Act to Encourage Maine Con-

⁷“While the IRS Continues to Do a Reasonable Job in Administering the Affordable Care Act (ACA), Taxpayers Still Encounter Difficulties Attempting to Comply With the Complex Provisions,” IRS Taxpayer Advocate (2017), https://taxpayeradvocate.irs.gov/Media/Default/Documents/2018-JRC/JRC18_Volume1_AOF_11.pdf.

⁸“An Analysis of Individual and Small Group Health Insurance Trends,” Mark Farrah Associates (June 2017), <http://www.markfarrah.com/healthcare-business-strategy/An-Analysis-of-Individual-and-Small-Group-Health-Insurance-Trends.aspx>.

⁹Jonathan Ingram, Nic Horton, and Josh Archambault, “The ACA’s Section 1332: Escape Hatch Or Straightjacket For Reform?,” Health Affairs (May 2016), <http://healthaffairs.org/blog/2016/05/26/the-acas-section-1332-escape-hatch-or-straightjacket-for-reform/>.

¹⁰“State Insurance Mandates and the ACA Essential Benefits Provisions,” National Conference of State Legislatures (March 2017), <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx>.

sumers to Comparison-shop for Certain Health Care Procedures and to Lower Health Care Costs.”¹¹

PL 232 is a first-of-its kind reform. It builds on transparency efforts passed into law in Massachusetts in 2012, and a successful incentive program for State employees in Kentucky and New Hampshire, but also includes an additional key consumer protection for patients facing higher deductibles, narrower insurer networks, and the insurers’ typical black box of provider prices.

The reform grants patients the right to shop for the best value care regardless of the network status of a provider. To be clear, this is not “any willing provider,” as the patient can only leave an insurer network if the actual cost out of network is below the average in-network price (think of it as a “any competitive provider” patient right).

Let me give you a real-life example of why this matters:

Jennifer is a single-mother working hard to provide for her two girls and has health insurance from her small employer with a \$2,000 deductible. She was recently referred for physical therapy. She had used a physical therapist 2 years ago that she loved, but when she tried to return to that provider she was told they were now out-of-network and she would need to pay the full cost of any service and none of that cost would apply to her in-network deductible or annual out-of-pocket threshold.

The in-network physical therapist cost \$225 an hour, three times more than her previous one at \$75 an hour. But Jennifer is stuck paying more and having to go to someone new and unproven. That’s not fair and drives up the cost of health care and health insurance for Jennifer and everyone else.

This is not an isolated incident. The number of consumers facing increased cost sharing has spiked. Small business employees who faced \$1,000 single-deductibles was just 16 percent in 2006. By 2016, the percentage spiked to 65 percent.¹²

Increasing health care costs are harming patients, driving up insurance premiums, putting independent providers out-of-business, setting up massive health systems that will be too big to fail, and too often preventing doctors from making the best care decisions with their patients. It is time we sent a life boat to patients and give them the *right to shop*, with the true price transparency and access that allows them to do so. If we want to truly lower health care costs, we must take these steps forward.

With bipartisan leadership, this committee and this Congress can lower premiums for those with pre-existing conditions and everyone else, create a more affordable continuum of health coverage, and actually lower the cost of health care with the three recommendations outlined above.

The CHAIRMAN. Thank you, Mr. Bragdon.

Mr. Tyson, welcome.

STATEMENT OF BERNARD J. TYSON, CHAIRMAN AND CHIEF EXECUTIVE OFFICER, KAISER FOUNDATION HOSPITALS AND HEALTH PLAN, INC., PLEASANTON, CA

Mr. TYSON. Thank you very much. To Chairman Alexander and Ranking Member Murray, to the members of the committee.

It is an honor to be here this morning to speak to you about this important issue.

There are two important laws for the health and well-being of the American people, who are not covered by an employer and/or have the personal wealth, to buy their own coverage. I think about this very often. They are, of course, the Social Security Act that brought us Medicare and Medicaid in 1965 and the Affordable Care Act of 2010.

Because of these two laws and because of us, I actually remain optimistic that eventually in my lifetime, we will succeed in making sure that every American has access to the front door of the

¹¹http://www.mainelegislature.org/legis/bills/bills_128th/chapters/PUBLIC232.asp.

¹²“2016 Employer Health Benefits Survey,” Kaiser Family Foundation (Sept 2016), <http://kff.org/report-section/ehbs-2016-summary-of-findings/>.

American health care system. That front door has a key and that key is called coverage.

With the ACA that was enacted in 2010 and the Medicaid exchange, we now have given that key to almost 20 million people, if not more than 20 more million people who did not have it before. There are 30 million to go.

I am trying hard to do whatever it takes to make health care affordable and accessible for the 20 million that we have gained from the progress we have made with a law in 2010 and to figure out, how do we make sure that the other 30 million has a key to the front door to the American health care system.

I have had the privilege of working for Kaiser Permanente for 33 years. I started in the medical records department after finishing my graduate degree in health care administration. Today, I sit as the chairman and CEO of an organization that takes care of nearly 12 million. I have over 200,000 employees and in our Permanente Medical Groups, over 22,000 physicians who come to work every day trying to make high quality care affordable, and accessible, and available to everyone.

Not only do we take care of almost 12 million people, we take care of also the 60-plus million people who exist in the communities in which Kaiser Permanente provide care and coverage.

Of the 12 million members, almost 1.5 million are in the ACA, and they wonder every day, "Kaiser Permanente, will I have you again next year?" They call. They come in. They ask questions trying to figure out how they can continue to get care and coverage from organizations like Kaiser Permanente.

I want to impress upon you three facts. One, real solutions exist that this is not a situation where we have to throw out the baby with the bathwater. I can show you markets where Kaiser Permanente exist and the Affordable Care Act is working fairly well with some additional changes that need to be made, and then in other markets, we have more work to do.

No. 2, we own the success or the failure of the American health care system together. It is not about the Government or the marketplace. It is about both of us working together.

No. 3, is that the real focus of the narrative, I hope in the future, will shift to the actual cost of the delivery system, which is where all the cost is. To figure out, how do we continue to reform the delivery system to provide even higher quality and more accessibility?

As I said in my paper that I submitted to you, I respectfully offer a six point plan to repair the ACA immediately and in the long term.

No. 1 is obviously the funding of the CSR, and I would recommend that that is a multi-year funding, and I understand the dilemma of the debates that has been going on here.

What could work with a multi-year funding agreement with the CSR is how to get more of the insurers back in the market. How to create market stability, and allow the marketplace to begin to act like a marketplace in which me and my competitors will start to figure out, how do we compete in a market to attract and retain these wonderful people like we do in every other line of business.

No. 2, promote consumer protections while enhancing State flexibility.

No. 3, provide Federal support for reinsurance programs.

No. 4, to enforce the individual mandate.

No. 5, to reinstate full support and funding for enrollment outreach activities.

No. 6, to consider repealing the health insurer tax.

In return, I would recommend that you demand me and my colleagues to step up to the plate. I can tell you with certainty that many will get back into the market. You do not have to take my word alone. Call them directly. I did.

I recommend, for example, that you call my friend and colleague, Joe Swedish, CEO of Anthem and Mark Bertolini, CEO of Aetna.

Thank you for the honor of sharing these thoughts with you and I look forward to our question and answers.

[The prepared statement of Mr. Tyson follows:]

PREPARED STATEMENT OF BERNARD J. TYSON

SUMMARY

- We need targeted refinements to the ACA that are multi-year and sustainable, to encourage insurers to return to markets across the country. Insurers returning to the markets will increase competition and improve access and affordability for Americans currently without adequate coverage options.
- These changes need to be in place by September 27 to make a positive difference for the 2018 plan year, so the solutions need to be practical and focused.
- To encourage issuers to return to markets, I recommend a six-point blueprint:
 1. Fund cost-sharing reductions (CSRs) on a permanent or multi-year basis.
 2. Provide adequate Federal support for reinsurance programs that encourage broader market participation.
 3. Protect consumers while enhancing State flexibility.
 4. Repeal the health insurer tax to reduce costs in the system.
 5. Enforce the individual mandate.
 6. Fully support outreach and enrollment assistance efforts.
- The government needs to be a better business partner, and insurers, in turn, need to return to individual markets they have left.
- We need to remember that this is only one small segment of rising costs in care. We need to reform our delivery system to encourage integration and efficiency, and reduce costs. Pharmaceutical costs are a significant part of the problem.

Chairman Alexander, Ranking Member Murray, members of the committee, thank you for inviting me to discuss the need for important and immediate refinements to our health care system. I am honored to speak before you today.

Kaiser Permanente is an integrated health system that provides care and coverage for nearly 12 million members in eight States and the District of Columbia. Each day, more than 200,000 dedicated employees and 22,000 Permanente Medical Group physicians come to work at Kaiser Permanente to care for our members and deliver on our commitment to improving the health of the 65 million people living in the communities we serve. Kaiser Permanente participated in the individual market before the current law took effect—and we continue to participate in the markets we serve. Of our nearly 12 million members, 1.5 million receive coverage and care from Kaiser Permanente through the Affordable Care Act (“ACA”)’s health insurance exchanges.

It’s important to remember the full context of the American health care system when considering what needs to be done to refine the ACA to stabilize the individual insurance market. Since the end of the Second World War, a foundational element of the American system of health coverage has been employer-based coverage. That approach, however, left gaps. In 1965, our country agreed to take care of the poor and the elderly through Medicaid and Medicare. Since then, our system of health coverage has continued to evolve, and the ACA presents itself as an important next step in that evolution. Today, we have about 155 million Americans cov-

ered by their employer, 40 million by Medicare and 70 million by Medicaid.¹ About 20 million people gained coverage through the ACA² and almost 30 million remain uninsured.³ Our work is not done. We have too many Americans who are poor and considered the “working poor” locked out of the front door to the health care system. For many, the process of obtaining and maintaining coverage is still too difficult. Lack of health care impacts their ability to contribute as much as they could to their communities, and to America.

My message to you today is simple: We must work together to find real solutions to make high-quality, affordable health care accessible to all Americans. These solutions also must be sustainable over multiple years and not just a patchwork fix for 2018.

However, I am also here today to deliver a message to my colleagues in health plans across the country: Our cooperation and participation remain essential. While Congress can lay the groundwork, we must reset, step up to the plate and participate in places where consumers currently lack choices and access to affordable coverage. The next step is on all of us together.

The need for immediate action is clear. Chairman Alexander, the Insurance Commissioner from your home State of Tennessee stated the problem clearly in May. “It’s that instability, that uncertainty, the insurers hate the most. They are going to price for that,” she told the *Nashville Tennessean*.⁴ Ranking Member Murray, Insurance Commissioner Kreidler from Washington State, expressed similar concerns in April when he wrote to Department of Health & Human Services Secretary Price: “My office strongly believe[s] that market stability is achieved when issuers can engage in long-range planning in a stable financial and regulatory context.”⁵ Deadlines loom in the coming weeks. The Federal marketplace requires signed agreements in place by September 27, and 2018 open enrollment begins on November 1. If we are going to provide meaningful relief to consumers for 2018, we need to do it very quickly—within a timeframe better measured in days, than weeks. We also need to be very focused on making refinements that can realistically help in the short time we have left before the 2018 plan year begins. As Chairman Alexander noted at the outset of these hearings last week, if we try to bite off too much, and add complexity, we will end up adding to the disruption.

The effect, physically and mentally, on ordinary Americans of instability in the markets is real, clear, and present. People on both sides of the aisle—whether families faced with rising premiums and out-of-pocket costs, physicians trying to provide the best possible care to patients, or insurers trying to balance risk in a tumultuous political environment—all recognize that action needs to be taken, and that Congress, the Administration, States and the private sector have to work together to do it.

The ACA remains the law. It also remains controversial. It is important to remember that before the ACA, many millions of Americans were unable to buy coverage or were priced out of coverage because of pre-existing medical conditions. Virtually no one wants to go back to the way it worked before; we certainly don’t. However, we’ve found ourselves in a situation where political, regulatory and financial uncertainty has driven higher premiums and fewer choices for consumers. Insurers have left markets across the country, and we need to work together to get them to return to more markets, in more places, serving more Americans. We also have an obligation to address these challenges for not only 2018, but on a sustainable basis so that we are not back in the same place at this time next year, having the same discussion and hoping for a different result.

All of us have different ideas about how to make universal coverage a reality, but today, I’m focused on two goals, both of which put the consumer in the forefront. First, we have to reduce costs and modernize our Nation’s care delivery system, and, second, we have to stabilize the individual market for 2018 and beyond. Systemic

¹ See *Health Insurance Coverage of the Total Population*, Kaiser Family Foundation, <http://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

² Nicholas Bakalar, *Nearly 20 Million Have Gained Health Insurance since 2010*, New York Times, May 22, 2017, <https://www.nytimes.com/2017/05/22/health/obamacare-health-insurance-numbers-nchs.html?mcubz=3&r=0>.

³ Kaiser Family Foundation, *supra* note 1.

⁴ Holly Fletcher, *Tennessee’s Insurance Chief Seeks Elusive Answers in Washington*, Nashville Tennessean, May 12, 2017, <http://www.tennessean.com/story/money/industries/health-care/2017/05/12/tennessees-insurance-chief-seeks-elusive-answers-washington/315186001/>.

⁵ Letter from Mike Kreidler, Washington State Insurance Commissioner, to Thomas E. Price, M.D., Secretary, U.S. Dep’t of Health & Human Services (April 8, 2017), <https://www.insurance.wa.gov/sites/default/files/documents/Kreidler-AWHP-letter-HHS-Sec-TomPrice.pdf>.

affordability solutions are critical, and I am going to provide the committee with six critical points to stabilize the individual market that will encourage insurers to return to markets across the country, and provide more—and better—options for all Americans in the individual market.

A. DELIVERY SYSTEM REFORM

We share an obligation across the health care delivery system to improve quality, innovate and reduce costs for the American people. This is an obligation that extends to the entire delivery system and to our partners in Federal and State government, as well.

As we move forward from here, we need to be honest about the fact that, for whatever the reasons, the government has not been an ideal business partner to date when it comes to the individual market. This extends beyond reduced consumer outreach or failing to make risk corridor payments over time. We need much more from the government to make this critical part of the market work. Many of the points I make today go directly to addressing this need.

Let us not forget that, important as these issues are, we've mostly just been talking about an individual market that is a relatively small portion of the overall health care market in the country. Health care and coverage is not affordable in America, and not just for individuals and families: Businesses large and small are struggling to pay for health care for their employees. State and Federal Governments are being stretched to the limits to find funding for the growing costs of Medicare, Medicaid, and other public care programs. We need to work together to lower the systemic costs of health insurance and care delivery in this country, across the entire delivery system.

The law requires insurers to spend 85 cents of every dollar on care. Let's focus not just on the 15 cents, but also begin to act on the 85.

Rising deductibles and premiums are not just about insurance coverage rules or short-term changes in the characteristics of the risk pool—they continue to rise because care delivery continues to cost more. At Kaiser Permanente, we are showing that it's possible to organize health services in a more efficient way. Systemic challenges remain, however. While drug and device pricing present problems,⁶ we need to modernize how we approach care delivery in the United States from a broader perspective. We need many more primary care, mental health and community health practitioners. Our market incentives and medical education system need to reflect that. While the ACA tried to catalyze those market incentives, it did not do enough, and more work needs to be done at all levels—by policymakers in Congress, regulators and in the private sector. I think we can all do this together if we commit to moving from sick-care, fee-for-service models of care to a system that emphasizes well-care, with incentives for value and keeping people healthy. However, we also need to think of our delivery system as offering a continuum of coverage and care.

B. STABILIZING THE INDIVIDUAL MARKET FOR 2018 AND BEYOND

At Kaiser Permanente, we participated in the individual market before the current law took effect—and we're still participating today. Along the way, we've learned some lessons from our experiences that inform what I'm proposing today. I recommend the committee focus on building out from a six-point blueprint for stabilizing the individual exchange markets. These are areas that are critical in encouraging insurers to return to more markets across the country, therefore enhancing competition and consumer choice. If Congress and the Administration can agree on these points, insurers will return to the exchange markets. Here's what's needed to get there:

1. Fund Cost-Sharing Reduction (“CSR”) Subsidies on a Permanent or Multi-Year Basis. The ACA provides important subsidies that help low income and working people manage deductibles and out-of-pocket costs, known as CSR payments. That program has become tenuous because of legal uncertainty, policy disagreements and a bit of politics. Thus, we've seen insurers raise rates—or withdraw from markets entirely—to account for the uncertainty.

Funding the CSR payments on a permanent, or at least multi-year basis, is probably the single most important thing Congress can do to quickly stabilize the individual market. Washington State Insurance Commissioner Kreidler noted in his letter to Secretary Price,

⁶See, e.g., Rabah Kamal and Cynthia Cox, *What are the recent and forecasted trends in prescription drug spending?* Kaiser Family Foundation, May 22, 2017, https://www.healthsystemtracker.org/chart-collection/recent-forecasted-trends-prescription-drug-spending/?_stf_category=spending#item-start.

“Failure to secure ongoing funding of CSRs . . . results in uncertainty year after year regarding funding, compounded by the timing of appropriations decisions made long after issuers are required to file their rates for the upcoming year. Fully funding CSRs will continue to ensure affordable health coverage options for lower income enrollees and a stable marketplace for issuers.”⁷

The Congressional Budget Office (CBO) estimates that terminating CSR funding after December 2017 would cause premiums for silver plans to be 20 percent higher in 2018 and 25 percent higher by 2020.⁸

Nor would addressing this problem on a single year, or year-by-year basis, bring the stability and robust participation by insurers that many of us would like to see. To be clear, if we are going to bring insurers back into the individual exchange market in a substantial way, CSR funding needs to be guaranteed by Congress on a permanent or multi-year basis. If we are back here at the same time next year working through another year’s worth of CSR funding, we will not have accomplished the larger goal of stabilizing the individual exchange markets.

2. Provide adequate Federal support for reinsurance programs that encourage broader market participation. The Federal reinsurance program, designed to ensure that costs for covering claims over a certain point are paid by a fund that all insurers pay into, expired in 2017. Congress can immediately help by establishing a Federal reinsurance program, or significantly contributing to similar operations at a funding of State-level efforts. States play a major role in the process, but even under an expedited waiver authority, will not be prepared to act as readily for 2018 and 2019 as a Federal mechanism. However, we can improve upon the ACA and stabilize a Federal reinsurance program by making its funding source broader-based. CMS itself noted the critical role the Federal program played in encouraging issuers to participate in places they otherwise may not.

“Both the transitional reinsurance program and the permanent risk adjustment program are working as intended in compensating plans that enrolled higher-risk individuals, thereby protecting issuers against adverse selection within a market within a State and supporting them in offering products that serve all types of consumers,” CMS stated in its 2017 summary risk adjustment and reinsurance report.⁹

Emphasizing reinsurance at the Federal and State level would ensure those benefits continue.

3. Protect consumers while enhancing State flexibility. It is important to provide States with flexibility to respond to market conditions and come up with innovative solutions that can ultimately improve coverage nationwide. However, existing law contains specific protections, known as guardrails, to ensure that waivers are consistent with the best interests of consumers. These guardrails (comprehensiveness, affordability, availability and deficit neutrality) make sense, and need to be preserved in any expanded waiver authority made available to States.

At Kaiser Permanente, we have partnered with State regulators to consider State-level reinsurance programs, which can be developed within the scope of existing § 1332 waiver authorities. At the same time, it makes sense to expedite the consideration of such State waivers by the Administration; it can be done faster than 180 days, especially for waivers substantially similar to those already approved. However, divesting the HHS Secretary of responsibility to verify validity of State waiver proposals would put consumers at a disadvantage. State flexibility is important, but so is the larger national goal of continuing to expand meaningful coverage for the American people. Where flexibility is provided, Federal funding needs to be adequate to the task.

4. Repeal the health insurer tax to reduce costs in the system. In 2018, the tax imposed by the ACA on health insurance offerings is scheduled to return. This tax increases the cost of health insurance and is a major deterrent to participation particularly by for-profit plans, and it raises costs for consumers. Reports have indicated that the tax, on average, will raise premiums. Seniors with Medicare Advantage plans, or those receiving coverage through Medicaid managed care, may be

⁷ Kreidler, *supra* note 5, at 2.

⁸ Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions* (August 2017), at 2, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

⁹ U.S. Dep’t of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year* (June 30, 2017), at 2, <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>.

among the hardest hit by the return of this \$100 billion tax.¹⁰ We urge Congress, as part of its refinement of the ACA, to repeal or further delay the tax.

I recognize that the fifth and sixth components of this blueprint are items largely resting under the executive branch's authority. While the first four speak to direct areas where Congress can act immediately, I am including these items to paint a fuller picture for the committee:

5. Enforce the individual mandate. We recognize that the individual mandate is not the most beloved provision of the ACA. There needs to be a mechanism to incentivize participation and spread out the costs of care across as many people as possible, both healthy and sick, to ensure that important provisions like guaranteed issue, guaranteed availability and prohibition against health status rating will work. Without an enforced requirement that includes healthy people, more people would wait until they get sick to buy health coverage, which drives costs to unsustainable levels—and makes insurers skittish about market participation. Alternatives to the individual mandate have been proposed, but we do not believe that such proposals are as effective as simply enforcing the current law.

The next step is for the Administration to take steps to enforce the individual mandate. That would make a significant difference. Some estimates indicate that the full consequence of an unenforced mandate could raise premiums by over \$1,100 annually in 2018—with additional “uncertainty penalties” that raise premiums still higher (especially when compounded by uncertainty regarding the CSR subsidies).¹¹ All consumers are better off when the mandate is enforced, even if we don't necessarily like the requirement. I'd urge Congress to find ways to work with the Administration to enforce the mandate.

6. Fully support enrollment outreach activities. The Administration's recent announcement that it will reduce funding for marketing activities by 90 percent¹² is a step in the wrong direction. Plans are spending their own money on marketing to consumers, Federal and State exchanges are engaged in marketing and outreach, and numerous non-profit agencies are working to encourage enrollment as well. Additionally, plans contribute financially to Federal operation of the Navigator consumer assistance programs, and should be able to benefit from that investment. Brokers also have a significant role to play in helping to encourage enrollment. If we are to continue expanding coverage under this public-private program, there is a lot more work to be done, especially with specific populations needing specialized linguistic or other culturally appropriate assistance, or those not positioned to benefit from internet-based interactions.

Kaiser Permanente has learned through experience that States like California that have made it easier for consumers to get coverage, through standardized benefit packages, generally have more stable markets. Another part of this equation is outreach. We know that in-person outreach is very effective at ensuring consumers get the right plans for them. The Administration can take steps to make the purchasing process more transparent to and easier on all consumers.

Congress should consider what it can do to go a step further and promote engagement—meeting consumers where they are, and explaining the law and the benefits of obtaining and maintaining coverage.

C. A NOTE ON MEDICAID

Before I conclude, I'd like to offer a couple observations about Medicaid. While I recognize that this program is outside of the HELP Committee's jurisdiction, it is essential that we acknowledge the critical role Medicaid coverage plays in our health care system, serving some 70 million Americans following the ACA's Medicaid expansion.

That expansion should be preserved, with adequate Federal resources to match. At the same time, we would argue that remaining States that have yet to take advantage of the expansion should be given leeway to innovate, within the construct of the program's substantive protection for society's most vulnerable.

¹⁰ Caitlin Owens, *How the health insurance tax will impact 2018 premiums*, Axios, Aug. 9, 2017, <https://www.axios.com/how-the-health-insurance-tax-will-impact-2018-premiums-2471-0366.html>.

¹¹ Sam Berger and Emily Gee, *The Trump Uncertainty Rate Hike*, Center for American Progress, April 26, 2017, <https://www.americanprogress.org/issues/healthcare/news/2017/04/26/431162/trump-uncertainty-rate-hike/>.

¹² U.S. Dep't of Health & Human Services, Centers for Medicare & Medicaid Services, Center for Consumer Information and Insurance Oversight, *Policies Related to the Navigator Program and Enrollment Education for the Upcoming Enrollment Period* (Aug. 31, 2017), <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Policies-Related-Navigator-Program-Enrollment-Education-8-31-2017pdf.pdf>.

We also need to recognize the significant interaction with the Medicaid program,¹³ when we consider individual market stabilization efforts. In terms of State flexibilities, I can't say where exactly the income cutoff should be between Medicaid and the private insurance market, but what is important is to ensure that individuals and families have the Essential Health Benefits that they need with the financial support that allows them to access care. It is also important that we don't divert funding from Medicaid to try to slightly lower premiums in the individual market, when there are so many other areas ripe for refinement, as I've identified today.

D. CONCLUSION

Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for holding these important hearings and inviting me to speak. Many Americans are hoping we can deliver, and these hearings are an important step in the right direction if we are to provide even more people with affordable, accessible and quality health care. I look forward to your questions.

The CHAIRMAN. Thank you, Mr. Tyson.
Ms. Tomczyk, welcome.

STATEMENT OF TAMMY TOMCZYK, FSA, FCA, MAAA, SENIOR PRINCIPAL AND CONSULTING ACTUARY, MILWAUKEE, WI

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

My name is Tammy Tomczyk, and I am a Senior Principals and Consulting Actuary with Oliver Wyman, a business unit of Marsh & McLennan Companies. I am also a Fellow of the Society of Actuaries and a member of the American Academy of Actuaries.

It is an honor to have the opportunity to provide testimony to you today.

Since passage of the ACA, my colleagues and I have been actively involved in helping health plans, regulators, and other stakeholders understand and react to the various changes brought about by the law.

Most recently, I have been working with the States to help them assess the impact that potential policy changes could have on premiums and enrollment in their market, and supporting States in their efforts to apply for 1332 Waivers.

Starting this year, States are afforded flexibility to waive certain provisions of the ACA in an effort to develop innovative ways to provide access to quality health care and strengthen their local insurance markets.

At the same time, States must demonstrate, through actuarial and economic analysis, submitted as part of their application, that the proposed changes satisfy each of four criteria commonly referred to as guardrails.

States that are granted a waiver may receive pass through funding equal to reductions in Federal spending that result from their waiver, which may then be used to pay for a portion of their reforms. Only Hawaii and Alaska currently hold approved waivers.

While Hawaii's waiver was unique in that it sought to waive requirements for the shop program that conflict with a longstanding State law, Alaska's waiver is focused on a State run reinsurance

¹³ Estimates provided to the board of Covered California, California's State-based exchange, estimates fluctuation of the subsidy-eligible population between programs at about 340,000 people annually. See *Covered California 2016-2022 Market Analysis and Planning (May 12, 2017)*, at 10, http://board.coveredca.com/meetings/2016/5-12/Covered%20CA%20and%20PwC%20Market%20Planning%20and%20Analysis__Board%20Draft.pdf.

program aimed at relieving health plans of costs associated with individuals with certain high cost conditions.

Early indications appear to show that Alaska's waiver has been successful in starting to stabilize its individual market. Rate increases for 2017 were reduced from 42 percent to just over 7 percent with the introduction of the reinsurance program. For 2018, Alaska's only health plan, currently offering coverage in the market, recently filed for a 20 percent rate decrease.

A number of other States are in the process of preparing or have recently submitted waiver applications to implement similar reinsurance programs.

Governors and State insurance commissioners have raised concerns about the length of time it takes to develop and receive approval for 1332 Waivers.

Actuaries will start to work on rates for 2019 in just a few months. Efforts to expedite the review and approval of applications, in particular waivers where another State has already received approval, will allow these positive effects to impact premiums sooner.

Actuaries typically consider actuarial equivalents to be an aggregate measure examining the impact that a change in policy or benefits has on the covered population as a whole. The guardrails, as written in current law, appear to take this same aggregate approach ensuring that average premiums do not decrease and the total number of individuals insured is the same or greater.

However, in December 2015, HHS issued guidance that includes prescriptive rules that seemingly go beyond these aggregate requirements and, in some cases, may limit a State's ability to implement certain changes even if those changes are expected to drive down average premiums and increase the overall number of individuals with insurance.

The guidance also specifies that compliance with the guardrails must be met each year. Allowing States to, instead, meet these guardrails over the lifetime of the waiver could allow for more impactful and innovative waivers, in particular those that may require a ramp-up or a phase-in period before becoming fully effective.

My written testimony outlines several additional areas for consideration for providing States flexibility to develop innovative and customized solutions that work locally.

These include permitting States to submit coordinated 1115 and 1332 Waivers; affording States more flexibility and Essential Health Benefit definitions; allowing for more flexibility around plan design that would permit States to explore additional value-based benefit plans; allowing States to waive or alter certain additional provisions of the ACA; and providing grants to States that support their efforts to study and apply for these waivers.

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

[The prepared statement of Ms. Tomczyk follows:]

PREPARED STATEMENT OF TAMMY TOMCZYK

SUMMARY

Section 1332 affords States the flexibility to request approval to waive or alter certain provisions of the Affordable Care Act (ACA), in an effort to develop innova-

tive ways to provide access to quality health care and foster strong insurance markets. At the same time, the ACA places limits on the scope of Section 1332 waivers, preserving certain aspects of the law such as prohibitions against imposing pre-existing condition requirements, underwriting based on health status, and lifetime maximum coverage limits.

Only two States, Hawaii and Alaska, hold waivers that have been approved so far. Alaska's waiver put in place a reinsurance program that utilizes Federal pass-through funding to pay for a large portion of the program, which has already worked to reduce rates in the individual market. Alaska's waiver received much attention by the administration and was highlighted by HHS Secretary Price as a model that other States should consider. Since then, Minnesota, Oklahoma, Oregon, and New Hampshire have submitted or are in the process of preparing similar waiver applications focused on reinsurance.

Each State is unique in terms of its demographic and socioeconomic make-up, insurance markets, Medicaid programs, and existing Federal waivers. While Section 1332 provides States with flexibility to revise and shape their insurance markets to meet local needs, there are some limitations that impede States' ability to pursue certain strategies to stabilize and strengthen their markets. Allowing States flexibility to study and implement State-based solutions that are most effective for their local market, is likely to help in States' efforts to stabilize their individual markets.

Some of the actions that Congress or the administration could consider to provide greater flexibility around 1332 waivers, and allow States to quickly address their unique challenges, include the following:

- Allow States to waive or alter some provisions of the ACA not currently included in Section 1332
- Allow States to demonstrate each of the guardrails are met in aggregate for the market
 - Allow States to meet deficit neutrality and other guardrail requirements over the lifetime of the waiver, rather than each year
 - Permit States to submit coordinated waiver applications that allow recognition of aggregate savings from current or proposed 1115 waivers and Section 1332 waivers when assessing whether a Section 1332 waiver application meets the deficit neutrality guardrail
 - Afford States more flexibility in defining the Essential Health Benefits
 - Allow for more flexibility around plan design, permitting States to better explore value-based benefit designs
 - Provide for a more streamlined and expedited waiver approval process that allows States to take actions that can impact premium sooner
 - Provide grants to States that support efforts to explore and apply for Section 1332 waivers
 - Provide additional up-front guidance around reporting requirements for approved waivers, allowing States to better plan for implementation

INTRODUCTION

Chairman Alexander, Ranking Member Murray, and distinguished members of the committee, it is an honor to have the opportunity to provide this testimony to you regarding State flexibility to help stabilize the individual insurance market.

My name is Tammy Tomczyk. I am a Fellow of the Society of Actuaries, a member of the American Academy of Actuaries, and I meet that body's qualification standards for providing this testimony. I have nearly 25 years of experience as a health care actuary and have been actively involved for more than 7 years in helping health plans, regulators, and other stakeholders understand and react to changes brought about by the Affordable Care Act (ACA).

Most recently, I have been working with States to help them assess the impact that potential policy changes could have on premiums and enrollment in their local insurance markets, and supporting States in their efforts to apply for Section 1332 waivers.

I am also a Senior Principal and Consulting Actuary with the firm of Oliver Wyman Actuarial Consulting, a business unit of Marsh & McLennan Companies (MMC). MMC is a leading professional services firm with a global network of more than 60,000 experts in risk, strategy, and people. The businesses of MMC, including Oliver Wyman, Mercer and Marsh & McLennan Agency, collaborate with our clients to navigate the increasingly complex health care marketplace to help individuals, families and employees stay healthy and productive, enable innovation, and lower costs.

While this hearing is focused on issues that most directly affect Americans who receive health insurance coverage via the individual market, it is important to remember the significant role U.S. businesses—which cover nearly 61 percent of Americans—play in our health care system.

Congress should take careful consideration of how potential reforms in the individual marketplace may impact employer-sponsored health care coverage. MMC shares your goal of expanding health coverage to more people while preserving the employer-based system that Americans value so highly.

My testimony will focus on the following topics:

- Flexibility currently available to States under Section 1332 of the ACA
- Ways in which States have used Section 1332 waivers to date
- Current limitations of Section 1332, its implementing regulation, and additional guidance issued by the previous administration
- Potential areas for additional State flexibility

BACKGROUND

Starting in 2017, Section 1332 affords States the flexibility to waive certain provisions of the ACA in an effort to develop innovative ways to provide access to quality health care and foster strong insurance markets. The ACA limits the scope of Section 1332 waivers, preserving certain aspects of the law such as prohibitions against imposing pre-existing condition requirements, underwriting based on health status, and lifetime maximum coverage limits. Key provisions that may be waived under Section 1332 fall within the following four basic categories:

Qualified Health Plans: States may revise the list of benefits that must be covered by plans sold through the Marketplace, including Essential Health Benefits, cost sharing limitations, metal-tier requirements, and definitions related to markets and employer size.

Health Insurance Marketplaces: States can put in place alternate ways for individuals and/or groups to enroll in coverage and receive financial assistance, make revisions to enrollment periods, modify risk pool definitions, and make changes regarding limitations for coverage to citizens and lawful residents.

Financial Assistance: States can alter both the ACA rules and Internal Revenue Code provisions related to tax credits and cost sharing reduction subsidies. These alterations include family contribution requirements, the benchmark used to calculate the amount of the subsidies, and the definition of minimum essential coverage.

Individual and Employer Mandates: States can modify one or both of the requirements that most individuals have minimum essential coverage or pay a financial penalty, and the requirement that employers with 50 or more employees offer coverage to employees working 30 or more hours per week.

In waiving one or more of the provisions listed above, States must demonstrate in their waiver application that the proposed changes satisfy each of the following four criteria, often referred to as “guardrails”:

1. Comprehensiveness of Coverage—States must demonstrate that, under the waiver, coverage would be at least as comprehensive as it is absent the waiver

2. Affordability of Coverage—States must demonstrate that, under the waiver, coverage would be at least as affordable as it is absent the waiver

3. Scope of Coverage—States must demonstrate that, under the waiver, coverage would be provided to at least as many residents as it is absent the waiver

4. Deficit Neutrality—States must demonstrate that the waiver will not increase the Federal deficit

Federal regulations outline several additional requirements that a successful waiver application must meet.¹ Prior to submitting a Section 1332 waiver application, a State must enact a law providing for its implementation. The State must provide public notice of the waiver application and allow for a comment period, including public hearings. Through actuarial analyses and actuarial certifications, the State must demonstrate that the proposed waiver satisfies the comprehensiveness, affordability, and scope of coverage requirements outlined above. To demonstrate the waiver will be deficit neutral to the Federal Government, the State’s application must also reflect economic analyses, including a 10-year budget plan. Finally, the application must both describe the data and assumptions used to demonstrate the guardrails are met, and provide an implementation timeline.

States that are granted a waiver may receive pass-through funding from the Federal Government equal to any reductions in Federal spending for premium tax cred-

¹ Application, Review and Reporting Process for Waivers for State Innovation, Federal Register Vol. 77, No. 38, page 11700, February 27, 2012.

its, cost sharing reduction payments, and small business tax credits.² The State can then use these funds to pay for a portion of its reforms. The waiver application must include information needed to estimate the pass-through funding amount including data on enrollment, premiums, and Federal subsidies. All waivers are approved for a period of 5 years,³ and States must comply with quarterly and annual reporting requirements.⁴

RECENT 1332 WAIVER ACTIVITY

While Section 1332 waivers may be viewed as an opportunity for States to take action to promote stability in their individual markets, only 14 states have enacted legislation authorizing the submission of a Section 1332 waiver as of August 25, 2017.⁵ Only two states, Hawaii and Alaska, hold waivers that have been approved by the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Treasury.

Hawaii's waiver was unique in that it sought to waive the requirement under the ACA that it operate a web-based Small Business Health Options Program (SHOP). The SHOP has requirements that conflict with a long-standing State law requiring employers to provide robust health insurance coverage to employees at minimal cost. Through its waiver, small employers will enroll directly with health plans offering coverage that meets the requirements of the Hawaii Prepaid Healthcare Act. The State will receive pass-through funding equal to small employer tax credits that otherwise would have been paid to employers, and these funds will be used to supplement the State's long standing Prepaid Premium Supplementation Fund.

Alaska's waiver is focused on a State-managed program, the Alaska Reinsurance Program (ARP), aimed at relieving health plans of costs associated with individuals with certain high-cost conditions by ceding those costs to a separate risk pool. Although costs for these individuals are ceded to the ARP, existence of the ARP is essentially unknown to them. Ceded members pay the same premium as similarly situated members whose costs are not ceded to the ARP, and members' coverage continues with the carrier through which they enrolled, meaning they continue to have access to the same network providers, receive the same covered services, and have the same cost sharing provisions as individuals who are not ceded to the ARP.

Initial 2017 rate filings for Alaska's individual market indicated premiums that were projected to increase by 42 percent. However, State action and the introduction of the ARP, which was initially funded using \$55 million in State funds, reduced those increases to roughly 7 percent. In addition, Premera, the State's only health plan currently offering coverage in the individual market, recently filed for a rate decrease of more than 20 percent for 2018.⁶

Oliver Wyman assisted the State of Alaska by providing the required actuarial analyses to support its Section 1332 waiver application. Our modeling showed that investing \$60 million into the high-risk pool in 2018, and lowering premiums by that amount, would result in a net decline in Federal outlays for premium subsidies and other items of \$49 million. The waiver proposed that the Federal Government provide pass-through funding of \$49 million to Alaska, leaving \$11 million to be borne by the State.

In March 2017, while Alaska's Section 1332 waiver was under review by the Federal Government, it received much attention from the administration and was highlighted by HHS Secretary Price as a model that other States should consider.⁷ Minnesota,⁸ Oklahoma,⁹ Oregon,¹⁰ and New Hampshire¹¹ have all passed Section 1332 authorizing legislation and are in the process of preparing or have submitted waiver applications. Each of these States is proposing to implement a reinsurance program and is using an approach similar to Alaska's. However these States' proposed reinsurance programs are not based on individuals' specified health conditions like Alas-

² ACA, § 1332(a)(3).

³ ACA, § 1332(e).

⁴ 31 CFR 33.124 and 45 CFR 155.1324.

⁵ <http://www.statenetwork.org/more-states-looking-to-section-1332-waivers/>.

⁶ Erica Martinson, "Premera expects big cut in health insurance premiums on Alaska's individual market," Alaska Dispatch News, August 2, 2017, <https://www.adn.com/alaska-news/health/2017/08/01/premera-expects-a-21-6-percent-decrease-in-individual-market-premiums-for-2018/>.

⁷ https://www.cms.gov/CCHIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/March-13-2017-letter_508.pdf.

⁸ <https://www.revisor.mn.gov/bills/bill.php?b=house&f=HF5&ssn=0&y=2017>.

⁹ <https://legiscan.com/OK/text/HB2406/id/1624145>.

¹⁰ <https://olis.leg.state.or.us/liz/2017R1/Downloads/MeasureDocument/HB2391/Enrolled>.

¹¹ http://gencourt.state.nh.us/bill_status/billText.aspx?sy=2017&id=714&txtFormat=html.

ka's and are instead structured similarly to the transitional reinsurance program that was in place under the ACA from 2014 through 2016.

Minnesota and Oklahoma have already submitted their waiver applications, while Oregon and New Hampshire have released draft applications. The expected impact of these reinsurance programs varies widely by State, from a reduction in average premiums of roughly 7 percent in Oregon¹² and New Hampshire,¹³ to a reduction in average premiums of as much as 20 percent in Minnesota¹⁴ and 34 percent in Oklahoma.¹⁵ All four States are projecting that the waiver will lead to an increase in the number of insured individuals.

CURRENT LIMITATIONS TO SECTION 1332 WAIVERS

While Section 1332 provides States with flexibility to revise and shape their reinsurance markets to meet local needs, there are some limitations that impede States' ability to pursue certain strategies to stabilize and strengthen their markets. Some of these limitations include the following:

- Section 1332 places restrictions on which provisions of the ACA can be waived. The current statute does not allow States to make certain changes that might help stabilize their individual markets and increase the number of young or healthy individuals enrolled in the risk pool. These changes could include widening the 3:1 age curve to produce premiums that align more closely with underlying risk by age, introducing benefits and other provisions that encourage individuals to maintain continuous coverage, and implementing rules that work to eliminate inappropriate steering of Medicare and Medicaid individuals into the individual market.

- Federal guidance issued in December 2015 includes prescriptive rules that limit a State's ability to produce actuarial analyses that support meaningful changes expected to drive down premiums and increase enrollment. For example, Section 1332 by itself does appear to allow States to modify premium structures to vary by both age and income, and lowering subsidized premiums for younger individuals could improve the average morbidity of the risk pool. However, guidance issued by the prior administration in December 2015 looks beyond statute and regulation and requires that the impact a waiver will have on specific groups, such as low income individuals, the elderly, and those with significant health needs, will also be considered when assessing whether a waiver meets statutory guidelines.

- The December 2015 guidance also specifies that compliance with coverage, affordability and deficit neutrality requirements will be measured each year, rather than in aggregate over the lifetime of the waiver. This could prohibit innovative waivers that may require a ramp-up or phase-in period to become fully effective and may not initially meet all of the guardrails even though they will over the lifetime of the waiver.

- While States may submit coordinated applications for a 1332 waiver and a Medicaid-related 1115 waiver, the December 2015 guidance indicates that each waiver will be evaluated separately under the applicable Federal guidelines, and that savings from an 1115 waiver cannot be used to off spending under a 1332 waiver when demonstrating deficit neutrality requirements have been met. This restriction limits States' ability to develop waivers that reduce costs and/or increase the number of individuals covered when looking at the broader population.

In addition, while Section 1332 does allow States, within the confines of the law, to modify how Federal funding is employed at the State level, it does not make available new Federal funding. This means that certain waivers, such as Alaska's reinsurance waiver and the reinsurance waivers currently being considered by several States, require additional funding at the State level. Therefore, States with budgetary constraints may be limited in the waivers they can pursue.

Finally, States that utilize Healthcare.gov may face barriers to the implementation of certain waivers, such as those that would alter premium and/or cost sharing subsidies, if the Federal exchange is unable to implement State-specific requirements. These same barriers may not exist for State-based exchanges.

AREAS FOR CONSIDERATION

Each State is unique in terms of its demographic and socioeconomic make-up, insurance markets, Medicaid programs, and existing Federal waivers. Therefore, solu-

¹² <http://healthcare.oregon.gov/Documents/draft-OR1332-waiver-app.pdf>.

¹³ <https://www.nh.gov/insurance/legal/documents/nh1332waiverapplication.pdf>.

¹⁴ <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Minnesota-Section-1332-Waiver.pdf>.

¹⁵ <https://www.ok.gov/health2/documents/1332%20State%20Innovation%20Waiver%20Final.pdf>.

tions that work best for one State may not be the most efficient or affordable solution for another. Allowing States to study and implement State-based solutions that are most effective for their local market may help in efforts to stabilize the individual markets.

Congress or the administration could provide greater flexibility around 1332 waivers and allow States to address their unique challenges and circumstances by taking the following actions:

- Allow States to waive or alter additional provisions of the ACA not currently outlined in Section 1332 while still maintaining basic consumer protections
- Rescind the December 2015 guidance on Section 1332 and allow States to:
 - Demonstrate each of the guardrails are met in aggregate for the market
 - Meet deficit neutrality and other guardrail requirements over the lifetime of the waiver, rather than each year
 - Permit States to submit coordinated waiver applications that allow recognition of savings from current or proposed 1115 waivers when assessing whether a 1332 waiver application meets the deficit neutrality guardrail
- Afford States more flexibility in defining the Essential Health Benefits (EHBs) that must be covered by all plans
 - Allow for more flexibility around plan design, permitting States to explore value-based benefits with lower out of pocket maximums for high-value services in exchange for slightly higher out of pocket maximums for lower-value services to ensure individuals in lower-cost bronze plans do not forgo needed services for managing chronic conditions

In addition, Congress or the administration could consider the following items in support of Section 1332 waivers:

- Provide for a more streamlined and expedited waiver approval process that allows States to take actions that can impact rates sooner, including fast-tracking approval of applications for waivers that have already been approved and implemented in other States
- Provide grants to States that support efforts to explore and apply for Section 1332 waivers
- Provide additional up-front guidance around reporting requirements for approved waivers, allowing States to better plan for implementation

Thank you again for the opportunity to provide this testimony, and I welcome any questions you may have.

The CHAIRMAN. Thank you for your really helpful suggestions.

We will now go to 5-minute rounds of questions. I will try to keep the questions and answers to about 5 minutes so all the senators have a chance to have at least one round of questions, and then we may go to two.

Senator Enzi.

STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman.

I am going to thank you for the excellent summary you did of last week's roundtable suggestions in your opening statement.

I want to thank Senator Murray for working with you and coming up with another group of outstanding people to provide testimony. This really is helpful.

One theme that has emerged from the course of the hearings we have had on the individual market is the need for meaningful, tangible reforms on the 1332 Waiver.

Governor Leavitt, from your testimony, you have some hands-on experience with the Waiver and that process. I thank you for any wisdom you can shed on specific changes you would make right now to the process for the Waiver. You mentioned tweaking the 1115 and 1332, and also that neutrality.

Could you expand on that a little more?

Mr. LEAVITT. Yes. I mentioned three areas that I think would fall under that category.

The first would be having a menu of standardized waivers that have actually come through their experience. If they have permitted a reinsurance facility in Alaska, Minnesota should not have to wait if it met the same criteria. A menu of those could be developed.

You maintain the guardrails, the national standards if you will, but you give States the capacity to use their own, a series of different options to craft their solution.

The second you alluded to was that right now waivers under Medicaid fall under Section 1115. Waivers related to exchanges fall under 1332. Those are often codependent. In other words, I cannot do what I need to do on 1332 unless I am able to do something with Medicaid under 1115.

Currently, those are parallel processes. There is no reason they could not be done together. The law would need to be amended to allow that.

Last, I mentioned the fact that budget neutrality, one of the important guardrails, that I believe there will be wide agreement on, is currently required to be achieved in every separate fiscal year.

Oftentimes when a State or if the Federal Government makes an investment that spans 5 or 10 years, there is an upfront cost that has to essentially be amortized into the following years.

If budget neutrality could be amended to be achieved during the waiver period, as opposed to in every specific year, it would enable States to find those solutions while maintaining the national standards that make up the so-called guardrails.

Senator ENZI. Thank you. I have some additional written questions regarding that.

Mr. BRAGDON, I want to thank you for the Milliman White Paper. It gives quite a bit of information about the Maine invisible risk pool and some flexible models that we might be able to use.

Could you give me a few more details, though, on your any competitor purchase?

Mr. BRAGDON. Thank you for the question, Senator.

The Maine law really looked at, how do you achieve this bipartisan consensus over two aspects of the cost of health care?

One is, if you will, on the republican side, there was concern about ever-increasing costs and ever-increasing deductibles. In the Maine legislature on the democrat side, there was concern as insurers get narrower and narrower networks, how do you maintain access to high value providers who, in many cases, are being arbitrarily shut out of networks?

The legislation that passed unanimously in Maine says that if we are going to empower patients, we have to give them two things. We have to give them true price transparency building off a Massachusetts law in 2012 that said, "Here are the actual negotiated prices for you as a patient in this particular insurance plan."

The second piece was that if you could find a provider that was lower than the average cost, even if that provider was out of network, you as a patient had a right to go to that provider. The insurance company had to treat it as an in-network expense.

It was this combination of giving patients the information and then the power to shop that, in State employee plans and other self-insured plans, shows that is the way to reduce the cost of health care.

Senator ENZI. Thank you and my time is almost expired.

Thank you, panel.

The CHAIRMAN. Thank you, Senator Enzi.

Senator Murray.

Senator MURRAY. Again, thank you to all of our panelists. This is very helpful.

Ms. O'Toole, let me start with you. Minnesota is a pretty unique insurance marketplace, and in the past couple of years, I know you took steps to adopt a basic health plan, limit insurers' financial risk to keep them in your market, and provide premium rebates to enrollees to keep your coverage affordable.

As you mentioned in your opening remarks, you are hopefully within a few days of getting a 1332 Waiver, and its purpose is to establish a reinsurance program. Correct?

Ms. O'TOOLE. That is right. Yes.

Senator MURRAY. OK. I am glad you agreed with the need for a long-term Federal reinsurance program, as well, when you were speaking. We heard a lot of bipartisan support for that approach at last week's hearings.

As you know, today we are talking about how we make it easier for States to get these waivers. My priority is that we protect the so-called 1332 guardrails that give States flexibility without hurting people with preexisting conditions.

Did those guardrails do anything to prevent Minnesota from applying for its waiver?

Ms. O'TOOLE. No, they did not. Our application is well within those guardrails.

Senator MURRAY. OK.

I really do support finding ways to let States like Minnesota innovate and bring down the cost of coverage while maintaining that quality of care. I want to make sure that we avoid proposals that actually increase deductibles or other out of pocket costs. Your waiver request made sure that you maintained that. Correct?

Ms. O'TOOLE. That is right.

Senator MURRAY. OK.

Mr. Tyson, thank you for your thoughtful testimony, and I especially want to thank you for making clear that the insurance marketplaces are a partnership between the Federal and State governments, and the insurers compete for business within that market.

The Federal Government needs to live up to its end of the bargain, and provide certainty and stability. That is important so that there is a level playing field for competition among insurers that helps drive down the cost for people seeking coverage. It is up to insurers like Kaiser to come to the table and provide high quality coverage options for patients and families.

In your testimony, you provided a number of options for stabilizing the individual market. I wanted to ask you, what are the two or three most important things the Federal Government can do to stabilize the insurance market in the short term?

Mr. TYSON. Thank you very much.

I know that it is a difficult time right now in terms of getting a bipartisan agreement. I know that we talk about CSR as a 1-year deal. It is a mistake. You have to solve it for the year, but quite frankly, including myself and my colleagues are thinking now about 2019 and 2020 is right around the corner.

I would strongly recommend that you consider at least a multi-year solution for the CSR of at least 3 years, if not more permanent. I understand that there are issues that you have to work through to get to that point.

Because what you want to do is create stability and credibility where the insurers will come back more into the marketplaces around the country.

The pay back to you will be that once the market starts to behave as a market, once the competitors begin to really compete against each other to add value—and by the way, play by the rules, the guardrails and the rules that have been established—you then get us to begin to act more like what you see in Kaiser Permanente where we compete on value.

We compete on price. We compete on coverage. We compete on access. There is a difference between getting coverage, but not being able to afford to go see the physician or go into the delivery system, and obviously on service and quality.

The second area I would recommend is around the reinsurance and to solve to the reinsurance issue that would also create better stability in the marketplace.

Then probably the third area would be around what is currently a tax holiday with the tax, is to consider that, which drives costs out of the system.

I would recommend that you focus in those areas.

Senator MURRAY. OK. Thank you very much.

I just have 30 seconds left, but Ms. O'Toole, I wanted to go back to you. You talked about outreach and assistance to get people into your marketplace.

As I am sure you know, the Trump administration cut the Federal marketplace outreach funding from \$100 million to \$10 million and cut the budget for Navigators. We heard at our hearings last week about how Navigators help people with complex financial situations and health conditions choose coverage that is right for them.

Based on your experience, how important is funding for consumer outreach and assistance?

Ms. O'TOOLE. It is critical, and it is critical not only to meet our mission of enrolling and informing as many consumers as we can about their coverage options, but it is also critical in balancing that risk pool.

We see in Minnesota that the older, sicker folks sign up first and it takes extra effort to get younger and healthier Minnesotans into that pool. That involves not only on the ground assistance, free, in-person assistance for consumers, but also a robust marketing campaign.

We work with both Navigators and brokers across the State. I call them our "Army of Assisters," and they are really critical to our success.

Senator MURRAY. OK. Thank you very much. I appreciate it.

Thank you, Mr. Chairman.
 The CHAIRMAN. Thank you, Senator Murray.
 Senator Collins.

STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

Governor Leavitt, thank you so much for your testimony and the guideline of “National Standards, State Solutions.” I think that is a great motto for the bill that we are crafting.

We know from the experience in some States, including the State of Maine, that a high risk or a reinsurance pool, can help drive down the cost of premiums. Milliman—in looking at the costs if the Federal Government were to play a role—has a range of costs. If you are going to cover everyone, all individual market policies, it could be as high as \$16.7 billion.

On the other hand, if you took the Alaska approach, it could be far less. We have had some conversations with the National Association of Insurance Commissioners and it might be in the neighborhood of \$3 billion.

My question to you is this. Given the savings that reinsurance can provide on the premium side, do you think that it would make sense for the Federal Government for a brief period of time, say a couple of years, to provide some seed money to help States set up reinsurance pools?

Mr. LEAVITT. Let us acknowledge if money was readily available to States, more would do it and do it more quickly.

In the long term there is, in fact, a need for States to have reinsurance facilities that are integrated with the balance of their priorities that I believe can be developed in a way that essentially are not just budget-neutral at the Federal Government, but also at the State level.

I am a strong advocate for reinsurance facilities, but I do think they have to integrate into a much broader construction of a health care system than the Federal Government can contemplate in every State and therefore, they need to be done at the State level.

What we can do at the Federal Government to facilitate it should also be a significant part of the discussion.

Senator COLLINS. Right. I am not suggesting that the Federal Government should dictate how it is set up. Maine had an invisible, high risk pool that neither providers nor beneficiaries knew that they were assigned to the high risk pool. It was funded through premium dollars, in part, with the seeded risk, but also by a \$4 per month surcharge, essentially, that was built-in to premiums for all plans.

A lot of States do not have funding available right now. I know Alaska ponied up some \$55 million originally, and that was very impressive. Down the road, they are using the savings from the Advanced Premium Tax Credits to help finance the pool.

I guess my question is, should we be trying to expand reinsurance pools by initially providing some assistance to States, just in the short term?

Mr. LEAVITT. That will be an appropriation decision, obviously, of the Congress.

I think it is safe to say that if the Congress were to do that, there would be an acceleration of State pools. I think, from my view, that would be a positive thing.

On the other hand, I think it is important that it is not an ongoing Federal responsibility.

Senator COLLINS. Right, I am talking short term. Thank you.

Ms. Tomczyk, you mentioned, as did the Governor, the issue with the guidance that was put out by the Obama administration in December 2015 that required that States demonstrate budget neutrality, and they had to do so in each year of the Waiver.

Is it not very difficult to produce savings from innovation in the very first year that you try a new approach?

Ms. TOMCZYK. Yes, it can be. It depends on, of course, what type of program you are trying to put in place.

Certainly, one of the challenges with the market today and the instability is a good functioning insurance market needs a broad cross section of risks, and we are having trouble drawing in the young and healthy individual.

There may be innovative solutions and programs that can be put in place to draw those people in, but it may take some time.

Many of these people may have come to the exchanges, and looked for coverage, and saw that it was too high. After programs are put in place to bring those premiums down, we need to get those people to come back and take a second look. That may take some time to implement.

I think if you can meet the deficit neutrality requirement over the long term, even though it may not in the first year, that that should be something to consider.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

The chairman and I hung around a little after the coffee today, as a number of you did, to discuss the interplay of State flexibility and the Essential Health Benefits.

I would like to get some clarity—and I want to include all of you—on what 1332 Waivers currently allow regarding Essential Health Benefits. If the law were modified to permit additional State flexibility, in terms of either changing the guardrails or what States are able to waive under these 1332 Waivers, what the potential implications would be for individuals with a preexisting condition?

I feel this is really important. This is a basic concept for us to get on the committee and in the Congress to get our hands around. It feels important that we educate ourselves and the public on this issue.

As I understand it, the Affordable Care Act requires that all plans offered on the exchanges cover the same set of Essential Health Benefits, which are broad categories for coverage including coverage for emergency services, maternity care, and mental health, and substance use disorders. States then identify an insurance plan that serves as a benchmark for what it will consider as meeting the Essential Health Benefits requirements.

Under Section 1332, States may seek to revise the list of benefits that must be covered on plans sold through the marketplace. They may even see changes to the Essential Health Benefit plans, as long as these changes meet certain consumer protections that were established in the ACA, and some folks refer to those protections as guardrails.

These guardrails require that any proposed change guarantee that coverage under the proposed waiver would be as comprehensive as coverage absent the Waiver as affordable, cover at least as many people as the ACA, and be budget neutral.

My republican colleagues want more State flexibility and are seeking changes to the 1332 Waivers. I oppose changes that would weaken the consumer protections in the law or the Essential Health Benefits package.

I would like all the panelists to clarify whether I am correct about what is allowed under existing law and also about what problems you could foresee if the guardrails or the Essential Health Benefits packages were changed under Section 1332.

Ms. O'Toole, since you are from Minnesota, I would like you to go first.

Ms. O'TOOLE. OK.

The CHAIRMAN. Let me just say this, this is going to take a little longer than the 5 minutes, but I am going to, with the consent of the other members, this goes to the heart of something we are going to have to resolve if we want to get an agreement.

I would like for each of you to answer and have time to answer Senator Franken's question.

Senator FRANKEN. Thank you, Mr. Chairman.

Ms. O'TOOLE. Thank you, Senator.

I believe you are correct on what you stated is the law and that has always been very important, those consumer protections, so important in Minnesota. I share your focus there. I think the potential problem that I see—

I talk with Minnesotans all the time and I know you do too, and I was just out at Farm Fest in greater Minnesota, in western Minnesota; a great gathering. I hear consumers. Two concerns, two top concerns that they have.

One, they are worried if their coverage is going to be there for them. They wonder if they are going to get coverage this year and into the future. They are worried about just basic coverage.

The second goes to one of my previous answers too. They need to know what they are buying and they need clarity about what they are buying, and what their coverage is, and what they are going to pay out of pocket. What I see as a potential issue, and I am hoping we can all help the committee thread this needle, but consumers really need that clarity in their coverage to make good decisions for their families.

Senator FRANKEN. I am sorry, but what you mean is when people are buying insurance, if the Essential Health Benefits are changed and insurance policies are allowed to not cover certain things, is it going to become more complicated to buy insurance?

Ms. O'TOOLE. That is right, Senator.

Senator FRANKEN. OK.

The CHAIRMAN. Why don't the other witnesses please answer Senator Franken's question?

Senator FRANKEN. Sorry.

Mr. LEAVITT. I am happy to respond, Senator.

There is a bit of ambiguity, in my view, on how this is laid out. The statute lists 11 essential benefits. At the same time, it uses the word "comprehensiveness". I think being able to determine what is comprehensiveness as it relates to those 11 benefits.

There is a concept that is often used in Federal statute referred to as "actuarial equivalency." Rather than trying to look at a list of benefits and say, "They have to all be provided at the same level," you can create some flexibility.

If this were a car, for example, we would say, "It is a \$25,000 car. You need a motor, but some people believe it is also essential to have a back up camera. You could have a 200 horsepower motor and a back up camera, or you could have 300 horsepower motor all for \$25,000 but you choose the list of options and how you will weigh them."

It is my view that the State flexibility would be profoundly enhanced, rather than just speak of comprehensiveness, if it could be "actuarial equivalent comprehensiveness" so that the States had the ability to construct an option menu of benefits and provide either the State or even consumers the ability to choose plans that weigh those differently.

Mr. BRAGDON. Thank you. I think your question is really on point.

First of all, in the current 1332 statute, States have flexibility with Essential Health Benefits. When I think of State flexibility, it should be a gain of addition not subtraction.

Right now, States could subtract things off the Essential Health Benefit list assuming that they pass through those guardrails.

I think part of the conversation about additional State flexibility should instead look at, how can you vary other things that can reduce cost besides just reducing the number of benefits? How could you change actuarial value, some of the comments that the Governor made? How could you have greater flexibility when it comes to cost sharing?

I think with State flexibility, you want to use all these different tools so that people have lower cost options. Because what is happening now in the unsubsidized market is people are choosing nothing, which has unlimited cost sharing, if you will, rather than something that is at a price that they cannot afford or they are not willing to pay for what they are buying.

You want to increase that State flexibility, but Essential Health Benefits are already on the table.

The CHAIRMAN. Mr. Tyson.

Mr. TYSON. To use that earlier analogy—I view the 11 Essential Benefits as being the tires on the car, the steering wheel, the seats, et cetera.

I believe after being in this market for so long and before the ACA, the way the insurance companies and others got their costs down was either to eliminate some of the benefits and/or continue to increase the deductibles.

What you ended up with was a lot of people buying something that, when they needed it, they found it completely useless at times to get access into the front door of the care delivery system.

I do believe that there is room for flexibility and we should explore that in partnership between the government and the health care delivery system.

I am not stuck that there is only one way, but I think that the essential benefits provides a great foundation for us to build on that gives a predictable set of benefits to be expected that we all then compete against.

The CHAIRMAN. Ms. Tomczyk.

Ms. TOMCZYK. My understanding is also that the current law allows the flexibility to alter the Essential Health Benefits. It is one of the guardrails, the comprehensiveness of coverage and that they can be altered at the State level, but they have to be actuarially equivalent.

There cannot be the takeaway that was being described. If you take something away, you have to put something else in. That package at a State level, each State may have different needs.

I think the flexibility for the States to design their own package, as long as it is consistent across the State, is a good thing. I think the law says that if you take something out, the value of what you end up with at the end of the day has to be the same. It has to be actuarially equivalent.

If we start talking about different packages at the consumer level within a State, I think we just have to be really careful about adverse selection. In other words, if you have that one consumer can choose to not have a certain benefit, or one consumer can choose to swap out a different benefit.

We will have to look at that closely to make sure that folks are not selecting just the packages that work for them, and therefore the costs of those benefits are not spread broadly across a very robust, broad risk pool.

The CHAIRMAN. Thank you, Ms. Tomczyk. Thank you, Senator, for the question and to all of you for the answers.

Senator FRANKEN. Thank you for the extra time.

The CHAIRMAN. We can go back to it after the first round.

Senator Young.

STATEMENT OF SENATOR YOUNG

Senator YOUNG. Mr. Bragdon, you have mentioned a couple of times in your testimony here today that we should address the underlying cost of health care, in part, by providing for greater price transparency.

True price transparency has been done in Massachusetts, and also ensuring that there is actual access that enables consumers to act on that transparency. You cite the Maine law that passed in a bipartisan fashion earlier this year.

Are there any initial indications that you can speak to about how that law is working for consumers?

Mr. BRAGDON. Thank you for the question, Senator.

The Maine law was actually built upon a program for State employees in New Hampshire that has been replicated in other States as well.

The approach simply says that patients need to have true price transparency, not the charge, but the actual negotiated price.

It went one step further because as networks are getting narrower and narrower, patients are being shut out of providers, even providers that are lower cost. There are a lot of perverse incentives in the health care system to encourage that.

The Maine law is going into effect beginning next year.

Senator YOUNG. I see, yes.

Mr. BRAGDON. We do not have early results. It gives patients that right to choose a high value provider even if it is out of network. There are incentives.

What the New Hampshire State employee plan saw was just with making the market more transparent, new providers came in at a lower cost because patients now could see that they could go somewhere cheaper, and they voted with their feet.

Senator YOUNG. Are there barriers that would be unique to the Federal level, Federal implementation of this right to comparison shop approach that we should be concerned about, if this committee were to embrace that approach?

Mr. BRAGDON. No.

Senator YOUNG. Very good.

You also have spoken with some specificity in your testimony about targeted and invisible risk sharing.

Can you elaborate on this idea? What do you mean exactly by "targeting?"

Mr. BRAGDON. Sure.

Several different actuaries have talked about the biggest premium driver, as a result of the ACA, was guaranteed issue saying that all individuals with preexisting conditions need to have access.

The idea is, how do you maintain that access, but take that unpredictability and high cost out of the system?

In the past, States used to do it by segregating folks to a high risk pool that had different plans and was treated differently.

The Maine approach, and this is actually quite similar to the program starting in Alaska, the Maine approach said that rather than doing that, let us specially take those individuals with high cost, preexisting conditions—in Maine's case, when they walk through the front door, in Alaska's case, after the fact—let us take them and let us limit insurance companies' exposure. Let us take away the high cost and take away the unpredictability on them.

You keep the policy choice of giving everyone access, but you limit the cost by targeting reinsurance just to those individuals.

Senator YOUNG. I see. You have advocated jumpstarting or providing seed capital at the Federal level to expand this idea in other States. Right?

I share what I thought I heard were Governor Leavitt's concerns about this being, perhaps, an ongoing Federal responsibility.

Do you share that concern?

Mr. BRAGDON. I think the ideal situation is to jumpstart it at the Federal level, but then to allow States to customize it. Maine chose 8 preexisting conditions; Alaska chose 33. There are real reasons for that variety.

The ideal is to get it started at the Federal level so you can get premium relief as quickly as possible, and then transition to the State so they can customize.

Senator YOUNG. Are there things we might do, Mr. Bragdon or Governor Leavitt, to prevent States from coming back to the Federal Government 2 or 3 years down the road and saying, "We would like continued funding," for whatever reason as States are incentivized to do?

Mr. Bragdon or Governor.

Mr. LEAVITT. One, you could structure it not as a grant, but something that the Federal Government expects over time, once the program is moving and functioning to be able to recapture some of the savings that are developed at the Federal level.

I would have to think that through more clearly, but I think what you have suggested is a danger.

Senator YOUNG. Yes, OK. Thank you.

I yield back the balance of my time.

The CHAIRMAN. Thanks, Senator Young.

Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman, and thank you for holding this hearing, as always.

Ms. O'Toole, I wanted to start with you because you are on the frontlines of this. Part of solving a problem is making sure we understand the nature of the problem that we are trying to solve.

It would help the committee if you could walk through what the sources of the historic volatility have been in the individual market, as you understand it. I am not talking about what we are dealing with today, although it may come to that, but the historic volatility that people face.

Because again, as the chairman said, what concerns us today is something that relates to 7 percent of the people that are insured in America. There is so much more that we need to deal with in our health care system than that, but we have had a challenge because our politics has been focused on this 7 percent. A lot of the reason for that is, I think, because of the volatility you described.

That is the context for my question and then I am happy for you to use as much time as you need to answer it.

Ms. O'TOOLE. Thank you, Senator.

In Minnesota, just like many other States, we have experienced a lot of volatility. When we were getting going, the carriers were not as clear on the risk pool. We had two major carriers withdraw right in the first couple of years and we saw premiums increase dramatically.

I would be lying to say that a lot of the confusion lately is around the politics that I see because I talk to consumers all the time and they are confused about what is going on.

The volatility has had a big impact on our market. The flexibility we see now and the opportunity to settle down our market is going to have a huge benefit to consumers. That is why you hear me talking about our reinsurance waiver and the importance of that flexibility to do that.

Also, our flexibility as a State-based exchange has helped us move forward more quickly in Minnesota because we have the reins at a local level. We know what we need to do and we are doing that.

Some of these solutions are very short term, though, and we need some longer term help from all of you.

Senator BENNET. Mr. Bragdon, I do not want to get lost in this again, but on the transparency question, my colleagues were asking about.

Does this mean that in Maine, if you are going in to get a hip replacement that you have some means for knowing what providers all across the State charge for a hip replacement? Is it, at its most basic level, is that what you are talking about?

Mr. BRAGDON. Yes, that is the first part of it and it builds on a Massachusetts law that was in 2012.

Senator BENNET. OK.

The last question I have for you folks, is it your understanding that the 1332 Waiver, as is it written now, would allow a State, if it wanted to, to apply to have a public option in their State; some option other than private or nonprofit insurance?

Ms. O'TOOLE. I am happy to dive in here.

I believe that it does and, in fact, in Minnesota, our Governor has proposed a public option. It would be a buy-in to our Minnesota care program, which is our basic health plan. That idea is still percolating but it is envisioned that if it ever comes to fruition, that it would be handled through a waiver.

Senator BENNET. Is that a consensus view on the panel?

Mr. BRAGDON. Yes, I would agree.

Mr. TYSON. I would agree.

Can I back up to your first question, if you do not mind?

Senator BENNET. Sure.

Mr. TYSON. Just to add to the perspective. One of the ways that I think about it, and would offer for your consideration, is what was happening before ACA.

You had a situation where individuals with preexisting conditions, in essence, were not covered. And/or if they got coverage, they bought it at a very expensive price.

What you have now with ACA is we are trying to make sense in the market of how do you now put this risk inside of the coverage for a segment of the population? The expert is sitting next to me about how you deal with the actuarial data and everything around that.

Senator BENNET. Yes.

Mr. TYSON. Then the second thing you have is a lot of people who, historically, have not had coverage to get care except for when they needed care, they showed up in the emergency department.

As we now have taken on more of this population and are providing them with coverage and they have access to get care, we are discovering different kinds of illnesses and areas that we have to focus on to, in essence, get them to really perform in a preventative way going forward.

That adds to the cost in the short term, but if managed correctly in the long term, you will end up with better-managed care and the person would have better outcomes.

Senator BENNET. My time is up, so I will yield back to the chairman—but it also, I think, relates to the misery that a lot of the others, the 93 percent that are not the 7 percent we are talking about here, are also feeling.

I would also share the view, as a couple of you suggested that one source of great unhappiness that I hear about from people is that when they buy their insurance, and then when it is time for them to use their insurance, they are denied the opportunity to use their insurance.

Insurance is not like buying a loaf of bread where you consume it today or this week. It is very different than that. I think that is what the Affordable Care Act tried to recognize.

I thank the witnesses for your excellent testimony and thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

Senator Murkowski, I know you are very interested in the Alaska waivers, and I gave Senator Franken a little extra time. If you need it for your questioning, please, take it.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

I appreciate the question from Senator Franken because I do think it does go to the core of what we are trying to get to here. I paid attention very clearly to your introductory remarks as well as those of Senator Murray as the ranking.

It seems to me that there is a path forward here to get a consensus product out of this committee. That is something that I wholeheartedly endorse, and embrace, and have been very consistent about.

It seems that one of those pieces is what we do with the CRS and dealing with the time on that. I think we can work that through.

It is this issue of flexibility to the States that we have identified as one avenue being through the 1332 Waiver program. I am not sure whether or not State flexibility is being interpreted as, somehow or other, code for something nefarious to take place.

I want to go back to Senator Murray's requirement here, and I think it is absolutely fair, that what we are looking to do here in this committee with this targeted approach is to stabilize the individual market in this short term period here without eroding protections and without increasing the premium costs.

As one who comes from a State with really high premium costs, even with the reductions that we have seen through the 1332, quite honestly, going from \$1,000 a month to \$800 a month still is no screaming deal. This is important to me as well.

I am going to ask you, Ms. Tomczyk, as the actuary at the table, in terms of some of these proposals that have been laid out here today and last week on ways that we can better enhance the 1332 Waiver, whether or not any of them actually would have a consequence, an unintended consequence of increasing premiums. Whether it is the proposal for the coordination between the 1115 and the 1332, the menu of waivers as Governor Leavitt has indicated, the budget neutrality issue, whether it is in each year or over the course of the Waiver.

Can you speak to whether or not these proposals, that are being discussed, would have an impact on premiums and premium increases?

Ms. TOMCZYK. Yes. Thank you for the question.

With any of these proposals, it may differ by State. Even things that we have not mentioned, each State is starting from a different place in terms of whether they have expanded Medicaid, whether they have transitional policies in the market.

Any proposal could have a different answer for each State and that is, I think, where the State flexibility is beneficial where States can look at what might work for them.

Overarching all of this, we still have the guardrails, the guardrails that are outlined in law. If any of the proposals were found to increase the number of uninsured individuals or increase premiums, my understanding is that waiver would not be approved because it is not passing the guardrails.

I think there some other options and flexibility that could be provided with that December 2015 guidance that I mentioned right now is maybe keeping States from looking at where they would work to reduce premiums in aggregate and they would work to increase the number of individuals who are insured.

It is that looking at the one level down at the subpopulations that is, perhaps, preventing some of those things from being explored further.

Senator MURKOWSKI. Effectively, streamlining a process is not going to increase premiums.

Ms. TOMCZYK. Yes, streamlining the waiver process. I do not think so.

Senator MURKOWSKI. Or allowing for a menu of standard waivers and then, to Governor Leavitt's point, you have national standards but State solutions.

Could that have potential impact to premiums? Are you saying it depends? It is State-specific.

Ms. TOMCZYK. Yes, I do not think having the menu itself to help expedite and streamline the process would add to the cost. Again, depending on what is on that menu, because each State is a little bit different, it could potentially pass the guardrails in one State and not another, if that makes sense.

When we talk about reinsurance because the way reinsurance works, it brings down premiums for all. Some type of standard menus for reinsurance waivers is probably going to work for just about every State.

As we start looking at more unique and innovative and maybe they would not be on this simple menu. Maybe the menu has to be simple, straightforward type waivers that would work in every State. There certainly are more innovative type waivers that may or may not work depending on the State specifics.

Senator MURKOWSKI. I appreciate that and I do not know whether anybody had anything that they might want to add to that.

It sounds from your answer that if we are talking about some of these, basically improving on a provision that was already outlined in the ACA by making it work as intended.

Ms. TOMCZYK. Correct.

Senator MURKOWSKI. Allow for a level of efficiency is something that we should be striving for regardless of what we do.

Ms. TOMCZYK. Yes.

Senator MURKOWSKI. Everyone is nodding their head.

Ms. TOMCZYK. At least give the States the opportunity to explore that, the flexibility, yes. I agree.

Senator MURKOWSKI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Murkowski.

Senator Whitehouse.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thank you very much, Chairman.

I want to thank both you and Senator Murray for the comments that you made at the beginning of the hearing and join Senator Murkowski in endorsing and embracing what appears to be an emerging path toward a bipartisan solution here.

To all of the witnesses, I assume that you will all agree that to the extent, either through a risk pool or through reinsurance, that you can lift the cost of certain very expensive conditions out of these markets, that that will have the effect of lowering premiums in those markets.

Is that an agreed baseline fact here?

[All nod affirmatively.]

Senator WHITEHOUSE. Yes, all heads nod.

The effect of lowering the premium would be expected to attract more participation in the market as would have been opposite of adverse selection.

Is that also a baseline principle we can agree on?

[All nod affirmatively.]

Senator WHITEHOUSE. Yes, all heads nodding. OK.

That takes us to the question, and I would like to have Mr. Bragdon and Ms. Tomczyk address this.

You have chosen, Mr. Bragdon, to do a reinsurance type mechanism. Alaska, Ms. Tomczyk, advised by your firm has chosen to do a conditions-based mechanism.

Do you see huge differences, advantage and disadvantage, between a conditions-based, i.e., once you are diagnosed, you move into either the reinsurance or the risk pool versus hitting a dollar cap level?

Make your best case for either or let me know if you do not think that is a very important difference as long as the underlying job is being done.

Let me ask Ms. Tomczyk first, Mr. Bragdon.

Ms. TOMCZYK. I think both of those types, or any type of reinsurance program, one thing it does is it adds predictability and stability to the market. As an actuary, it makes it a little bit easier to price when you are taking those most volatile claims out of the market.

Senator WHITEHOUSE. The condition once established is set, then you do not have to worry about chasing billing records and other things to get to a spending cap.

Correct?

Ms. TOMCZYK. Right, and I will be corrected if I am incorrect.

I think the Maine program is also condition-based, but folks enter the pool at the time of application. They look at the conditions that they have, and if they have one of those conditions, they go into the pool. Whereas Alaska, individuals can develop those conditions throughout the year and then they move over to the pool.

One advantage that I think that has from a predictability and a pricing standpoint is the insurer is protected against those large claims if someone develops them during the course of the year.

Senator WHITEHOUSE. Mr. Bragdon, do you fundamentally have a conditions-based program that moves to that through your multiplicity of claims method? How does it work?

Mr. BRAGDON. The Maine approach looked at eight preexisting conditions at time of application, and then at the same time, if certain individuals, based on how they looked at the time of application were going to be high cost, insurers could voluntarily put them into the pool.

I think whether you do the Alaska approach or the Maine approach, both are similar. You are correct in that they are based on certain preexisting conditions. The idea being that if guarantee issue, policy choice has a premium increase because of the uncertainty and the high cost, then target the reinsurance to that driver. That is the approach.

Senator WHITEHOUSE. You are both fairly comfortable with either way, as long as we are accomplishing the goal of extracting those costs from the market allowing premiums to come down and allowing more participation in the market because premiums have come down.

Ms. TOMCZYK. Yes.

Senator WHITEHOUSE. OK. Good.

The last question, which I will actually make, because my time is running out, as a question for the record comes out of Mr. Tyson's testimony.

He has said very clearly, "We need to reform our delivery system to encourage integration and efficiency and reduce costs." That the ACA tried to catalyze market incentives to support delivery system reform, but did not do enough and that we need to move from sick care, fee for service models of care to a system that emphasizes well care with incentives for value and for keeping people healthy.

What I have asked other panels, I will also ask each of you, which is in that context to evaluate the opportunities in improving patient safety and reducing hospital-acquired infections; one.

Learning from the wide variations in care and outcomes, and how to drive toward the better care and outcomes models within that range of variation.

Three, reducing administrative overhead. There is way too much warfare between payers and providers that produces no health care benefit.

Four, improving our adherence to the wishes of patients at end of life, so they are not being dragged through a lot of procedures that they do not want.

Finally, reforming the payment system to encourage health care rather than sick care.

I am out of time, so I will standby for questions for the record.

Mr. Chairman, just as one general observation, I would like to note that the other senator from Maine is in the audience. It is not uncommon for me to see, when there is a very interesting hearing going on, Senator King just showing up in the audience in judiciary hearings, here in the HELP committee.

I just wanted to note that he is here also reflecting Maine and it reflects, I think, an admirable curiosity on the part of Senator King that he turns up at hearings and just sits quietly in the audience.

Senator FRANKEN. Or maybe he has nothing to do.

[Laughter.]

Senator WHITEHOUSE. Pay no attention to the Senator from Minnesota.

The CHAIRMAN. We are glad to have both senators from Maine and this is not the first time Senator King has come.

Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. Thank you.

By the way, Senator Murray's comments, although not mentioning me by name, I saw people in the audience looking at me because, obviously, I am trying to advance the Graham-Cassidy-Heller Amendment.

Let me be explicit. We are not trying to be partisan; this is bipartisan.

Even Ms. O'Toole, I mentioned somebody in our pre-meeting. It turns out for a 60-year-old person in a Minnesota family, they are paying over \$31,000 a year for their Bronze Level plan with a family deductible of \$13,700.

Even in a State doing relatively well, it is \$44,000 out in a bad year plus a pharmaceutical deductible.

I will also say, we do not want to be partisan. I have met with ten different democratic senators as we have discussed this. Under our plan, Wisconsin does incredibly well. Virginia does incredibly well.

No, Tim. When you see the language, your State will get hundreds of millions of dollars more over 5 years to care for lower income Virginians.

We have specifically tried to make this a nonpartisan, taking the portion that Senator Collins agrees with and giving flexibility to the States. Senator Collins, for the record, does not like the per-cap cap, but I will just say that it was just that good work.

Let me just commit. We are not trying to be partisan with the Graham-Cassidy-Heller. We are actually just trying to be fair to all Americans no matter where she or he lives.

I hope partisan is not something that, unfortunately, just originates on one side of the aisle because truly I have made an effort, and I know Senator Collins did when we were working together, and other senators have to reach across the aisle on something which is bipartisan.

By the way, other States represented by democratic senators do substantially better including Missouri and Florida.

That said, what we have heard from our democratic and republican insurance commissioners and Governors is they want flexi-

bility. They think they can do more with flexibility than the Federal Government can do telling them how to do it, and then they come and ask, "Can we have an exception?"

Mr. Leavitt, I really agree with, liked what you had to say. A combined 1115–1332 Waiver with guardrails is your recommendation of how to proceed.

Is that a fair summary?

Mr. LEAVITT. That is an option States should have.

Senator CASSIDY. Yes.

If the Graham-Cassidy-Heller Amendment, which basically takes the dollars a State would receive under the status quo, and gives it to them with guardrails, a combined 1115–1332.

As you said in the pre-meeting, a kind of a check off list, "If you do this, this, and this, you can have the money. We are going to watch to make sure you are going to do this, this, and this, but you have the money." Again, that seems kind of consistent with the direction you think we should go in.

Mr. LEAVITT. In many cases, it is not money. In many cases, it is the authority to move and to organize a system in a particular way.

In essence, what you have suggested is true.

Senator CASSIDY. I totally get that. I know more about Alaska's health care system than I ever thought I would know, but I think I know they have 11,000 people in the individual market.

The idea that you can have a risk pool based upon 11,000 people, I can make a joke about marijuana being legal in Alaska, but the point is that you just cannot do it. You would have to be hallucinating to think that you can.

Mr. TYSON, would you agree with that because you are the fellow that actually has to put together a plan, as the head of Kaiser? A risk pool of 11,000 people would be difficult to score, I presume, difficult to bid on.

Mr. TYSON. Yes.

Senator CASSIDY. You had mentioned in your earlier pre-meeting that the folks you are seeing in the individual market before and since the ACA have always been an unstable group.

If you could combine those with your Medicaid expansion risk pool which, I think, in California probably numbers in the millions, I presume that would make it far more stable. A fair statement?

Mr. TYSON. Yes, that is very fair.

Senator CASSIDY. What Governor Leavitt suggested, which would be that you would combine the two. You have the option of combining the two, particularly for a State like Alaska would be a kind of bipartisan solution giving the Governor the option to put together something that would take care of those in the individual market. At least conceptually, that would be a fair approach, I presume.

Mr. TYSON. With the proper guardrails in place, I think, as stated earlier, you would create those guidelines, create those guardrails, and then allow some flexibility to look at the marketplace and how the marketplaces are unique in some cases, but generic in other cases. To look at other ways of coming up with solutions.

Senator CASSIDY. Is it fair to say, though, that California is different than Alaska in terms of how you would design insurance?

Mr. TYSON. Probably so, in some areas.

Senator CASSIDY. Yes.

Mr. TYSON. Yes.

Senator CASSIDY. Yes, so I just say that because, again, I will repeat. I will finish where I started.

We do not attempt to be partisan with Graham-Cassidy-Heller. We are actually trying to be bipartisan, allowing a State, a blue State and a deep red State, God bless you, to come up with a solution which is specific for your State, which works best for the lower income folks, and at the same time, delivering more dollars to States like Wisconsin and Virginia than they ordinarily have.

I yield back.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman.

Thank you all for sharing your expertise with us today. I am very encouraged about these hearings and the bipartisan approach that we are taking to the issues of market stability and affordability.

I agree that we should consider ways to help the States implement innovative reforms that work for their constituents, particularly to help address high health costs like prescription drugs, to name one.

I am concerned with proposals that would allow States to roll-back the vital consumer protections and benefits that our families rely on today.

Last week, we heard from a panel of Governors that we should do more to help States share best practices. Best practices on innovative outreach efforts to enroll more young and healthy people.

I believe that this is an essential element of stabilizing the insurance market. We should pursue Federal and State reforms that would allow more young adults to enroll in comprehensive and affordable coverage.

Ms. O'Toole, as a State exchange, you implemented unique marketing and outreach campaigns in Minnesota, specifically for various communities, for example, ethnic minorities, targeted to help more Minnesotans enroll.

Mr. Tyson, you have had similar experiences with targeted outreach on California's exchange.

How can Congress facilitate the sharing of best practices to help others learn from your efforts and help States, including those with Federal marketplaces, implement similar efforts to enroll more young and healthy people and make the process more transparent?

I would love to hear from each of you.

Mr. TYSON. I do believe that the marketing efforts that we have deployed in California, and other parts of the country, have been very important to both educating the public, to really describing what it is that we can offer as a health care system in those markets around the country. To deal with the uniqueness of the population, in some cases, in which they have not had the experience of getting coverage. There is a whole educational piece.

In addition to that, we had to add staff into our call centers to educate them after they make the purchase, to understand how to access care, to understand what it means to have a deductible versus a co-payment, and the kind of basic things that you educate the different populations on.

I also think that the whole advertising of it has been very effective in California in which we tell our story around why this is a good thing for individuals and families.

I can tell you from my own experience of working in these vast communities around the country, and now focused in California, is that these are individuals who really do want to provide coverage and care to their families and for them individually. They really do want to understand how to get engaged in it.

The challenge continues to be, how do we continue to make this more affordable to them? Ongoing reforming of the health care delivery system, I think, is the best path to really deal with the affordability of care.

Senator BALDWIN. Thank you, Mr. Tyson.

Ms. O'Toole, I want to give you the opportunity to answer that question, but let me add just an additional component that, I think, reflects on Minnesota.

You shared that Minnesota's flexibility in implementing special enrollment periods when needed for your constituents had helped you enroll additional thousands in the marketplace.

In 2014, I secured a special enrollment period for Wisconsinites who were being transitioned, by virtue of our Governor's decision of not expanding Medicaid, off of our BadgerCare program, which resulted in about 2,000 more individuals receiving coverage.

Can you talk also about that flexibility in your response?

Ms. O'TOOLE. I am happy to. Thank you, Senator.

I think to your first question, and I will try and be succinct here, I think the critical part of outreach and enrollment and marketing is that we invest in it because I see that as meeting our mission of informing and helping as many people enroll into coverage as possible. Also, it helps to stabilize the risk pool and I cannot underscore that enough.

I think when we have control over our outreach efforts, I think, we also benefit from the Federal investment too and I think it is absolutely critical to continue that.

In terms of special enrollment periods, our flexibility to do that has also been critical. We had a bipartisan agreement come out of Minnesota about premium relief. It was a 1-year, almost a rebate, for people who did not benefit from the tax credits because we had upwards of 50 percent premium increases last year.

That law passed with a week to go in open enrollment, and that was not enough time for Minnesotans to enroll. We added a week onto the end of open enrollments, kept our doors open, had assistants all over the State working like mad to help people and we enrolled an additional 5,000 people in that week.

I think it was just critical that they could take advantage of the relief.

The CHAIRMAN. Thank you, Senator Baldwin.

Thank you, Ms. O'Toole.

We are running toward the end of our hearing time. We have several senators remaining, so we are going to try to keep to the 5 minutes on the questions and answers.

Senator Murphy.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. Thank you very much, Mr. Chairman.

Let me underscore the importance of marketing. I was just with the head of Connecticut's exchange, one of the most successful in the country. This week we will know whether our insurers are staying in for the next enrollment period.

Folks that were on our exchange could not imagine a worse time for the President to have announced the dramatic rollback of marketing. Even though we do a lot of it ourselves in Connecticut, we rely on those national marketing campaigns as well. It was a moment where at least one of our insurers is right on the precipice of walking away, this announcement may be the straw that breaks the camel's back.

I followed Senator Young out following his question about how you make sure that any Federal assistance on setting up reinsurance funds does not become a permanent burden, extra burden on Federal taxpayers. I understand that to be a very legitimate concern that many of our republicans will bring.

I just suggested to him, and I will suggest it to you and leave it for the panel to think about, that maybe there is a way to place a bet that the cost savings that Alaska has achieved will be achieved in other States, but do it in a time limited fashion.

If the savings are not achieved after a period of several years that the Federal contribution clause back. That may be a way to protect the Federal investment while recognizing that States may not be able to make these investments upfront.

Maybe there is some middle ground where we can recognize that helping States set up these pools is important, but protecting taxpayers is important as well.

I just have one question, and it is frankly that maybe be a little bit of a devil's advocate on a concept that I actually support, which is State-based reinsurance, perhaps backed up by the Federal Government, and I want to ask this of Mr. Tyson.

Your whole business model is built upon accountable care. We spent a lot of time talking about the importance of building a system of insurance and a system of reimbursement based upon getting insurance companies, and big physician groups, and hospitals to care about outcomes.

One of the risks of taking off of insurance companies the cost of very highly medically acute patients is it then does not put the risk on patients who do not get preventative health services and who spiral out of control into the highest 5 or 10 percent of spenders, takes it away from the insurance company.

As a representative of a company who thinks a lot about how you build accountable systems of care, imagine a world in which we do have a State-based, universal system of reinsurance.

How do you make sure, then, that insurance companies, who would still be providing the care for everybody else, have an incentive system in place to make sure that they just look the other way

as somebody gets really medically complex because they do not have to worry about it on the backend?

Mr. TYSON. It is a very, very good question and a very thought provoking question, just to preference my comments by saying that. I think it is just an excellent question.

It goes back for me to the earlier conversation we had this morning, which is if we are not dealing with the delivery system the reform of care itself, while we can watch costs go down on a temporary basis if we are focused on the claim side or just the coverage side, sooner or later they are going to have to access that system of care and that is going to ultimately drive the cost of care back up.

Really figuring out how to bring the two together, which is both the coverage and the care aspect, and to create an accountable system is going to be critically important in the long run for this to be successful.

Added to that would be, how do you make sure that you are incenting the system to perform the way it is intended to perform, which is to take those individuals at high risk with the illnesses as we described? To make sure that their care is being provided in a way that it manages the costs in the long run. That is critically important.

Senator MURPHY. How do you do that if you are not responsible for it financially?

Mr. TYSON. You want to create that financial linkage to the delivery system. We have it in Kaiser Permanente because we provide the care and the coverage under one roof, if you will, the model itself.

Over time, you want to build those kinds of mechanisms with that high risk pool against the provider population as well.

I know we did not talk about that today in the proposals, but it is something for the long term that we would need to solve to. Or, you are right, no one will own, if you will, the cost of care for that high risk population.

Senator MURPHY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman.

The Affordable Care Act makes sure that when you buy something called "health insurance," that it is real and not just some junk plan that is not worth the paper that it is printed on.

Your plan has to cover, now, mental health problems, and maternity care, and addiction treatment. It cannot limit how many chemo treatments you get, and every plan has to cover a share of average, out of pocket costs.

Silver Plans, the ones that most people buy, that share is at least 70 percent; and those are huge steps forward in the insurance market.

A lot of families are still paying a lot of upfront costs before their insurance kicks in and many Silver Plans, for example, have very high deductibles.

When you visit your primary care doctor, you write a check. When you get a biopsy, you write a check. When you have a mole removed or you get minor knee surgery, you write a check, you write a check, you write a check until you have paid down your deductible and insurance starts picking up the tab.

Ms. O'Toole, I want to ask you in Minnesota's basic health plan program for low-income families, insurers are required to offer plans with very low deductibles.

Can you say a word about why that is so important?

Ms. O'TOOLE. Yes. Thank you, Senator.

We are really proud of our basic health plan. It has been around for 25 years. It predates the ACA and then was certified under the ACA. It is called Minnesota Care.

Minnesota Care covers about 80,000 to 90,000 Minnesotans who do not qualify for Medicaid, but are still very low income. You think about a family making about \$30,000 who could be exposed to a \$10,000 deductible. That is not doable for them.

What Minnesota Care has done is allow these families to get the security of coverage and to seek health care services for their families has been critical.

Senator WARREN. Thank you. That is really important to hear.

In Massachusetts, one way we have made it easier for consumers to know they are getting a good deal when they buy their insurance is to require every insurer to offer plans with standard benefit structures. That it is specifically designed to have low, upfront costs. Every person buying a plan on the exchange has this option available to them.

Mr. Tyson, I know that in several States where Kaiser offers coverage, like California and in Oregon, they have the same requirement as we have in Massachusetts.

You mentioned in your written testimony that standardized benefits can stabilize the market by making it easier for consumers to get coverage.

I take it that means that offering these standardized plans has not limited your ability to compete for customers in those States if you cannot charge for things like emergency care or an ultrasound as part of the deductible.

Is that right?

Mr. TYSON. That is correct.

Senator WARREN. Good. I am glad to hear that.

Mr. TYSON. That is correct, and I fully support that you end up really doing the work that is required to continue to look at how to drive down the cost of care and building efficient systems to actually do that.

Senator WARREN. Right. The Federal Government now runs the insurance exchanges in 28 States. They considered having the same requirement, but then they backed down and made this optional rather than required.

Mr. Tyson, Kaiser also sells plans on exchanges that are run by the Federal Government, so where it is optional.

If the Federal exchange required insurers to offer standardized plans where some services fell outside the deductible, like emergency room care, would that harm your ability to participate in those markets?

Mr. TYSON. We would still participate, obviously, because of our commitment. We would look at how to keep that as standard as possible across the program because we feel that that is vitally important for the person to have access into the care delivery system when needed.

We can show you the history over 70 years that if the person does not get the care early, you end up paying much more later downstream. In addition to that, the person is unnecessarily suffering a longer period of time.

Senator WARREN. Right. Pay now, or pay more later, plus all the additional suffering.

There has been a lot of talk that in order to stabilize markets and reduce peoples' cost, we need to go back to junk plans that do not actually cover much of anything. I think that is a bad idea and so does my republican Governor, who was here to testify last week.

We need to be making it easier, not harder, for families to buy quality plans and that means holding insurers to higher standards, not lower standards as we do this. I think we have demonstrated, you can have competition that really helps consumers here. Thank you.

Thank you, Mr. Chair.

The CHAIRMAN. Thanks, Senator Warren.

Senator Hassan.

STATEMENT OF SENATOR HASSAN

Senator HASSAN. Thank you, Mr. Chair, and Ranking Member Murray, again, for holding these hearings.

Thank you to all the witnesses for being here today. We really appreciate your time and your expertise.

Just as a kind of introductory matter, because I have been going back and forth to different hearings, I take it that there is general agreement among you that in terms of market stabilization right now having the CSR's continue for more than a year is a really important thing.

Do I see head nods generally?

[All nod affirmatively.]

Senator HASSAN. OK. I will take that as a yes.

I wanted to touch on an issue that is particularly challenging in my State of New Hampshire. I know many of you are familiar with how States are grappling with the opioid addiction crisis. New Hampshire has been particularly hard hit.

I understand from a former Governor's point of view how important flexibility is and how important the flexibility within the 1332 Waiver process is.

I also believe it is critical that we make sure people have access to comprehensive coverage and really protect those guardrails in 1332s.

Mr. Tyson, this is a question for you. Essential Health Benefits like coverage for substance use disorders ensure that people get treatment. In my home State right now, it is particularly important that those trying to buildup treatment capacity know that there is going to be coverage for treatment.

Do you agree that as we consider stabilization options, we need to make sure that people maintain coverage of these Essential Health Benefits, including substance use disorder services?

Mr. TYSON. Yes, I agree.

Senator HASSAN. Thank you very much.

Another question that has come up in some of the testimony, as I reviewed it, was testimony, I think, from Mr. Bragdon discussing widening the ACA's age bands.

As you know, currently plans cannot charge older adults more than three times what they charge younger adults. Widening the age band would let plans charge older adults more than this.

Actually, way back before the ACA, when I was in the State senate in New Hampshire, there was a bill passed that allowed the widening of age bands and we saw increases of a couple hundred percent for middle-aged folks, especially people who own their own businesses. I have concerns about the idea.

Mr. Tyson, I am interested in Kaiser Permanente's perspective here. Does your organization support widening the age bands?

Mr. TYSON. We prefer not to. We do think that the issue of how you balance the overall costs, how do you incent the younger, healthier population to get into the pool? How do you make sure that you are not overtaxing the elderly population and/or the high risk population as part of that calculus?

Senator HASSAN. Yes.

Mr. TYSON. We would prefer not to widen it to the extreme.

Senator HASSAN. Thank you very much.

Last, we have talked, a number of us have asked questions about the importance of advertising and outreach here. Ms. O'Toole, I wanted to go back to that for a second.

If we reduce funding for advertising and for Navigators, if the Federal Government reduces that funding, what do you think that does in terms of market stability?

Ms. O'TOOLE. Thank you, Senator. I think it makes it worse.

Senator HASSAN. Thank you, very much. That is all the questions I have at this time.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Hassan.

Senator Kaine.

STATEMENT OF SENATOR KAINE

Senator KAINE. Thank you, Mr. Chair.

I want to, again, express my appreciation to both Senator Alexander and Senator Murray for these hearings.

Healthcare is the most important expenditure anybody ever makes with a dollar in their pocket. There is not one that is more important.

I think the stakes are existential for us to get this right because, frankly, the last 8 months, the American public has just been assaulted with words like "repeal," "implode," "sabotage." This government is scaring people to death about the most important expenditure that they are ever going to make in their life.

If we had had a discussion about the future of the Affordable Care Act with the Administration just committing, "We are going to continue to make the cost sharing payments. We are not going

to upset the applecart while you are having discussion,” people still would have been concerned.

The combination of a discussion about repeal with an Administration that, frankly, has rooted for an implosion has people very, very frightened in the most important area in their life.

You are holding these hearings so that Congress can try to step up and be an Article One Branch again. Not an Article Two-and-a-half Branch reacting to something that the President does, but an Article One Branch.

As important as health care is, there is an ever bigger existential stake. I think the American public has to see the democrats and republicans can work together to solve their problems. They have to see that.

An Administration praying for implosion is not showing them that. They have to see from Congress that in the most important expenditure anybody makes in their life, we are willing to work together as democrats and republicans to solve problems.

I see this committee as a, I am not going to say last hope, but after many, many months, if we do not get it right, if we cannot find common cause, even if it is in modest ways about this most important area, I do not see anybody doing it. I think the stakes are very, very high for us.

I wish my colleague, Dr. Cassidy, Senator Cassidy was here because he pointed here, “I am not trying to do something partisan,” and I agree with him. The proposal that he and Senator Graham has is not intended to be a partisan proposal. It is pursuing a process that, unfortunately, is very, very partisan.

Because trying to come up with a bill to get through the narrow budget reconciliation goal and pass with 51 votes, and having no language about it—we still do not have it—and trying to force it through on a snap vote in 2 weeks without being able to adequately consider it.

I am reading articles about its negative effect on Virginia. I am glad that my colleague today said it was going to help Virginia. All of the published articles say it is going to hurt my State.

You cannot fix health care just with one party. You cannot fix health care with just some snap vote with language that nobody has seen.

The process that we are underway here on, where we are hearing from experts—you are the third panel, democrats and republicans—to tell us what works, what does not work, and what needs to be fixed is the only way that we are going to be able to address this most serious issue.

It is not going to be through tweets. It is not going to be through a snap vote. It is going to be through earnest people with differences of opinion listening to experts, and then engaging in the hard work of listening to each other and crafting compromise.

You have committed to this and that is why we are here. I do not mean to put even more pressure on my chair and ranking, but the stakes could not be higher. They could not be higher.

I just have one question. Governor Leavitt, who I have known for many years, talked about a couple of areas of flexibility where States might really find the ability to craft solutions. The two that he mentioned are, and I am just going to ask the panel members

whether you agree with these two or whether you have some differences of opinion, because you have different perspectives on this.

The first one was that the guidance given by the Obama administration at the end of 2015 that said that the budget neutrality requirement on these waivers should be adjusted so that budget neutrality should be measured over the period of the waiver rather than required in every fiscal year to which the waiver applies.

Does everybody think that that adjustment would be a positive flexibility move or does anybody see problems there that we ought to know about? Anybody see problems?

I am going to ask for it in writing too, so if you think about it afterwards, and you can think of something that I have not thought of, I would like to know.

Second, Governor Leavitt suggested that we ought to figure out a way to more significantly combine the 1332 and 1115 Waiver provisions so that there are not two separate processes that often States are making proposals that are integrated, and there ought to be a more streamlined way to consider them together.

Does anybody see real world problems to that, that I am not seeing?

[No audible response.]

Senator KAINE. That can be a little bit problematic here because a 1332 Waiver deals with the exchanges, which is under the jurisdiction of this committee and 1115 Waivers deal with Medicaid, which is under the jurisdiction of the Finance Committee.

Who outside this building cares about that? We are talking about health care and we ought to come up with something that can effectuate the flexibility promise of these two waiver provisions and not needlessly gum them up.

I will ask those for the record, but it sounds like Governor Leavitt has gotten essentially an "amen" across the aisle on both of those flexibility recommendations, and I think they are good ones.

Senator KAINE. I appreciate it, Mr. Chair.

The CHAIRMAN. Thank you, Senator Kaine.

Senator Murray, do you have any remarks before we conclude or questions?

Senator MURRAY. I just want to thank you, again, and I really appreciate all of the participation here.

I think that we are all working in a very coordinated way to try and come up with a thread-the-needle solution that can get through Congress and it is not easy. If we focus on that short-term stability issue, and making sure we do not accidentally increase costs for people, and make sure we move in the right direction, we can get there.

It is not going to be easy, but we remain committed to work with you.

The CHAIRMAN. Thanks, Senator Murray.

Mr. Bragdon, just for clarification, you mentioned that the Maine invisible risk pool model nationally would cost \$3 to \$5 billion based upon a Milliman report.

Is that right?

Mr. BRAGDON. Correct.

The CHAIRMAN. Senator Collins mentioned \$16.7 billion. What is the difference?

Mr. BRAGDON. Sure. It is to whom the strategy applies to.

One thing that States can do right now in 1332 Waivers is they can segment the risk pool to those folks who are on-exchange, most of whom are receiving subsidies, and those folks who are off-exchange paying full boat.

The smaller price tag is to have a targeted approach to those folks off-exchange and that is why it is cheaper. You get more bang for your buck.

The CHAIRMAN. It would be a risk pool for everybody off the exchange or the two out of three people who pay some of their insurance?

Mr. BRAGDON. It would depend on how you structure it.

The CHAIRMAN. You could do it either way.

Mr. BRAGDON. Correct.

The CHAIRMAN. It would be a way to reduce premiums for the people who are really getting hammered.

Mr. BRAGDON. Correct.

The CHAIRMAN. Who are the people who have no Government support or less Government support, and that would significantly reduce the cost of the invisible risk pool.

Mr. BRAGDON. Correct.

The CHAIRMAN. In Maine, my second clarification question, Maine put a \$4 per policy charge to pay for it.

Did that pay for all of it?

Mr. BRAGDON. It did, because like the Alaska plan, it also required insurers to contribute their premiums for everybody who was covered by the pool.

Traditional reinsurance is just a pot of money to the insurance companies. This kind of targeted reinsurance says to the insurer, "This is a partnership. You give us all," or in Maine's case 90 percent.

The CHAIRMAN. If you are going to give us the person, you give us the premium money.

Mr. BRAGDON. Exactly, and that pays about 40 percent of the cost, which is why you get more bang for the buck. It is targeted to folks with preexisting conditions and insurers have to pony up as part of a partnership.

The CHAIRMAN. There has been lots of talk about reinsurance, as Senator Murray said. Senator Kaine has introduced a bill on reinsurance.

Then others of us have pointed out, we have a \$20 trillion debt here. Actually, we hit \$20 trillion today. In theory, there is no extra Federal money lying around, but based on what you just said, the State of Maine could—

Why could States not fund their own invisible risk pools with a plan like you just described?

Mr. BRAGDON. They can, they just have to go through the 1332 process in order to get there. They cannot do it now under the ACA in the current framework. You have to make policy decisions and pass through all those guardrails.

The CHAIRMAN. Yes.

Mr. BRAGDON. That is why States need more flexibility.

The CHAIRMAN. Finally, I see Senator Franken is back on the question he asked. Several of you mentioned both in the committee and afterwards the words “actuarially equivalent,” in terms of dealing with the issue—if you give States more flexibility and a benefit package—do you infringe upon the Essential Health Benefits in a bad way?

The suggestion as I understood it—and I will ask you to comment on this, if I have mischaracterized this or even if I have characterized it correctly—is that if you use the words “actuarially equivalent,” instead of the word “comprehensive,” that you could arrange the benefits in a different way in the same package, but they would have to, in the end, be of the same value to the consumer.

Would you comment on that, and that will be my last question? Governor Leavitt, did I say that correctly?

Mr. LEAVITT. I believe you have captured the concept.

The CHAIRMAN. Ms. O’Toole? Does anybody else have a comment on that?

Mr. BRAGDON. No, I agree.

The CHAIRMAN. Mr. Tyson.

Mr. TYSON. Just a caveat, the precaution is to make sure it does not get set up where you go back to adverse selection.

The CHAIRMAN. OK.

Ms. Tomczyk, any comment on that from an actuarial point of view?

Ms. TOMCZYK. No, I agree. I think that is how all of the guardrails are actually designed is to be actuarially equivalent. When we talk about the number of people covered, that is pretty easy, if you have X people.

The CHAIRMAN. That is what you think it should mean today under the current language? There is some question about whether it does.

Ms. TOMCZYK. Yes, I think it would definitely, it would benefit from clarity in terms of what it means today. It is not very clear, I am trying to think of the exact wording, but comparable coverage. That the comprehensiveness—

The CHAIRMAN. “Comprehensive” is the word.

Ms. TOMCZYK [continuing]. Has to be comparable.

The CHAIRMAN. From your point of view, “actuarially equivalent” would be a definition of a reasonable goal for that.

Ms. TOMCZYK. Yes, and something that we, at least as actuaries, know what it means.

The CHAIRMAN. That means something to you, those words?

Ms. TOMCZYK. It does.

Senator FRANKEN. Yes. Full employment.

[Laughter.]

The CHAIRMAN. Yes. We are winding up the hearing. I do not know if Senator Franken, did you come back?

Senator FRANKEN. Just for that joke.

The CHAIRMAN. Good.

[Laughter.]

The CHAIRMAN. This has been extremely helpful. You have given us a lot of time. You have focused on a variety of issues, but specifically on probably the single issue that is essential for us to resolve

before we see if we can get some sort of consensus among us in the next few days.

Our goal, as we have stated before, Senator Murray said and I have stated, we want to see—while it is a formidable challenge—if before the end of the month, we can have a limited, bipartisan agreement that would affect the individual market in 2018 to help keep rates from going up. We have focused on a number of ways to do that.

Thank you very much for being here.

The record will stay open for 10 days. Let me encourage you, if you have comments, particularly on that last question about language, we would like to have it in the next three or 4 days.

The CHAIRMAN. On September 14, the HELP committee will hold the last in our series of four bipartisan hearings on individual health insurance marketplace stability. I look forward to that.

The committee will stand adjourned.

[Additional material follows.]

ADDITIONAL MATERIAL

RESPONSE BY ALLISON LEIGH O'TOOLE TO QUESTIONS OF SENATOR WHITEHOUSE

MNSURESM,
ST. PAUL, MN 55101,
October 20, 2017.Hon. SHELDON WHITEHOUSE,
Hart Senate Office Bldg., Rm. 530,
Washington, DC 20510.

DEAR SENATOR WHITEHOUSE: Thank you for your questions regarding ways to address cost and improve quality in our health care system. While all five of the areas you identify have merit and deserve consideration, there are two areas where great progress could be made.

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 health care-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. 1. Advancing payment reform to encourage prevention and primary care.

Minnesota has had great success in advancing payment reform through several initiatives, including Health Care Homes, Integrated Health Partnerships, innovative county-based public programs, and Behavior Health Homes.

These initiatives have improved the health of Minnesotans and reduced health care costs by over a billion dollars over the last several years. In Minnesota we have found that oftentimes reforms begun in the public sector can help drive innovation in the private, and vice versa.

Health Care Homes

The Health Care Homes (HCH) program is one of the centerpieces of Minnesota's health reform initiatives. Through a focus on redesign of care delivery and meaningful engagement of patients in their care, Health Care Homes is transforming care for millions of Minnesotans. This is a shift from a purely medical model of health care to a focus on linking primary care with wellness, prevention, self-management and community services.

In order to receive health care home certification, providers must demonstrate a team approach to primary care delivery and meet standards for care coordination, as well as factor in social determinants of health in their care delivery. Additionally, providers must engage with their patients on critical prevention issues.

The Health Care Home model serves patients in both public and private coverage. Currently, the Minnesota Department of Health has certified 361 clinics, or 54 percent of all primary care clinics in Minnesota. About 3.6 million Minnesotans receive care in clinics certified as health care homes.

A 2016 *University of Minnesota Study* estimated that the Health Care Home model saved \$1 billion over a 5-year period.

Integrated Health Partnerships

In 2013, the Minnesota Department of Human Services launched its Integrated Health Partnerships (IHP) demonstration, which strives to deliver higher quality and lower cost health care through innovative approaches to care and payment.

With this demonstration, Minnesota is one of a growing number of States to implement an ACO model in its Medical Assistance (Medicaid) program, with the goal of improving the health of the population and of individual members. In their first

year of participation, delivery systems can share in savings. After the first year, they also share the risk for losses. Delivery systems' total costs for caring for Medical Assistance members are measured against targets for cost and quality.

Over the last 4 years, *Minnesota has saved over \$200 million in health care costs* through these partnerships and seen a 14 percent drop in expensive hospital stays.

Participation in the program has grown every year of the program, from six in 2013 to over 20 in 2017. These providers cover 460,000 Minnesotans, or about half of Minnesota's public health care program population (Medicaid and MinnesotaCare).

Hennepin Health

Hennepin Health is a county-operated Managed Care Organization that targets complex, unmet care needs linked to mental illness and substance use. This innovative care model offers a single point of contact for navigating health and social services and is operated in partnership with the State. Hennepin Health covers about 10,000 Medicaid beneficiaries in the city of Minneapolis and surrounding areas and has done noteworthy work integrating traditional health care with other social services, including housing, food support and behavioral health treatment. A *2016 study tracked 120 homeless members* for whom Hennepin Health had secured housing and found per-person spending on inpatient hospital stays dropped 72 percent and emergency department spending fell 52 percent.

Behavioral Health Homes

Beginning July 1, 2016, behavioral health home services became a Medical Assistance (MA) covered service in Minnesota. This health home model is a provision of the Affordable Care Act that is available to States to serve the needs of complex populations covered by Medicaid. It provides an opportunity to build a person-centered system of care that achieves improved outcomes for individuals and reduced costs to the health care system. Innovative behavioral health home services providers across Minnesota are improving care for Medicaid enrollees who have serious mental health issues.

There are currently 26 behavioral health home services providers certified by the Minnesota Department of Human Services (DHS). The providers integrate their care models by:

- Using a multi-disciplinary team to deliver holistic, coordinated care;
- Addressing individuals' physical, mental, substance use and wellness goals;
- Engaging and respecting individuals and families in their health care, recovery and resiliency;
- Respecting, assessing and using the cultural values, strengths, languages, and practices of individuals and families in supporting individuals' health goals.

Minnesota is still early in this initiative and is still evaluating its outcomes.

2. Identifying ways to reduce administrative overhead and dispute, specifically the bureaucratic warfare between insurance companies and providers over reimbursement.

Managed Care Contracting Reform

In 2011, Minnesota transformed the way it contracts for health care services for Minnesotans on public programs by instituting a competitive bid process for managed care organizations. This process challenged managed care organizations to innovate at the payer level by forcing them to compete against one another for the State's business. Competitively bidding these contracts, along with other managed care reforms, *saved over a billion dollars* in its first round and subsequent rounds of bidding produced an *additional \$650 million in savings*.

Standardized Electronic Billing Transactions

Minnesota requires health plans to submit many of its billing *transactions electronically and in a standardized format*. Standardized data formats encourage insurance companies to compete on quality of care rather than billing processes and reduces administrative overhead.

One area not included in your question about where progress can be made regarding cost containment is prescription drug prices. Prescription drug prices are one of the biggest drivers of health care costs, and utilizing the purchasing power of government programs like Medicare to help drive those costs down would be a welcome step in improving both the solvency of the Medicare program as well as the pocket-books of American citizens.

If you or your staff are interested in more information on these or other initiatives underway in Minnesota, please do not hesitate to ask.

Sincerely,

ALLISON O'TOOLE,
CEO, MNsure.

[Whereupon, at 12:22 p.m., the hearing was adjourned.]

