

**STABILIZING PREMIUMS AND HELPING INDIVIDUALS IN THE INDIVIDUAL INSURANCE MARKET FOR 2018: HEALTH CARE STAKEHOLDERS**

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**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  
HEALTH CARE STAKEHOLDERS

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SEPTEMBER 14, 2017

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**STABILIZING PREMIUMS AND HELPING INDIVIDUALS IN THE INDIVIDUAL INSURANCE MARKET FOR 2018: HEALTH CARE STAKEHOLDERS**

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**THURSDAY, SEPTEMBER 14, 2017**

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

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

Present: Murray, Enzi, Paul, Collins, Murkowski, Scott, Young, Casey, Franken, Bennet, Whitehouse, Baldwin, Murphy, Warren, Kaine, and Hassan.

OPENING STATEMENT OF SENATOR ALEXANDER

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

This morning we are holding our fourth hearing on stabilizing premiums and ensuring access to insurance in the individual health insurance market for 2018.

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

To begin with, we ought not to take for granted the three hearings this committee has had over the last 10 days.

For 7 years, hardly a civil word was spoken between Republicans and Democrats on the Affordable Care Act. It was Trumpcare versus Obamacare, day in and day out. But for the last 10 days, senators from both sides of the aisle have engaged in serious discussion for several hours at a time about what Congress can do between now and the end of this month to help limit premium increases for 18 million Americans next year and begin to lower premiums in the future; and also to prevent insurers from leaving the markets where those 18 million Americans buy insurance.

Last week, between the meetings held before our hearings such as the one we had today and the hearings themselves, for two consecutive days, half of the members of the U.S. Senate participated in bipartisan conversations about getting a result on health insurance.

I want to thank Senator Murray once again for her leadership in helping make that happen. These have been focused hearings, they have been bipartisan hearings, and I think they have been refreshing for most of the members of the Senate who are hungry for that sort of opportunity to see if we can work together to get a result.

At last week's hearings, we heard from State insurance commissioners, then from Governors, and on Tuesday, from experts in State flexibility. During those hearings, three themes emerged, in my opinion, that represent a working consensus for stabilizing premiums in the individual insurance market in 2018.

First, the first theme is congressional approval of continued temporary funding of the cost-sharing payments that reduce co-pays and deductibles for many low-income Americans on the exchanges.

Second, 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.

Third, this was advocated by State insurance commissioners, Governors, and senators from both sides of the aisle to give States more flexibility in the approval of coverage, choices, and prices for health insurance.

Most of the discussion about flexibility has centered on amending Section 1332 State innovation waiver, because it is already a part of the Affordable Care Act.

In looking at 1332, we heard a number of commonsense suggestions about how to improve and speed up the process, such as reducing the 6-month application review period and allowing a copycat application so that if Senator Murray's State gets something approved, why can't Tennessee come along and say, "We want to do what Washington State did with one change?" Such changes will make it easier for States to use 1332 waivers to create programs, like the reinsurance program in Alaska or the invisible high-risk pool in Maine, to help cover higher-cost individuals.

At Tuesday's hearing on State flexibility, witnesses recommended how to amend 1332 to give States the authority to offer a larger variety of health insurance plans with varying benefits and payment rules. That was discussed extensively at our hearing on Tuesday by all five witnesses, and several witnesses suggested that "actuarial equivalency"—they used those two words—is a useful way to do that. That means, in effect, that while States might be able to offer plans with varying levels of benefits, that the value of those plans to consumers has to be similar to the plans currently offered on the Affordable Care Act exchanges or in the individual market.

At our hearing on Tuesday, former Governor Michael Leavitt, a former Secretary of Health and Human Services, suggested that with this approach plans would be of equal value but wouldn't have to be carbon copies of one another.

He used a car as an example. He said if you looked at several \$25,000 cars, one might have a backup camera, one might have more horsepower, but they are still \$25,000 cars. So health plans might have different benefits, but they have to be of the same value to the consumer. He testified that this "actuarial equiva-

lence” would give States, in his words, “the ability to construct an option menu of benefits and provide either the State or even consumers with the ability to choose plans that weigh those differently.”

The Governor of Massachusetts made a similar suggestion last week at our hearing. He said that with current regulations and guidance, 1332 waivers are administered in such a way that Massachusetts cannot offer anything but an existing Affordable Care Act exchange plan.

Governor Baker 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 co-payments and deductibles, with the value of services.”

He continued, “Massachusetts is committed to providing access to quality, affordable health insurance for our residents. Rather than walking away from that commitment, we believe that increased flexibility would allow us to meet this commitment in more effective ways.”

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

I made clear at Tuesday’s hearing, and I want to repeat, that I am not in any way proposing that we change the patient protection guardrails already written in Section 1332, including the pre-existing condition protections—that nobody can be charged more if they have a pre-existing condition and 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 there may be no annual or lifetime limits on your health benefits. That is not a part of the proposal, changing any of that.

Our goal is to see if we can come to a consensus by early next week so that we can hand, Senator Murray and I can hand, with hopefully the support of several Republicans and Democrats, could hand Senators McConnell and Schumer an agreement that the Congress can pass by the end of the month that would help limit premium increases for 18 million Americans next year and begin to lower premiums after that, and to prevent insurers from leaving the markets where these 18 million Americans buy insurance.

So that is our schedule.

Now, what happens if we don’t succeed?

Last year, 4 percent of American counties had one insurance company on the exchange. This year, 36 percent have one insurer on the exchange. For 2018, CMS tells us that one-half of the counties will have one or zero insurers on the exchange. In Tennessee, it is 78 of our 95 counties.

We have heard from the State insurance commissioners that this by itself, this monopoly in so many counties, drives up premiums because it creates those monopolies. Without cost-sharing reductions, as has been pointed out by several senators, the Congressional Budget Office, the Joint Committee on Taxation, and our witnesses have said that premiums will increase an additional 20 percent in 2018.

So premiums go up 20 percent, the Federal debt goes up \$194 billion over 10 years to pay for the higher premiums, and 5 percent of the people will be living in bare counties after just 1 year. That is according to CBO and Joint Tax, and our witnesses.

So let's keep in mind also that even if President Trump wanted to extend the cost-sharing payments, the courts might not allow him to do that, unless we act. The Federal District Court for the District of Columbia has said that the President, whether it is President Obama or President Trump, does not have the authority to continue the cost-sharing reduction payments because Congress never appropriated the funds. That is what the Court said.

I want a result, and a part of a result that limits premiums in 2018 and begins to lower premiums in the future, is flexibility for States in the approval of coverage, choices, and prices.

To get a result, Republicans will have to agree to something many do not want to agree to, additional funding through the Affordable Care Act, and Democrats will have to agree to something that some are reluctant to agree to, and that is more flexibility for States. That is called a compromise.

I simply cannot go to the Republican majority in the Senate, the Republican majority in the House, and to the Republican President to extend the cost-sharing payments without giving States more meaningful flexibility.

Now to today's hearing. Today we are looking at what patients are facing if we do not reach a compromise.

For example, we will hear from a patient, a doctor, and a hospital about what happens when an insurance plan leaves your State, and when you lose your doctor in the middle of your care.

It is clear that to truly protect patients, we need to stabilize the markets, limit premium increases, and begin to lower premiums in the future.

I look forward to the testimony of our witnesses.  
Senator Murray.

#### OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Well, thank you very much, Chairman Alexander. I am really grateful to you for returning us to this committee process, and I think it has been very productive. This is really the way things ought to go and the way we should be getting things done in the Senate, and I really appreciate your leadership in this.

I want to thank all of our colleagues who are joining us today, and our witnesses who are taking time out, as well.

As the Chairman said, this is our last scheduled hearing on bipartisan steps we can take to stabilize the individual insurance market so that millions of Americans will not face higher premiums and fewer coverage options in 2018 and beyond.

I am really pleased that we have had very productive, bipartisan conversations over the last 2 weeks.

In the coffees we have held with our witnesses and in the hearings themselves, we have gotten valuable input from Governors, experts, and members on both sides of the aisle, as well as from Senators who don't serve on this committee but care deeply about making sure our health care system works better.



I am really grateful for all of this input, and I think it indicates an enormous amount of common ground on key issues, so I want to take this opportunity to talk about that in a little bit more detail.

We have heard from many people, including Republican and Democratic witnesses, who see the need for multiple years of certainty on out-of-pocket cost reductions, as well as the need for reinsurance to assist States in strengthening markets.

We have acknowledged the importance of making sure outreach around open enrollment is robust and effective so that families are informed about their coverage options.

I was also glad to hear in Tuesday's hearing that we agree on the need to uphold patient protections in any deal we reach.

I have been glad to hear ideas, inside these hearings and out, for offering more flexibility to States, many of which take approaches that do not undermine our core goal of stabilizing the markets and lowering costs for families.

Governors have suggested ways to speed up and streamline the process in ways that do not result in coverage loss, raise patients' costs, or undermine quality of care.

Insurance commissioners and patients have talked about ways to increase flexibility and actually allow for improvements for patients, but without putting insurance companies back in charge or undercutting core patient protections. So I am really encouraged by that and hopeful we can get a result.

Now, to be clear, some of the proposals I have heard discussed would leave people vulnerable to negative consequences like undermining the essential health benefits or taking us back to a time when plans did not cover maternity care, substance use disorder treatment, mental health, or prescription drugs, and that would be unacceptable, and I do not think either side expects that we settle on those larger issues in this current negotiation.

But I am very confident there is room for common ground right here in the coming days that makes it easier for States to innovate in ways that make health care work better for patients, and I am looking forward to continued discussion on that.

I feel optimistic that there is much more we agree on than disagree on, and I think many of us here today feel the same way. I want to again express my appreciation to all of your work, Mr. Chairman, in getting us to this point.

People across the country are looking to Congress for solutions on health care. It is a deeply personal issue and one that has been far too partisan and divisive for too long. I hope that our conversations over the last few weeks can mark a turning of the page away from that kind of partisanship and that we can take some steps in the next few days in a very short amount of time, and then I hope we keep the conversation going in this committee in the months ahead.

So with that, again, I want to thank all of our witnesses for being here for the coffee this morning, for your input, for your willingness to come and share with us your ideas.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

I am pleased to welcome our five witnesses to today's hearing. I thank each of you for taking the time to testify.

Our first is Dr. Manny Sethi. He's President of Healthy Tennessee and an orthopedic trauma surgeon from Nashville. He and his wife are founders of Healthy Tennessee, a non-profit organization designed to promote preventive health care across the State. He is an assistant professor at Vanderbilt University and the Director of the Vanderbilt Orthopedic Institute Center for Health Policy.

Senator Baldwin, would you like to introduce our next witness?

#### STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Yes. Thank you, Mr. Chairman and Ranking Member.

I am honored to introduce Dr. Susan Turney, CEO of the Marshfield Clinic Health System in Marshfield, Wisconsin. Dr. Turney has a wealth of experience, including as a practicing internal medicine physician. She has also held leadership positions at the Medical Group Management Association and the Wisconsin Medical Society.

Marshfield serves over 1 million rural Wisconsinites through its health system and its insurance plan, Security Health Plan. The population is older, has lower average incomes than most in our State, which is why they have such a critical story to share about the benefits of the health laws' protections, but also why we need to ensure immediate and long-term stability for the Wisconsin market to allow Marshfield to maintain this success.

In fact, Security Health Plan recently expanded in our State to ensure that we would not have a bare county after another insurer left, and we must now do our part and provide long-term Federal certainty.

Dr. Turney, welcome to the committee. Thank you for joining us to share your expertise and experiences. We really appreciate it.

The CHAIRMAN. Thank you very much, Senator Baldwin.

Senator Bennet, would you introduce the next two witnesses, please?

#### STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman.

It really is a privilege to have two people here from my home State of Colorado. Christina Postolowski is the Rocky Mountain Regional Director for Young Invincibles, a non-profit, non-partisan research and advocacy organization working to expand economic opportunity for young adults. Previously, Ms. Postolowski served as a consumer representative to the National Association for Insurance Commissioners. Her work has appeared in national and State news outlets.

Robert Ruiz-Moss serves as Vice President for Anthem, where he oversees the company's individual market business across 14 States, including Colorado. Mr. Ruiz-Moss has extensive experience in health care. In fact, Governor Hickenlooper, who testified before the committee last week, appointed him as an original board mem-

ber of the Colorado Health Benefits Exchange. Mr. Ruiz-Moss is also an alum of the University of Colorado at Boulder.

It has been a good month for our State in the HELP Committee, and I think it has been a good month for our committee overall.

Mr. Chairman, I want to apologize to the witnesses that I have two other hearings this morning, so I am going to be going back and forth. Thank you.

The CHAIRMAN. Thank you, Senator Bennet.

Senator Scott, would you introduce our remaining witness?

#### STATEMENT OF SENATOR SCOTT

Senator SCOTT. Thank you, Mr. Chairman.

It certainly is my pleasure and my honor to introduce Director Ray Farmer to the committee. Since his appointment as Director of South Carolina Department of Insurance in 2012, he has distinguished himself as a steady leader and a humble man of integrity guiding our State through times of uncertainty. A veteran in his field, he comes to us with over four decades of experience, previously serving as a Deputy Insurance Commissioner of the Enforcement Division for the Georgia Department of Insurance, and later as Vice President of the American Insurance Association.

Over the course of his career, Director Farmer has been recognized numerous times for his contributions to the public good. He was recently elected as Secretary-Treasurer for the National Association of Insurance Commissioners, affording him insight into the challenges of the insurance industry across the country.

His profound knowledge base, extensive experience, and core values have made him an indispensable resource for me, my staff, and our State. I am grateful to have him here with us today, and I look forward to your testimony, Director Farmer.

The CHAIRMAN. Thank you, Senator Scott.

Now we will ask the witnesses each to take about 5 minutes and please summarize your testimony, and then we will go to a round of questions from the senators.

Let's start with Dr. Sethi.

#### **STATEMENT OF MANNY SETHI, M.D., PRESIDENT, HEALTHY TENNESSEE, ORTHOPEDIC TRAUMA SURGEON, NASHVILLE, TN**

Dr. SETHI. Well, good morning, Chairman Alexander, Senator Murray, and distinguished members of the committee. Thank you so much for the invitation to discuss the very serious challenges Tennesseans are facing in obtaining health insurance.

I currently serve as the President of Healthy Tennessee, a non-profit organization that my wife and I founded over 7 years ago. Our mission has been to improve the lives of Tennesseans through preventative care by way of online education, statewide symposiums, and free health fairs for those in need. I am also a practicing orthopedic trauma surgeon at a major academic medical center, and today I speak on my own behalf.

I am a product of rural Tennessee and the American Dream. My parents were both immigrants from India and doctors in the small town of Manchester. I learned my first lessons about health riding

shotgun in my dad's blue 1980 Oldsmobile as he would make house calls.

Thirty years have passed since that time, but we continue to rank near the bottom for almost every chronic health condition, an issue that is central to the survival of the individual market in our State. We certainly face many health challenges in Tennessee, but one problem is certainly not a dearth of government funding. In fact, last year alone we spent \$12 billion, with a "B," 33 percent of our State budget, on Medicaid. We must get on the front side of this problem with prevention before it is too late.

Our organization has traveled across Tennessee, one community at a time, hosting free preventive health screenings for those in need and educating citizens about the benefits of living a healthy lifestyle. Our efforts are all powered by local communities, an all-volunteer army of local nurses and doctors with boots on the ground who give of their time to help a neighbor in need.

From rural Appalachia all the way to Memphis, we have seen patients who can no longer afford the rising premiums of the individual market, many who suddenly lost coverage when an insurer pulled out. My dad always used to tell me, "People don't care what you know until they know that you care." So at our events, we always start with a lot of listening. We spend months meeting local community leaders in each area we visit to determine the best path forward.

I will never forget this trucker I met in Hawkins County. His blood pressure was 200 over 100, which is out of control, and his body mass index was 50, indicating severe obesity. As I spoke with this gentleman, I heard the story of a very proud and hard-working man who just wanted to make ends meet. He didn't want a hand-out.

But here is the problem: His income was too high for a subsidy on the individual market, and he just simply could not afford the insurance or a basic blood pressure pill. With premiums rising over 139 percent in 3 years, like so many Tennesseans, he was priced out of coverage. We started to talk about diet, about weight loss, physical activity modification, and other conversation measures that would help him. As our conversation progressed, I could really see the light bulb turn on. He understood.

Now, personally, I believe that repeal and replace was our best option to achieve a more patient-centered system. But today we find ourselves in a moment when the individual insurance market is in critical condition, and we must take action rapidly. I view the potential solutions to this problem through the lens of a trauma surgeon.

First, we must stop the bleeding, and then we can make health care healthy again. We have to take three steps fast. First, as you have heard over the last 2 weeks, let's continue the cost-sharing reduction program. Premiums are skyrocketing in our State as insurers fear they are going to be left to bear the cost.

Second, let's continue to create Federal reinsurance program risk pools and allow individuals with serious chronic conditions to get coverage and allow more affordable options for younger, healthy patients.

Third, I believe that a one-size-fits-all program made right here in Washington, DC, just doesn't fit the needs of Tennesseans. Open the door to innovation and allow States to create their own insurance products like catastrophic coverage for all.

But in the longer term, to tackle this crisis we must focus on the rising costs of health care and emphasize incentivizing healthy behaviors and placing more transparency around cost. For example, I believe that health savings accounts send a very powerful message to consumers about wellness and accountability. We must also transition health care reimbursement toward a value-based model that incentivizes better outcomes. Finally, we need to be less talk and more action about prevention. More spending will not solve this problem.

To make real progress, we must empower local communities and not the Federal Government to create local solutions. If we trust our citizens, we will meet with success. It is very simple: people want to help people. I have seen it across Tennessee.

Thank you so much for allowing me to share my story with you. It is an honor to be here.

[The prepared statement of Dr. Sethi follows:]

PREPARED STATEMENT OF MANNY K. SETHI

SUMMARY

Throughout the last decade, Tennessee has consistently found itself ranking near the bottom of all States in terms of the health of its citizens. Recent statistics show that 13 percent of the adults in Tennessee have diabetes (we rank 46th), 34 percent are obese (we rank 42nd) and almost 39 percent of the adult population in Tennessee has high blood pressure (we rank 44th). Surely we can do better, but the statistics speak for themselves and the people of Tennessee face daunting threats to health and wellness.

Our struggles to get healthy in Tennessee are directly related to the challenges we face in the individual insurance market. Seventy-eight of ninety-five counties have one insurer remaining. In 1 year, coverage rates have jumped anywhere from 44 percent to 62 percent. Some families are paying as much as \$3000 per month and have seen an increase of \$1000 in their monthly rates. In fact, over the past 3 years, premiums have risen by more than 139 percent.

Healthy Tennessee is a non-profit (501c3) organization that seeks to improve the lives of Tennesseans through preventative care by way of online education, statewide symposiums, and free health fairs for those in need.

Our organization has traveled across Tennessee, one community at a time, hosting preventative health screenings and educating patients on the benefits of a healthy lifestyle. Our efforts are powered by local communities; an all-volunteer army of local nurses and doctors with boots on the ground, who give of their time to help a neighbor.

We have cared for folks who can no longer afford the rising premiums of the individual market, and people who have suddenly lost coverage when an insurer pulled out. We have attempted to get on the front end of health problems with prevention by educating citizens on their own health. Our events focus on encouraging conservative measures to improve overall wellness such as modifications in diet, weight loss, and physical activity.

There are three steps to be taken in the short-term to rescue the individual insurance market. First, we must continue the cost sharing reduction program. Second, we must quickly create risk pools for those individuals with serious chronic conditions, reducing premiums for young, healthy citizens. Third, I believe we must open the door for innovation and allow more flexibility for States to create their own insurance products.

In the longer-term, to tackle this crisis we must focus on the rising costs of healthcare with an emphasis on incentivizing healthy behaviors and creating more transparency around pricing. For example, health savings accounts send a powerful message about wellness to the consumer. We must also transition healthcare reimbursement toward a value based care model to incentivize improved outcomes.

We must be less talk and more action about prevention. To make real progress, we must empower communities and not the Federal Government to create local solutions. If we trust our citizens, we will meet with success. People want to help people; government just needs to get out of their way.

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#### INTRODUCTION

Good Morning Chairman Alexander, Ranking Member Murray, and distinguished members of the committee. Thank you for the invitation to speak about the ongoing and serious challenges Tennesseans are facing in obtaining and maintaining health insurance.

I currently serve as President of Healthy Tennessee, a non-profit organization that my wife and I co-founded 7 years ago. Our mission has been to improve the lives of Tennesseans through preventative care by way of education, statewide symposiums, and free health fairs for those in need. I am also a practicing Orthopaedic Trauma surgeon at an academic medical center, and today I speak on my own behalf.

#### THE CHALLENGES IN TENNESSEE

I am a product of rural Tennessee and the American Dream; my parents were both immigrants from India and doctors in the small town of Manchester. I learned my first lessons about health in our State as a boy, sitting shot-gun in my dad's blue 1980 Oldsmobile as he made house calls.

Thirty years have passed, but we continue to rank near the bottom for almost every chronic health condition. Recent statistics show that 13 percent of the adults in Tennessee have diabetes (we rank 46th), 34 percent are obese (we rank 42nd), and almost 39 percent of the adult population in Tennessee has high blood pressure (we rank 44th).

Our struggles to get healthy in Tennessee are directly related to the challenges we face in the individual insurance market. Seventy-eight of ninety-five counties have one insurer remaining. In 1 year, coverage rates have jumped anywhere from 44 percent to 62 percent. Some families are paying as much as \$3000 per month and have seen an increase of \$1000 in their monthly rates. In fact, over the past 3 years, premiums have risen by more than 139 percent.

There are obviously many health challenges in Tennessee, but the problem is certainly not a dearth of government spending. In fact, last year we spent \$12 billion dollars, 33 percent of our State budget, on healthcare. The opportunity costs of this spending are enormous and come at the expense of investments in education and infrastructure. Instead, we must focus on getting on the front side of this problem with prevention before it's too late.

Over the last 7 years our organization has traveled across Tennessee, one community at a time, hosting preventative health screenings and utilizing patients' own information to educate them about their health. Our efforts are powered by local communities across Tennessee; an all-volunteer army of local nurses and doctors with boots on the ground who give of their time to help a neighbor.

#### OUR EXPERIENCES

From rural Appalachia to Memphis, we have seen patients who can no longer afford the rising premiums of the individual market—many have in fact opted to pay the tax penalty. We have cared for families in rural counties who have lost their coverage all together when an insurer pulled out. We hear these stories from hundreds of folks who attend our fairs.

I have personally cared for patients who were victims of near life ending trauma. Together after multiple surgeries and clinic visits, we built the bonds of trust that come with time, when suddenly these individuals found their insurance coverage canceled. Having to play by the rules of the one insurer remaining in their county, they were forced to find a new doctor. I had an unbreakable bond with these patients, but it all changed due to circumstances out of our control. I just don't think that's right.

My dad always told me, "People don't care what you know until they know that you care." So, at our health events we start with a lot of listening. In fact, we spend months meeting local community leaders to understand the best path forward in each area we visit.

I will never forget the trucker we met in Hawkins County. His Body Mass Index (BMI) was over 50, consistent with severe obesity, and his blood pressure was out

of control, measuring 200/100. As I spoke with this gentleman, I heard the story of a very proud and hardworking Tennessean who struggled to make ends meet and didn't want a hand out. His income was too high for a subsidy on the individual market and he just simply couldn't afford the insurance, or a basic blood pressure pill for that matter.

With premiums that have doubled since 2014 and no government subsidy, he was priced out of coverage like so many of our citizens. Rising premiums led to 30,000 Tennesseans leaving the individual market last year alone.

Together, we discussed diet, weight loss, and physical activity as conservative measures to help him. As our conversation progressed, I could see the light bulb turn on. He understood.

#### POTENTIAL SHORT AND LONGER-TERM SOLUTIONS

I personally believe that repeal and replace was our best option to find a more patient centered system that offers greater access and patient choice at affordable rates. But now, we find ourselves in a moment where the individual market in Tennessee is in critical condition and on the verge of collapse. We must rapidly take action, and I view the potential solutions through the lens of a trauma surgeon. We must first stop the bleeding, then work on getting healthcare healthy again.

We must take three steps immediately. First, in order to stabilize the insurance markets, we must continue the cost sharing reduction program (CSR). Premiums are rapidly rising as insurers fear they will be left bearing the costs. These soaring costs are forcing young members out, saturating the market with higher-need and higher-cost patients, and further escalating prices in a troublesome cycle.

Second, we must quickly create risk pools for those individuals with serious chronic conditions, allowing more affordable coverage options for young, healthy citizens.

Third, I believe a one size fits all plan from Washington D.C. doesn't meet the needs of Tennesseans. Open the door for innovation and allow more flexibility for States to create their own insurance products. For example, a catastrophic plan should be available regardless of age or income status, which is currently not the case.

In the longer-term, to tackle this crisis we must focus on the rising costs of healthcare with an emphasis on incentivizing healthy behaviors and creating more transparency around pricing.

For example, health savings accounts send a powerful message about wellness to the consumer. We must also transition healthcare reimbursement toward a value based care model to incentivize improved outcomes.

Finally, we need less talk and more action about prevention—more spending won't fix this problem. What ever happened to common sense approaches? What's wrong with using our resources on the front end to prevent chronic diseases from developing, instead of wasting billions of dollars when it's too late?

#### CONCLUSIONS

To make real progress, we must empower communities and not the Federal Government to create local solutions. If we trust our citizens, we will meet with success. People want to help people; government just needs to get out of their way.

It is an honor to be with you today. Thank you for this opportunity, and I look forward to answering any questions you may have.

The CHAIRMAN. Thank you, Dr. Sethi.

Dr. Turney, welcome.

#### **STATEMENT OF SUSAN L. TURNEY, MD, MS, FACP, FACMPE, CHIEF EXECUTIVE OFFICER, MARSHFIELD CLINIC HEALTH SYSTEM, INC., MARSHFIELD, WI**

Dr. TURNEY. Thank you very much. I'd like to thank you, Chairman Alexander, and also Senator Murray, and the rest of the committee, and your tireless staff, for organizing these hearings to really look for a bipartisan means to address health coverage in the individual and in the small group market.

Marshfield Clinic Health System is made up of several organizations, including a research foundation, a multi-specialty physician-based practice with several hospitals, and an insurance subsidiary

that is known as Security Health Plan. We do provide coverage throughout most of Wisconsin and commercial Medicare and Medicaid markets. Our health system has over 1.4 million patient encounters annually and does see patients from all 72 counties in the State.

As Senator Baldwin mentioned, we serve a population that is older and poorer than the rest of Wisconsin, with a large portion of the population served by public health programs.

Since the passage of the ACA, we have reduced the number of uninsured that we see by nearly 50 percent, from over 13,000 to under 7,000 patients; and at the same time, with the unique approach that the State of Wisconsin took implementing the ACA to ensure that there were no gaps in coverage, this has resulted overall in decreasing the number of uninsured across the State by 40 percent.

Our health plan, Security Health Plan, does participate in the exchange marketplace, and we have enrolled nearly 30,000 residents in the plan. It is important to note that nearly 95 percent of those who enroll in this product receive subsidies to cover the cost of their health insurance, and over half receive the cost-sharing reduction subsidy.

Well, we all agree that the ACA is not perfect, but before it was implemented we saw much larger variations in the health insurance for our patients, and many of the products that were sold on the market were substandard, not covering medications, certain procedures, hospitalizations or pre-existing conditions. These items have significantly stabilized and have helped reduce the cost for our patients, as well as for the health care industry at large.

Regulatory relief that was offered earlier this year by Secretary Tom Price at HHS gave insurers tools to better manage their ACA individual population, but we do have several suggestions, and you're certainly going to hear a theme here.

First of all, we believe that fully funding the cost-sharing reduction payments is extremely important. Security Health Plan's ACA individual population, as I already noted, is heavily dependent on the cost-sharing reduction, subsidies that are paid monthly, to help our patients decrease the amount that they have to pay out-of-pocket. We recommend that Congress fully fund CSR payments to health insurance carriers for 2018 and beyond, and allow States that have already reached their filing date to reopen the bids so that we can allow for that appropriate adjustment rate, and we will make it happen.

Second of all, we need to re-extend the reinsurance program. The transitional reinsurance program that was established by the ACA did help us significantly, and it helped control and bring down premiums for the 3-years that it was in existence. Our plans show that without this reinsurance, in 2014 rates would have been 20 percent higher, and in 2015 they would have been 12 percent higher.

We recommend that Congress create a reinsurance program similar to that which expired so that we can stabilize premiums in that individual market for the long term.

Third, we want to make sure that we reinstate the enrollee outreach programs. It is really critical that that happen. We cover



25,000 square miles. We have very limited resources in our communities, and health insurance and the subsidies that are available to help our area residents afford the coverage is a very complex and confusing topic for them. We recommend that the Navigator services should be reinstated and that the funds should be prioritized to these rural areas for community outreach.

We will need to continue to alter our health care system. We need to meet the future needs of the American people, and we believe that these recommendations would be a big step in meeting those needs.

Thank you for your time, and after we present I'd be happy to answer any questions.

[The prepared statement of Dr. Turney follows:]

PREPARED STATEMENT OF SUSAN TURNEY

SUMMARY

This testimony will discuss the Marshfield Clinic Health System's experience with the Affordable Care Act (ACA) individual market, both on and off the Federal marketplace, and our perspective as a rural health system caring for this population.

MCHS is made up of several organizations, including: a research foundation, a multi-specialty physician-based practice with several hospitals, and an insurance subsidiary known as Security Health Plan providing coverage throughout Wisconsin in commercial, Medicare and Medicaid markets. Our Health System has over 1.4 million patient encounters annually and sees patients from every county in Wisconsin.

MCHS serves a population that is older and poorer than the rest of Wisconsin. In many communities a large portion of the population is covered by public health programs. The subsidization of health coverage for low income Wisconsinites under the ACA has helped mainstream tens of thousands into traditional commercial coverage through the Health Insurance Marketplace. The State of Wisconsin took a unique approach to the implementation of the ACA that has resulted in the uninsured rate dropping by nearly 40 percent. In many of the areas we serve there are very few large employers, so the population has been dependent on the individual and small group insurance market to achieve health coverage. SHP participates in the exchange marketplace and has enrolled 28,000 residents in ACA plans. Between 95 and 98 percent of those who enroll in our Health Plan's insurance through the Health Insurance Marketplace receive subsidies to cover the cost of their health insurance.

**Stabilizing the market**—Regulatory relief offered earlier this year by Secretary Tom Price at HHS gave health insurers tools to better manage their ACA individual population, but those reforms didn't go far enough to fully stabilize the market. We believe that the suggestions below will improve the ACA and ensure coverage for vulnerable populations.

- a. *Cost sharing reduction payments*—SHP’s ACA individual population is heavily reliant on the cost sharing reduction (CSR) subsidies paid monthly to help our members lower their out-of-pocket costs. Nearly half of the total enrollment in SHP’s ACA products is eligible and enrolled in this important program. We recommend that Congress should fully fund CSR payments to health insurance carriers for 2018 and beyond and allow States that have already reached their filing deadline to reopen carrier’s bids to allow for an adjustment to rates.
- b. *Extension of the reinsurance program*—The transitional reinsurance program established by the ACA helped to hold down premiums in 2014, 2015 and 2016. Our Plan’s experience shows that premiums would have been nearly 20 percent higher in 2014 and 6 percent higher in 2015, had this program not been in effect. We recommend that Congress create a reinsurance program similar to the program that expired in 2017 to stabilize premiums in the ACA individual market for the long term.
- c. *Continuous coverage provision*—The ACA provisions that provide for a 3-month grace period and avoid tax penalties has created a perverse incentive for enrollees to stay insured for just enough time to avoid the penalty. We recommend that Congress should create a continuous enrollment provision or late enrollment penalty similar to Medicare’s Part B and Part D to incentivize 12 month enrollment in the ACA individual market.
- d. *Risk adjustment program enhancements*—We recommend that HHS’ risk adjustment program should pay carriers a capitation for members whose risk scores exceed a certain predefined value. Lower-than-current future rate increases would reduce expenditures for the advanced premium tax credits.
- e. *Federal funding for enrollee outreach*—Health insurance and the subsidies available to help area residents afford coverage is a complex and confusing topic. We recommend that navigator services should be re-instated and funds prioritized to rural areas for community outreach.

There is no doubt that the Affordable Care Act has flaws. There are aspects of the law that will need to be continually altered to meet the future health care needs of the American people. Our objective in this testimony is to offer resolutions that will immediately help to stabilize the market and ensure that our patients and members continue to have access to the care they need.

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TESTIMONY

On behalf of the physicians and staff and patients of Marshfield Clinic Health System (MCHS) I am honored to make the following statement. Throughout my comments I will be discussing our Health System’s experience with the Affordable Care Act (ACA) individual market, both on and off the Federal marketplace, and our unique perspective as a rural health system caring for this population.

The ideas that we offer in the following testimony are what we believe will have the greatest impact on stabilizing the market in the short and long term. The ideas presented are not partisan. Instead, they seek a higher ground for our discussion focused on how we can best help the patients and members we serve maintain health coverage to ensure the best possible health care outcomes.

I. A HISTORY OF CARING FOR RURAL WISCONSIN

The mission of MCHS is to enrich our patients’ lives by creating healthy communities through accessible, affordable and compassionate health care.

MCHS is made up of several organizations, including: a multi-specialty physician-based practice with several hospitals in various stages of development and construction, and an insurance subsidiary providing coverage throughout Wisconsin in commercial, Medicare and Medicaid markets. We have 663 physicians and 400 non-physician providers across 80 medical specialties and more than 9,000 staff MCHS has over 1.4 million patient encounters annually and sees patients from every Wisconsin county, every State in the United States and nearly 30 Foreign Nations.

There are many examples of how MCHS has been innovative in serving the care needs of our rural service area. Below are some recent examples that demonstrate our commitment to defining the future of health care services for our patients:

- **Precision Medicine Program:** Three Wisconsin-based medical and scientific organizations—Marshfield Clinic Research Institute, University of Wisconsin School of Medicine and Public Health and Medical College of Wisconsin—have collectively been awarded more than \$5 million to help implement in Wisconsin the National Institutes of Health’s (NIH’s) *All of Us* Research Program that aims to benefit communities across the country.

The *All of Us* Research Program is an ambitious nationwide effort to advance research into precision medicine, an approach for disease treatment and prevention that takes into account individual variability in biological makeup, environment and lifestyle for each person. The Wisconsin awardees will use their collective resources to enroll interested individuals and gather health information to help researchers understand how these factors can help determine how to best prevent or treat disease.

- **Comfort and Recovery Suites:** MCHS expanded its ambulatory surgery centers in Marshfield, Eau Claire and Wausau, Wisconsin to include comfort and recovery suites for post-surgical procedures performed in their ambulatory surgical centers. The comfort and recovery suites offer the same high-quality, post-operative care received in a hospital but at a considerably lower cost. This approach has saved the MCHS insurance subsidiary, Security Health Plan, more than \$1 million in just under 2 years and patient satisfaction is extremely high with an average rating between 4.5 and 5 on a 5-point scale.

- **Dental Care Program:** The Marshfield Clinic Dental Initiative has improved the overall health care for the population we serve by providing clinical and economic value to patients and communities. The program is comprised of ten dental centers with 41 dentists and 39 hygienists. This staff provides dental services to almost 90,000 patients from all 72 counties in Wisconsin. The dental centers serve all patients, whether Medicaid, Medicare, commercially insured or uninsured, with a sliding scale fee so that everyone can have access to dental care. As an indicator of the importance of this dental care, we have documented evidence that when we open a dental center in an underserved community the incidence of ER visits due to dental problems drops dramatically.

- **Behavioral Health Integrated Care Model:** MCHS experiences difficulty in recruiting clinical psychiatrists, despite overwhelming demand for these services. In order to serve the unmet needs of patients and increase access to care, Marshfield Clinic developed the Behavioral Health Integrated Care Model. This care delivery model improves the value of care delivered by encouraging appropriate patients to be managed by a primary care physician and integrated care coordinator, rather than using more costly services.

MCHS is currently collecting outcomes data to demonstrate changes in depression and anxiety symptoms for patients enrolled in the integrated care model. While the outcomes have not yet been validated, the evidence suggests that we will see:

- A reduction in patient claims for behavioral health treatment
- A reduction in ER visits
- A decrease in visits to primary care

The health system is working with Security Health Plan to determine the overall change in cost of care for patients after 18 months in the program.

For more than 100 years, MCHS has been living our mission of enriching lives in Wisconsin through accessible, affordable and compassionate health care. As we embark on our second century, we look forward to building on our past successes and continuing to innovate, maximize efficiencies and reduce patient costs while providing even higher quality care and a great patient experience.

## II. CHALLENGES OF SERVING RURAL WISCONSIN

MCHS serves approximately one million residents across our rural service area. Residents in our area have an average annual income of approximately \$42,000 for a family of four, which is below the State average of more than \$66,000. In addition to lower than average incomes, we also have an older population than the State average. In ten of the 31 counties that we serve there are fewer than two workers per Medicare beneficiary and in the balance of our service area there are three.

While these statistics do not tell the whole story, what they show is that in our communities, a large portion of the population is covered by public health programs. The subsidization of health coverage for low income Wisconsinites under the ACA has helped bring tens of thousands into traditional commercial coverage through the Health Insurance Marketplace. This has been vital to the health of our patients.

Wisconsin took a unique approach to the implementation of the ACA that has resulted in the uninsured rate in the State dropping by nearly 40 percent. Wisconsin expanded Medicaid to every resident under 100 percent of the Federal Poverty Level

in 2014, which ensured there was no gap in available coverage, unlike other States that did not accept Medicaid expansion. Those who did not have employer health benefits were covered by the ACA individual market and the subsidies available. This approach helped to minimize the cross subsidization health care providers often have to implement to offset the losses they experience in providing care to Medicaid recipients. The reduced cross subsidization resulted in keeping employer health insurance increases more moderate. Overall, Marshfield Clinic Health System's experience in the way Wisconsin structured its insurance market has been positive and has resulted in more residents achieving coverage.

In many of the areas we serve there are very few large employers, so the population has been dependent on the individual and small group insurance market to achieve health coverage. This market was subject to large variations in the cost of health insurance before the ACA. Many of the insurance products available prior to the implementation of the ACA's annual limitations on cost sharing and elimination of annual and lifetime maximums were substandard and did not adequately cover expensive services such as medications, certain hospitalizations and pre-existing conditions.

The ACA made several important changes which stabilized the market in a way that has been beneficial to the patients that we serve. We might also add that this area is very well served by multiple, high-quality insurance carriers that compete on the Health Insurance Marketplace so there is competition between and among the carriers that holds premium cost increases below national averages, accruing to the benefit of consumers.

MCHS's insurance subsidiary, Security Health Plan, participates in the exchange marketplace and has enrolled 28,000 residents in ACA plans. Between 95 and 98 percent of those who enroll in our Health Plan's insurance through the Health Insurance Marketplace receive subsidies to cover the cost of their health insurance.

In the communities we serve, 57 percent of enrollees in Security Health Plan's products are older than age 50.

- 7 percent are Under 21
- 9 percent are 21–29
- 13 percent are 30–39
- 14 percent are 40–49
- 27 percent are 50–59
- 30 percent are 60+

This population of enrollees is dramatically different than the population Security Health Plan covered prior to the ACA. This has resulted in an increased use of services to care for the chronic conditions of the population, resulting in higher costs to the health care system and higher premium increases.

During this same time our population of patients covered by Medicaid decreased from 66,197 to 55,910—a reduction of 14.3 percent. We believe that a large percentage of these patients migrated into the exchange market. In order for these individuals to maintain coverage it will be important that there be a mechanism that allows them to afford health care on an out-of-pocket basis.

Additionally, prior to the enactment of the ACA we provided high volumes of uncompensated services. MCHS receives and treats all patients regardless of their ability to pay, and it was our experience that in 2012, before the implementation of the ACA, we were treating 13,277 residents who were uninsured and whose ability to pay for the care they received was limited. In 2016, our most recent tally of individuals without any insurance or ability to pay had dropped to 6,948, nearly a 50 percent reduction in the number of uninsured patients we serve.

As a community-based organization, our objective has been to find a way to get the population covered and promote an awareness of prevention of disease in the community.

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### III. OUR PHILOSOPHY

Throughout the repeal and replace debate, MCHS has maintained that it is imperative the individual market remain a stable, viable option for people to get and maintain health care coverage. In Wisconsin, the uninsured rate has been reduced by nearly 40 percent, in part because there are many more thousands of people who have newly attained coverage through the ACA individual market.

In 2014 and 2015, Security Health Plan was the largest carrier of ACA products in Wisconsin. Today, we remain in the top three. This is primarily because, as we noted earlier, we serve a largely rural and lower income portion of Wisconsin. The subsidies off red to lower income enrollees are a critical lynchpin in our patients' and members' ability to secure health insurance coverage.

Unlike stand-alone health insurers and their contracted providers, integrated delivery systems like Marshfield Clinic Health System and Security Health Plan have the unique ability to serve this market in a way that is economically practical as well as perfectly aligned with our mission to enrich lives through accessible, affordable and compassionate health care.

We believe the current instability in the ACA individual market will cause more of our community members to forego coverage and Marshfield Clinic Health System's mission of caring for our communities no matter a patient's insurance status puts us as a rural health system at greater risk if this occurs. Our community members who are uninsured will show up in our ERs, urgent cares and provider offices as uncompensated care in the short term. In the long term, uninsured residents will end up in our Health Plans Medicare products, or Medicaid products, or even more inspirationally, in their group commercial products after seeking gainful employment. If these patients don't have continuity of care, they will have higher costs in the future because their care needs haven't been adequately met.

Most recently, our Health System renewed its commitment to this market by filing the second to last remaining county in the United States in the ACA individual market. This was a decision that allowed us to live our mission and step up to serve the community at a time when other health insurers are stepping back. We remain committed to the ACA individual market and patients and members that rely on it to ensure they can maintain their best health.

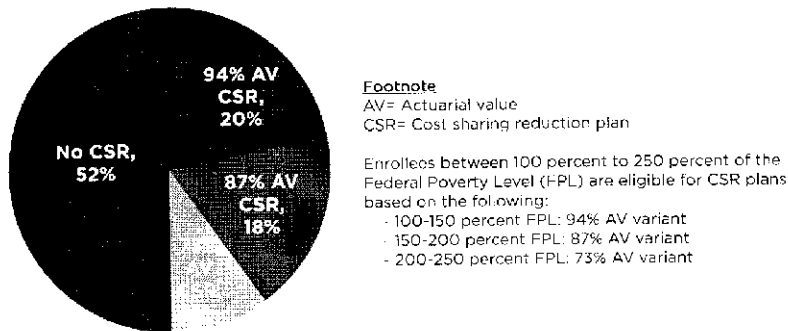
IV. STABILIZING THE MARKET

It's through the lens of our organizational philosophy that we offer a perspective unlike most other health systems or stand alone health insurance carriers on fixes that would stabilize the ACA individual market over the long term.

Some of the regulatory reliefs offered earlier this year by Secretary Tom Price at Health and Human Services did assist in giving health insurers tools to better manage their ACA individual population, but those reforms didn't go far enough to fully stabilize the market. We believe that the ideas outlined below give us the greatest chance to build on the base of the ACA and ensure continued coverage for the vulnerable population served by our Health System.

a. Cost sharing reduction payments

Security Health Plan's ACA individual population is heavily reliant on the cost sharing reduction (CSR) payments paid monthly to help our members lower their out-of-pocket costs when they use health care services. As you can see in the chart below, nearly half of the total enrollment in Security Health Plan's ACA products is eligible and enrolled in this important program. And nearly 40 percent of our total population is enrolled in the lowest income bracket of between 100 percent to 200 percent of the Federal Poverty Level who receive the highest amount of CSR subsidy.



Like many States, Wisconsin's Office of the Commissioner of Insurance created certainty where there was none by instructing carriers to assume that CSR payments will not continue in 2018. Non-payment of the subsidy has a profound impact to the rates insurers, including Security Health Plan, will charge. The assumption

of non-payment of the CSR subsidy has pushed Security's rate increase to double over what it would have been if CSR payments would continue as promised.

Because our filed rates for 2018 assume CSRs will not be paid, the population of enrollees that will be primarily impacted are those above 400 percent of the Federal Poverty Level who don't receive either advanced premium tax credits or cost sharing reduction subsidies. These enrollees are subject to the full force of these substantial, and completely unnecessary, rate increases.

Finally, we take exception to the implication that these CSR payments are a "bail-out to insurance companies." The CSR payments are simply a pass-through payment to providers, with no financial benefit to health insurers. Health insurers are simply the mechanism by which these payments are made to providers on behalf of members who receive these subsidies. Continuing funding for the program is fulfilling the promise the Federal Government has made to these enrollees.

**Recommendation: Fully fund CSR payments to health insurance carriers for 2018 and beyond and allow States that have already reached their filing deadline to reopen carrier's bids to allow for an adjustment to rates.**

*b. Extension of the reinsurance program*

Offsetting high-cost claims through reinsurance is a well-established mechanism to protect against unanticipated losses and resulting premium increases; it has worked effectively for programs including Medicare's prescription drug program.

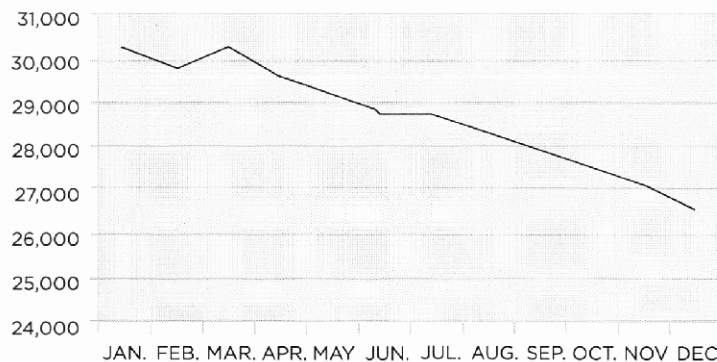
The transitional reinsurance program established by the ACA achieved its intended outcomes of holding down premiums in 2014, 2015 and 2016. Our Health Plan's experience shows that premiums would have been nearly 20 percent higher in 2014 and 12 percent higher in 2015, respectively, had this program not been in effect.

A continuation of the reinsurance program would stabilize the market and reduce premiums for everyone enrolled (both on and off the Federal marketplace).

**Recommendation: Create a reinsurance program similar to the program that expired in 2017 to stabilize premiums in the ACA individual market for the long term.**

*c. Continuous coverage provision*

One of the struggles that health insurance carriers have faced in this market is the stability of population who are insured. The 3-month grace period provision for those covered by the advanced premium tax credit aligns with the individual mandate provision that someone can have up to 3 months of being uninsured and still avoid the tax penalty. This has created a perverse incentive for enrollees to stay insured for just enough time to avoid the penalty. The chart on the next page shows our experience in 2016, which is strikingly similar to the experience in each of the previous years.



In order to create aligned incentives between the enrollee and the health insurer, the solution would be to create a continuous enrollment provision or late enrollment penalty similar to Medicare's

Part B and Part D. If enrollees failed to maintain coverage for at least the previous 12 continuous months, the health insurance carrier could institute a late enrollment penalty. The key to making this effective is creating a level playing field for the penalty across all health insurers to ensure that additional unintended consequences were not created.

This provision isn't just for the benefit of health insurers and their risk tolerance, but as an integrated delivery system, we know that when patients have an ongoing relationship with their care provider that is facilitated through continuous health insurance coverage, patient outcomes are improved.

**Recommendation: Establish a late enrollment penalty and/or a continuous enrollment penalty to incentivize 12 month enrollment in the ACA individual market.**

*d. Risk adjustment program enhancements*

The current risk adjustment program is intended to transfer funding from health insurers that have lower risk enrollees to health insurers that have higher risk enrollees. Each year, the program has a net neutral impact to the Federal budget because transfers between carriers net to zero.

In actual experience, the risk adjustment program seems to be transferring funds from rural markets into urban markets and from new insurance carriers to established insurance carriers. These transfers, although supported by the complex risk adjustment formula, are not operating in the original intent of the program.

As an enhancement to this program, we would suggest that risk adjustment not be budget neutral, but instead be structured similarly to Medicare Advantage risk adjustment. In Medicare Advantage, the Centers for Medicare and Medicaid Services pays an increasing amount of capitation to health insurers based on the number of health conditions a particular enrollee has. This program more equally compensates health insurance carriers for the risk of the enrollees in its population.

Understanding that the ACA individual market and the Medicare market are inherently different in the amount of risk assumed by the Federal Government, we would suggest a scaled back program that offers some additional funding based on the chronic conditions of each enrollee instead of the insurance market as a whole within a State.

A program like this, coupled with the temporary reinsurance program noted previously, would hold premium increases in check. By keeping health insurance premium increases at a lower annual increase than is currently projected, the Federal Government could net savings for this program through lower future payments of the advanced premium tax credits.

**Recommendation: Enhance the risk adjustment program to pay carriers a capitation for members whose risk scores exceed a certain predefined value. Savings from this program would be captured from lower-than-current future rate increases that would reduce Federal expenditures for the advanced premium tax credits.**

*e. Federal funding for enrollee outreach*

Health insurance and the subsidies available to help area residents afford coverage are complex and confusing topics. Because of this, Marshfield Clinic Health System has invested in having more than 25 certified application counselors onsite at our busiest centers. This service is a critical resource for the community in helping patients, especially the uninsured, understand the coverage options available to them.

Because our program is funded by the System's Family Health Center through a grant from the Health Resources and Services Administration, it is not in jeopardy from the recently announced cutbacks to outreach activities. However, through our own experience, we have found how important these programs are to lowering the uninsured rate in our communities.

Even with our strong commitment to promoting coverage availability, we cannot serve this need alone and we rely on the other community organizations that receive this funding to fill the gaps.

**Recommendation: Reinstate funding for navigator and assistor programs and prioritize dollars to rural areas for community outreach of insurance options.**

## V. CONCLUSION

There is no doubt that the Affordable Care Act has flaws. There are aspects of the law that will need to be continually altered to meet the future health care needs of the American people. The goal in my testimony is to offer solutions that will immediately help to stabilize the market and ensure that our patients and members continue to have access to the care they need.

Thank you to the committee for offering us the opportunity to provide our point of view on this important topic.

The CHAIRMAN. Thank you, Dr. Turney.

Mr. Ruiz-Moss, thank you for coming today.

**STATEMENT OF ROBERT RUIZ-MOSS, VICE PRESIDENT,  
INDIVIDUAL MARKET SEGMENT, ANTHEM INC., DENVER, CO**

Mr. RUIZ-MOSS. Thank you, Chairman Alexander, Ranking Member Murray, and members of the committee. I am Vice President of Individual Business at Anthem. It's a privilege to appear before you today to share Anthem's recommendations on how we can work together to bring stability to the individual health insurance market and promote our common goal of making high-quality, more affordable health care accessible for all.

Based on Anthem's vast experience and expertise, we feel uniquely positioned to offer our perspective. For more than 75 years, we have been focused on caring for America's health, a responsibility we take seriously, and today we continue that focus through our service to 74 million Americans.

Anthem has participated in the ACA exchanges since their inception and has continued to offer coverage even as many competitors have withdrawn. Unfortunately, the underlying lack of stability in the markets has led to difficult decisions regarding Anthem's participation next year. We must come forward to address this challenge, and these hearings are a great step in that direction.

Our experience has shown us that three fundamental considerations are necessary to ensure a viable insurance market. First, a balanced risk pool. Today, too few healthy individuals are enrolling in coverage, and many are doing so only when they require services, quickly dropping the coverage when it is no longer needed. Nearly 20 percent of Anthem individual market members maintained coverage for 6 months or less last year.

Second, a predictable and stable regulatory environment. The rules governing the individual market need to stabilize so consumers know what to expect and so health plans, providers and consumers can plan effectively.

And third, predictable government financing. To ensure the individual market provides affordable options for consumers, premium assistance and cost-sharing reduction funding must be predictable and reliable. With the open enrollment period beginning November 1st, the need for swift action is clear. To improve the stability of the market in 2018, there are legislative and regulatory changes that, if made quickly, could improve the individual market environment for consumers next year.

The first step is funding certainty for CSR subsidies. CSRs play a pivotal role in ensuring more affordable access to health care for low-income consumers. If CSRs are ended, the CBO predicts the premiums for Silver exchange plans will jump nearly 20 percent, driving people to forego coverage and costing the Federal Government \$2.3 billion more in fiscal year 2018.

The second step is repealing the health insurance tax. The moratorium on the health insurance tax ends at the close of 2017. If reinstated, this tax will result in premium increases for consumers between 3 and 5 percent.

The third step is market stability funding. For the individual market to find its footing, it's critical that consumers have affordable options. Federal reinsurance would enhance coverage afford-



ability for all and maintain access for individuals with high-cost needs.

The fourth step is to ensure continuous coverage provisions. Sufficient measures must be in place and enforced to encourage healthy individuals to purchase and maintain coverage. All these steps will help address the short-term instability undermining individual health insurance markets.

However, these steps alone will not solve all the challenges facing the individual market. Given the layers of Federal and State regulation covering the individual market, additional actions are needed to be taken to ensure long-term stability. My written testimony includes a number of recommendations, but I would highlight one in particular that Anthem encourages the committee to pursue, improving the Section 1332 waiver process which enables States to implement innovative programs.

It's also important to note that market instability is only a symptom of the disease facing our health care system, which is the rising cost of care. The cost of health care is simply too expensive and continues to rise at an unsustainable rate, which is the true impediment to ensuring all Americans have access to high-quality, affordable coverage. Anthem is committed to working with this committee and other policymakers to advance solutions to this crisis and continue to bend the cost curve.

We stand at a challenging moment, but we are confident that our collective efforts can bring about meaningful improvements for health care consumers.

Thank you for the opportunity to testify today. I look forward to your questions.

[The prepared statement of Mr. Ruiz-Moss follows:]

PREPARED STATEMENT OF ROBERT RUIZ-MOSS

SUMMARY

Persistent instability in the individual market continues to threaten consumers' access to affordable, quality health care. A stable insurance market is dependent upon three fundamental key conditions. First, there must be a balanced risk-pool through the broad spreading of risk, as well as market dynamics which promote ongoing enrollment by individuals of all risks—healthy and unhealthy. Second, it requires a predictable regulatory environment with a known set of rules and conditions under which rates can be reliably developed. Finally, it requires predictable financing to ensure affordability for consumers. Unfortunately, those three conditions have failed to fully materialize, which has made the planning and pricing of health plans in the individual market increasingly difficult, leading to a deteriorating and contracting risk-pool with higher costs and fewer choices for consumers.

For more than seven decades, Anthem, Inc. has served consumers in the individual market, standing by families and communities at some of the most important moments of their lives. Across its portfolio of affiliated health plans and subsidiaries, Anthem today serves more than 74 million Americans. This depth of experience and breadth of reach, not only affords Anthem a line-of-sight into the challenges threatening the individual market, but also grants us insight into ways stakeholders, lawmakers, and regulators can work together to bring much-needed stability to the individual market in time to benefit consumers in 2018 and beyond. Our immediate recommendations to help stabilize the individual market for 2018 include:

- Funding certainty for cost-sharing reduction (CSR) subsidies
- Repeal of the health insurance tax (HIT) or an extension of the current moratorium
- Market stability funding, e.g., reinsurance
- Continuous coverage provisions
- Predictability in regulations and corresponding implementation

While Anthem believes that these steps will help bring short-term stability to the individual market next year, we feel strongly that attention must be paid to finding long-term stability, as well. To accomplish this, Anthem recommends that additional focus be directed to the following: Section 1332 waivers; long-term stability funding; limiting third-party premium payments; and, returning more regulatory authority to the States over the individual and group markets.

Taken together, the above recommendations will bring stability to the individual market in, both, the near-and long-term. However, we must also seek solutions to address the underlying threat to our entire health care system—specifically, the spiraling cost of care.

Consumer research points to ‘affordability’ as being the most important factor guiding consumers’ decisions when it comes to their health care. As they look to make these important choices, they depend on assurances that policymakers and industry stakeholders are making the necessary investments to optimize affordability. Anthem has made this pursuit a foundational element of our identity. Accordingly, we encourage a greater emphasis on value-based care, the need to address the escalating cost of prescription drugs, and the transformational improvements to our health care system made possible by increased investments in innovation.

Despite the challenges facing the troubled individual market, Anthem is optimistic that the collective efforts of stakeholders across the health care spectrum will result in the kind of meaningful, lasting improvements that ensure consumers will continue to enjoy access to the quality, affordable health care they deserve.

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#### INTRODUCTION

Thank you, Chairman Alexander, Ranking Member Murray, and members of the committee for the opportunity to testify today. I am Robert Ruiz-Moss, Vice President, Individual Business Segment at Anthem, Inc., and it is my honor to appear before you to share Anthem’s ongoing experience in working with stakeholders across the health care spectrum to achieve a functioning, stable individual health insurance market.

Anthem is uniquely positioned to offer our perspective. For more than 75 years, Anthem has been focused on caring for America’s health. Today, we serve more than 74 million Americans. As an independent licensee of the Blue Cross and Blue Shield Association, Anthem operates affiliated Blue-health plans in 14 States or State regions across the country. Through our Medicaid presence, we are able to broaden that reach, partnering with 20 States to serve 6.5 million beneficiaries. When combined with our growing Medicare business and diverse portfolio of specialty products and subsidiaries, Anthem plays a pivotal role in the health and well-being of communities across this country and for generations of American families.

I have over 25 years of experience across numerous facets of the health care industry, including serving as an original board member of the Colorado Health Benefits Exchange, appointed by Governor John Hickenlooper. Since joining Anthem in 2009, my primary objective has been refining the company’s business model to meet the health care coverage needs of consumers in the reformed individual market.

Anthem remains committed to transforming health care by making it more affordable, higher quality, and more accessible for all. We are grateful for the work that you and your colleagues have done to improve our health care system. However, the uncertainty that continues to surround the individual market has only served to undermine its ability to function effectively, leading to increased costs and limited choices for consumers.

I appreciate this opportunity to speak to you today about some of the challenges we have observed in the individual market—from the opening of the Exchanges in 2014 to today—and to offer our recommendations for ways in which health care stakeholders, lawmakers, and regulators can work together to bring stability to that market in 2018 for the millions of consumers who rely on it.

#### FUNDAMENTALS OF A VIABLE, FUNCTIONING INSURANCE MARKET

For more than seven decades, Anthem has served consumers in the individual market. Throughout that time, our commitment to providing our members access to affordable, quality health care coverage has been unwavering. As consumers’ expectations have shifted, we have evolved to be responsive stewards of the trust they have placed in us to manage their health care benefits. Since the creation of the insurance exchanges through the Affordable Care Act (ACA), we have continued to serve consumers in all of the States where we provide fully insured individual health plans.

While we are pleased that a number of steps have been taken to address the long-term challenges facing the individual market, the underlying lack of stability and predictability in the structure of the market continues to undermine our ability to map out a sustainable path forward. For Anthem, that has resulted in our having to make difficult decisions regarding our participation in markets across the country next year, which we do not take lightly.

A stable insurance market is dependent upon three fundamental conditions. First, there must be a balanced risk pool. A balanced risk pool is the result of health plans' ability to offer products that create value for consumers through the broad spreading of risk, as well as market dynamics which promote ongoing enrollment by individuals of all risks—healthy and unhealthy. Second, it requires a predictable regulatory environment with a known set of rules and conditions under which rates can be reliably developed. Finally, it requires predictable financing to ensure affordability for consumers. Unfortunately, those three conditions have failed to fully materialize, which has made the planning and pricing of health plans in the individual market increasingly difficult, leading to a deteriorating and contracting risk pool with higher costs and fewer choices for consumers.

**1. Balanced Risk Pool:** Not enough healthy individuals are enrolling in coverage. This, in combination with the increased prevalence of “buying to use” behavior, in which individuals only purchase coverage in order to receive services before dropping that coverage, has accelerated deterioration of the individual market risk pool. The effects of this behavior are reflected in the average risk score of enrollees in the individual market, which Anthem data shows to be 10 percent higher than that of enrollees in the small group market in 2016, with the gap widening further so far this year. In addition, nearly 20 percent of Anthem individual market members only maintained their coverage for 6 months or less in 2016.

**2. Predictable Regulatory Environment:** Health plans serving consumers in the individual market are regulated by two, and in some cases three or four, separate governmental entities with varying requirements, mandates and timelines to follow. For example, in States that established a State-based exchange, health plans are subject to regulation from the Federal Government, State government and State exchange operating entity. In addition, some States have separate regulating entities for HMO and non-HMO plan offerings, which in addition to the Federal Government and State exchange operating entity, lead to four separate governmental regulating entities. Accordingly, plan participation in the individual market requires the careful orchestration of a multitude of moving parts in order to bring a product to market. For health plans, that means gathering input from clinicians, actuaries, claims departments, pharmaceutical benefits managers, and countless other functions, in the development of a high-quality product that is not only tailored to suit the varied health care needs of today's consumer, but is also affordable. Unfortunately, these efforts are rendered ineffective if the regulatory environment in which these products are developed is unreliable. The rules governing the individual market must be predictable and stable to ensure a balanced and functional operating environment for health plans.

**3. Predictable Financing to Ensure Affordability for Consumers:** It is critical that the individual market provide affordable options for consumers. Any payments from government sources to help achieve that objective must be predictable and reliable to ensure a stable market. There are many low-income individuals who cannot afford to purchase coverage in the individual market without financial assistance. As such, the uncertainty surrounding funding for the cost-sharing reduction (CSR) subsidies, coupled with the looming threat of the reintroduction of the health insurance tax (HIT), have only contributed to the volatile dynamics undermining health plans' ability to responsibly price products tailored to meet consumers' expectations of quality and affordability. These uncertainties have caused health insurance plans, including Anthem, to be cautious about continuing their participation in the individual market.

#### RECOMMENDATIONS TO STABILIZE THE INDIVIDUAL MARKET FOR 2018

With open enrollment scheduled to begin on November 1, 2017, consumers will be looking to make important decisions regarding their health care needs. In order for them to make the best decisions for themselves and their families, they want assurances that lawmakers, regulators, and industry stakeholders are taking the necessary steps to ensure a viable, functioning individual market for the near- and long-term. While the window is closing, and our geographic participation is set, for 2018, there is still time for lawmakers and regulators to improve some of the condi-

tions that have contributed to the instability of the individual market—but only if they act quickly. Drawing on our considerable experience providing health insurance coverage for more than 1.5 million consumers in this market, we believe the following steps must be taken immediately at the Federal level to improve the individual market environment for consumers in 2018:

- **Funding certainty for CSRs:** Cost-sharing reduction subsidies play a pivotal role in ensuring access to health care services for very low-income enrollees, helping these individuals better afford their co-pays, deductibles, and other out-of-pocket costs. Currently, 6.4 million consumers are benefiting from CSRs. However, uncertainty over funding for CSRs for the remainder of 2017 and 2018, including threats to cutoff this funding, both immediately and in the future, only contributes to the instability undermining the individual market. In its recent analysis<sup>1</sup> of the effects of terminating payments for CSRs, the Congressional Budget Office predicted that premiums for benchmark plans on the exchanges would go up by nearly 20 percent next year. Further, according to analyst projections, eliminating CSR payments would also result in a net increase in Federal costs of \$2.3 billion<sup>2</sup> for fiscal year 2018 as the result of the increased benchmark premium also increasing the premium subsidies. Independent analysis<sup>3</sup> also lays out the possibility of additional market exits as health plans are forced to decide whether the overall uncertainty of the market, coupled with the possible elimination of CSR funding, is too much risk to bear. Stakeholders<sup>4</sup> across the health care spectrum have found common cause in their shared recognition of the stabilizing role that funding certainty for CSRs play in the individual market.
- **HIT repeal or extension of the moratorium:** The moratorium on the health insurance tax ends at the close of 2017. The reintroduction of the HIT next year would result<sup>5</sup> in premium increases—ranging from three to 5 percent—across all fully insured health insurance coverage, resulting in further disruption to the individual market. An extension of the current HIT moratorium—or full repeal of the onerous tax—would help prevent consumers from having to shoulder this burden, while introducing an additional stabilizing element to the individual market.
- **Market stability funding:** For the individual market to find its footing, it is critical that consumers have affordable options. Given the skewed distribution of health care spending—especially in the individual market—policy mechanisms<sup>6</sup> are necessary to help spread the costs associated with covering high-risk individuals.<sup>7</sup> In order to restore confidence in this fragile market, predictable and broadly financed stabilization funding must be made available. One way this can be accomplished is through a Federal reinsurance<sup>8</sup> program that reduces risk<sup>9</sup> and enhances coverage options for individuals with costly health needs while lowering premiums for all consumers.

<sup>1</sup>“The Effects of Terminating Payments for Cost-Sharing Reductions,” Congressional Budget Office, August 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

<sup>2</sup>Larry Levitt, Cynthia Cox, and Gary Claxton, “The Effects of Ending the Affordable Care Act’s Cost-Sharing Reduction Payments,” The Henry J. Kaiser Family Foundation, 25 April 2017, <http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/>.

<sup>3</sup>Dianna Welch and Kurt Giesa, “Analysis: Potential Impact of Defunding CSR Payments,” Oliver Wyman Health, 12 May 2017, <http://health.oliverwyman.com/transform-care/2017/05/impact-defunding-csr-payments.html>.

<sup>4</sup>“Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, and Stability,” AHIP Issue Brief, April 2017, [https://www.ahip.org/wp-content/uploads/2017/04/CostSharingReductions\\_IssueBrief\\_4.25.17-1.pdf](https://www.ahip.org/wp-content/uploads/2017/04/CostSharingReductions_IssueBrief_4.25.17-1.pdf).

<sup>5</sup>Chris Carlson, Glenn Giese, and Steven Armstrong, “Analysis of the Impacts of the ACA’s Tax on Health Insurance in 2018 and Beyond,” Oliver Wyman, 8 August 2017, <http://www.stopthehit.com/wp-content/uploads/2017/08/Oliver-Wyman-2018-HIT-Analysis%E2%80%8E-August-8-2017.pdf>.

<sup>6</sup>“Steps Toward a More Sustainable Individual Health Insurance Market,” American Academy of Actuaries, April 2017, [http://www.actuary.org/files/publications/Sustainable\\_Health\\_Insurance\\_Marketplace\\_042417.pdf](http://www.actuary.org/files/publications/Sustainable_Health_Insurance_Marketplace_042417.pdf).

<sup>7</sup>“Using High-Risk Pools to Cover High-Risk Enrollees,” American Academy of Actuaries, February 2017, [http://www.actuary.org/files/publications/HighRiskPools\\_021017.pdf](http://www.actuary.org/files/publications/HighRiskPools_021017.pdf).

<sup>8</sup>Ashley Ridlon, “Stabilizing the Health Insurance Market: What the Experts Say,” Bipartisan Policy Center, 8 June 2017, <https://bipartisanpolicy.org/blog/stabilizing-the-health-insurance-market-what-the-experts-say/>.

<sup>9</sup>Michael Chernen and Christopher Barbey, “Supporting the Individual Health Insurance Market,” Health Affairs, Blog, 7 August 2017, <http://healthaffairs.org/blog/2017/08/07/supporting-the-individual-health-insurance-market/>

• **Continuous coverage provisions:** Consumers purchasing coverage through the individual market should be treated like consumers with coverage through their employer and not be allowed to purchase insurance only when they need services. Health plans are required to take all applicants, regardless of health status. To ensure that the risk pool is functioning as intended, with healthy individuals balancing higher risk participants, broad participation is required. Accordingly, sufficient incentives must be in place to encourage healthy individuals to purchase and maintain coverage. Currently, the individual mandate under the Affordable Care Act is the mechanism in place that is intended to promote continuous coverage. However, the weak enforcement of the individual mandate—since its inception in 2014—coupled with the organic weakening that has occurred as a result of the widening gap between the cost of 12-months of premiums and the mandate’s financial penalty, is a primary driver of growing instability in the individual market. If the individual mandate is repealed, and health plans are still required to take all applicants, there must be an alternative mechanism to incentivize individuals to purchase and maintain health coverage. This can be accomplished through the introduction of rules incentivizing both enrollment and maintenance of continuous coverage. For example, establishing a waiting period to access benefits or assessing a late enrollment charge for someone who has failed to meet the continuous coverage requirement.

• In addition, while we appreciate efforts by both the previous and current Administrations to constrain special enrollment periods (SEPs) by requiring pre-enrollment verification of eligibility, more must be done to discourage “gaming” of the enrollment rules, including:

- Limiting the number of life events that trigger an SEP to better align with the employer-sponsored market;
- Requiring State-based exchanges to implement the same pre-enrollment verification rules required for the Federal exchange;
- Tightening premium payment grace period rules or returning authority to State regulators, to more closely align with pre-ACA grace periods, which were typically shorter than the current 90-day period under Federal law, thereby limiting gaming opportunities, while still giving consumers a reasonable time to pay for coverage; and,
- Requiring that consumers be able to demonstrate continuous coverage to qualify for an SEP.

• **Predictable regulation and implementation:** As previously referenced, health plans serving consumers in the individual market are regulated by two, and in some cases three or four, separate governmental entities with varying requirements, mandates and timelines to follow. Stability and predictability of law and regulation is essential to a company’s ability to engage in a market and effectively plan and execute its business operations. Successful partnership between government and business relies upon clear and predictable rules. The implementation of even small regulatory changes in the individual insurance market can be tremendously burdensome, requiring, at a minimum, sufficient lead time to plan and execute under the current rate and product filing requirements. Additionally, issuance of sub-regulatory guidance such as FAQs must be predictable and timely.

With the 2018 open enrollment period scheduled to begin on November 1, 2017, the window for making legislative and regulatory changes to promote a viable market is growing smaller, but it has not closed. While the changes that we are recommending will not change our geographic participation for 2018, they can still be implemented and operationalized for the 2018 plan year to improve the market environment for consumers—but, only if actions to effectuate those changes are taken very quickly. I urge the committee to act on these recommendations as soon as possible in order to provide a more stable market environment in 2018 that leads to more affordable, quality health coverage options for consumers. While the focus of this hearing is on stabilizing the individual market for 2018, it is important to note that the aforementioned recommendations will also have a lasting, positive effect on the individual market environment in 2019 and beyond.

#### RECOMMENDATIONS FOR LONG-TERM IMPROVEMENTS TO THE INDIVIDUAL MARKET

The process for planning products and geographic participation for 2019 will begin in a few months. As such, we encourage the committee to also devote time and attention to several issues that will help ensure the long-term stability of the individual market, including: Section 1332 waivers under the ACA; long-term stability funding; limiting third-party premium payments; and returning to the States more regulatory authority over the individual and small group markets.

- **Section 1332 Waiver Flexibility:** Section 1332 waivers offer a valuable opportunity for States to implement innovative programs to stabilize and promote long-term sustainability in their markets. Given the length of time that it takes to develop and obtain approval of a waiver, any future changes to the Section 1332 waiver requirements or process may not impact 2018. Such changes, however, could greatly benefit States seeking to make changes to their markets in 2019 and beyond.

Unfortunately, rigid requirements and a burdensome process have dissuaded States from seeking innovation waivers until recently, when continuing instability prompted a number of States to pursue waivers in an effort to ensure that their residents would have access to affordable coverage in 2018. Waivers for reinsurance programs, in particular, have shown great potential for promoting stability, reducing premiums, and increasing the number of individuals covered in a State. For example:

- Alaska recently received approval of a waiver to implement a reinsurance program for 2018. Premiums are expected to be 20 percent lower in 2018 than they would have been without the waiver. In addition, Alaska predicts that an additional 1,641 individuals will have health insurance coverage due to the lower cost of health care through stabilization of the individual market.
- Minnesota and Oklahoma have also submitted applications seeking to implement reinsurance programs in their marketplaces for 2018, while Colorado and Maine are exploring possible waivers of their own.

We recommend providing States flexibility to make innovative changes tailored to their markets by simplifying and streamlining the process for obtaining Section 1332 waivers and affording them greater flexibility in navigating the guardrails for obtaining a waiver. Specifically, actions should be taken to:

- Reduce the time period for Federal review of waiver applications, expediting the approval of waivers similar to those already approved for other States;
- Allow States to authorize filing a waiver application via executive order or certification by the Governor and department of insurance, as opposed to requiring legislation; and,
- Allow States to satisfy the budget neutrality requirements for a waiver over its lifetime, as opposed to year by year.

- **Long-Term Stability Funding:** In addition to the need for market stability funding in the short-term, we recommend establishing predictable and reliable long-term funding, from broadly based revenue, to help spread the costs of high-risk individuals. There are several viable ways to direct such funding, including reinsurance programs and high risk pools.

- **Prohibit Third Party Steerage:** Another recommendation that will improve the long-term stability of the individual market is to prohibit third parties from steering high-cost patients from public programs into the individual market. Health plans set rates based on the assumption that certain populations, like end-stage renal disease (ESRD) patients, will be covered under Medicare and/or Medicaid. Currently, certain third parties are taking action to seek higher reimbursements from health plans by paying premiums on behalf of Medicare and/or Medicaid-eligible Americans to move them into the individual market. This practice is increasing costs for consumers by driving more high-risk individuals into an already unstable market, while disadvantaging consumers from accessing specialized public programs established for their unique care needs.

- **Reduce Duplicative Regulation while returning authority to States:** Health plans serving consumers in the individual market are regulated by two, and in some cases three or four, separate governmental entities, which leads to duplication of regulation by Federal and State entities in some instances. Specifically, the ACA created duplicative Federal regulation in several areas where States are better positioned to know what works best for their markets. While increased Federal oversight has led to greater uniformity, it has also compounded the regulatory schemes that health plans must comply with, which often increases costs for consumers. We recommend reducing duplicative regulation and returning regulatory authority to the States in the following areas to give health plans greater ability to customize products to meet the local needs of consumers, while maximizing quality and affordability:

- **Individual and small group rate and benefit design review:** The States have a long history of reviewing forms and rate requests for health insurance plans. Fully recognizing and relying on State activity in these areas will ensure that experienced regulators continue to review rates and forms while elimi-

nating a duplicative process that often requires submissions of different forms, through different platforms, on different timelines at the Federal level.

- **Network adequacy determination and enforcement:** States are best positioned to evaluate plan networks as they are familiar with consumer needs, provider availability, market dynamics, geographies and patterns of care—all of which are relevant to evaluating the adequacy of a health plan’s network.

- **Grace periods for nonpayment:** The ACA contained a provision requiring for a 90-day grace period, meaning consumers could get coverage for the whole year while only paying for 9 months of coverage. Regulation in this area should be governed by State law, which prior to the ACA established grace period standards that were typically shorter than 90 days, limiting gaming opportunities, while still giving consumers a reasonable time to pay for their coverage.

#### ANTHEM’S COMMITMENT TO TRANSFORMING HEALTH CARE

Anthem values the important role we play in the lives of millions of consumers. Our commitment to transforming health care is built upon the foundational belief that by driving innovation, we can deliver greater value for our members and provider partners, and ultimately, improve the sustainability of the system as a whole. We do this every day by focusing on four strategic areas: provider collaboration, consumer centricity, quality, and cost of care.

- **Provider collaboration.** Stakeholders are increasingly sharing risk. Behind this trend is our health care system’s growing emphasis on value-based care. Anthem is working hard to cultivate the kind of close, collaborative models with providers that result in a better holistic health care experience for our members.

- **Consumer centricity.** As consumers’ comfort with their health care options has increased, so, too, have their expectations. This fluency has led to an increased demand for a more personalized health care experience. Anthem has responded by investing in new tools that enhance our members’ interaction with their benefits, while improving the quality of that care and lowering costs.

- **Quality.** Anthem understands that it is not enough for health care to be affordable and accessible—it must also be high quality. This is why we have made our goal to transform and improve health care a foundational component of who we are as an organization. We see quality as more than just a clinical goal, though, and are actively remaking ourselves, developing the necessary structures and process improvements across every business operation to further enhance our high quality standards.

- **Cost of care.** Our final strategic focus has to do with managing the total cost of care. While bringing stability to the individual market is a short-term imperative, a long-term health care crisis is being overshadowed: The continually rising cost of health care. Cost is the biggest and most pressing challenge facing our health care system. The cost of health care is simply too expensive and continues to rise at an unsustainable rate. Fifty years ago, spending on health care amounted to approximately 5 percent of the country’s gross domestic product. By 2015, that number jumped to an alarming 17.8 percent, and is projected to reach 19.9 percent by 2025. Our country cannot simply continue to just spend more money on health care. We must seek solutions to address the underlying causes of cost growth in health care.

Consumer research tells us that ‘affordability’ is now the most important factor guiding consumers’ health care decisions. It is also a top priority for employers, as well as for our Federal and State government partners. Improving affordability requires a focus on the cost of care—at both the individual and population levels. Anthem is doing our part to address the cost of health care. Examples include:

- **Value-based care.** We now pay nearly 60 percent of our reimbursements through value-based care models. Today, more than 64,000 doctors across our family of health plans receive value-based payments and are accountable for the cost and quality of care for more than 5.5 million of Anthem’s commercial members. Further, through our partnership with health care analytics firm, Castlight Health, we are able to provide members with the type of price and quality information that empowers them to make better informed choices. Also, Anthem has successfully built reference-based benefits programs with large employers, like the California Public Employee Retiree System (CalPERS)<sup>10</sup>, in which set price limits are established for cer-

<sup>10</sup>Ann Boynton and James C. Robinson, “Appropriate Use of Reference Pricing Can Increase Value,” *Health Affairs*, Blog, 7 July 2015, <http://healthaffairs.org/blog/2015/07/07/appropriate-use-of-reference-pricing-can-increase-value/>.

tain services—e.g., hip replacement—so consumers are armed with information about price and quality as they go to select their provider. Reference-based benefits have driven greater consumer engagement, addressing the disparity that often exists in provider costs, without compromising access to quality care. In fact, independent studies estimate savings for CalPERS of over \$7.5 million per year on several procedures alone, including colonoscopies and arthroscopies.

- **Mitigating escalating drug prices.** Spending on prescription drugs is now the fastest growing area of health care costs,<sup>11</sup> and is expected to continue rising faster than overall health care spending. Last year, the cost of drugs exceeded the cost of inpatient hospital stays in Anthem's commercial business. This trend is most acutely felt in the area of specialty drugs, where—across the entire health care system—spending on this category rose 13.1 percent in 2014, and is projected to exceed \$400 billion by 2020. Closer to home, we project that by next year, spending on specialty drugs alone will account for approximately half of Anthem's total prescription drug spend—up from about 30 percent currently. Meanwhile, according to expert analysis,<sup>12</sup> just ten breakthrough drugs are projected to cost government programs an estimated \$50 billion over the next decade.

Given drug costs' disproportionate impact on the overall health care cost curve, the necessity of finding workable solutions cannot be overstated. With that in mind, Anthem joined forces with biopharmaceutical manufacturer, Eli Lilly & Co., in an attempt to confront the issue. Our partnership was born out of a shared understanding that our health care system needs vested stakeholders to put aside parochial interests in the service of moving toward real, achievable solutions. In keeping with the transition to paying for value that is currently reshaping other areas of the health care sector, similar value-based payment arrangements for pharmaceuticals must also be explored.

Anthem believes that this transition toward a value-based system for prescription drugs will help drive payment innovation. So, together with Lilly, we released two policy proposals aimed at changing Federal regulations to help mitigate the challenges ahead in adopting sensible payment reforms for pharmaceuticals: 1) explicitly allowing for communication between health benefits companies and drug manufacturers regarding their products prior to FDA approval; and, 2) changing existing restrictions that hamper efforts to establish value-based contracts for new drug therapies. These two policy proposals are not a panacea for addressing rising drug costs, but they would have a positive real world impact and, more importantly, can help advance the current debate into legislative and regulatory action.

- **Innovation.** Anthem believes in the power of innovation to bring about transformational improvements to our health care system. That belief has seen us make considerable investments in technologies, like our LiveHealth Online telehealth platform that allows users to virtually connect to the care they need, when and where it is most convenient to them. Telehealth holds tremendous promise for improving access to health care in the day-to-day lives of consumers and during emergency situations. For example, Anthem is making access to LiveHealth Online free for the people of Texas and Louisiana impacted by Hurricane Harvey.

Adopting a forward-thinking approach to anticipating consumers' evolving expectations, we have also established an Innovation Studio in Atlanta that brings together industry and technology leaders in a collaborative environment to brainstorm ideas and come up with new solutions that will enhance their experience. One innovation that is being piloted is a mobile bill-paying app that allows our members to pay premiums or medical bills directly from their mobile device. In its first 6 months of use, we received more than 50,000 transactions via the app.

Separately, as we look to help our members better manage their total cost of care, we interact with them more comprehensively along their entire continuum of care—from prevention to treatment to follow-up. This is made possible by our deep understanding of, and significant investment in, data analytics, which have enabled us to develop clinical programs and quality improvement initiatives that benefit consumers directly. For example, through our Anthem Cancer Care Quality Program—developed with our AIM Specialty Health subsidiary—we are able to make actionable data available to oncologists to help them make better informed treatment decisions. Last year, more than 1.6 million Americans were diagnosed with cancer. While advances in treatment continue to offer hope, it remains a challenge for pa-

<sup>11</sup> Jeff Lagasse, "Prescription Drug Spending Shows Fastest Growth, Overall Spending Outpaces Previous Two Years, Report Shows," *Healthcare Finance*, 23 November 2016, <http://www.healthcarefinancenews.com/news/prescription-drug-spending-shows-fastest-growth-overall-spending-outpaces-previous-two-years>.

<sup>12</sup> "The Future Cost of Innovation: An Analysis of the Impact of Breakthrough Therapies on Government Spending," Avalere Health, LLC., June 2015, [file:///C:/Users/aa47057/Downloads/1433970206\\_061015\\_Avalere\\_AHIP\\_WhitePaper\\_LP\\_Final\\_03%20\(1\).pdf](file:///C:/Users/aa47057/Downloads/1433970206_061015_Avalere_AHIP_WhitePaper_LP_Final_03%20(1).pdf).



tients, their families, and their physicians to select from available therapies when seeking the best treatment options. With treatments costing about \$100,000 on average per patient per year, information on health outcomes and cost effectiveness is critical.

These key investments in our health care data analytics capabilities speak to our ongoing effort to unlock greater savings for our members. Last year alone, we processed more than 730 million claims. The sheer enormity of that data translates into 17 petabytes of health information about our members—which is the equivalent of 1,700 times the entire printed collection housed in the Library of Congress.

#### CONCLUSION

For all the challenges facing us, we remain optimistic about what lies ahead. Anthem is doing our part, but we cannot do it alone. We must also recognize that given the layers of Federal and State regulation over the individual market, Federal actions alone will not achieve long-term stability. The level of deterioration and contraction of risk pools vary by State, in some instances due to challenges at the State level in need of attention. However, we are confident that the collective efforts of stakeholders and Federal and State legislators and regulators from across the political spectrum, will continue to result in the kinds of improvements that make a difference in the health and well-being of consumers everywhere. We applaud the committee for advancing a thorough and balanced dialog aimed at bringing much needed stability to the individual health insurance market.

While a balanced risk pool and a more predictable and stable regulatory environment remain necessary components of a viable, functioning individual health insurance market, we must also turn our attention to the underlying cost of health care. Working in our favor are advances in both science and medicine, technological enhancements, and the mutual goal that affordable, high-quality health care should be accessible to all.

Thank you, again, for inviting me to share Anthem's perspective today and for the opportunity to work with you as we strive to ensure better health care for our Nation's consumers.

The CHAIRMAN. Thank you very much.  
Ms. Postolowski

#### **STATEMENT OF CHRISTINA POSTOLOWSKI, ROCKY MOUNTAIN REGIONAL DIRECTOR, YOUNG INVINCIBLES, DENVER, CO**

Ms. POSTOLOWSKI. Thank you very much, Chairman Alexander, Ranking Member Murray, and members of the committee, for the opportunity to speak with you today.

My name is Christina Postolowski, and I'm the Rocky Mountain Regional Director of Young Invincibles. We are a non-profit, non-partisan organization working to expand economic opportunity for young adults ages 18 to 34.

Since the passage of the Affordable Care Act, the young adult uninsured rate has been nearly cut in half. More than 8 million young people between the ages of 18 and 34 have received coverage through the law, and millions more are benefiting from the law's consumer protections.

The typical uninsured young person makes just \$20,000 a year, and given their low incomes, millions of young people are benefiting from Medicaid expansion and the law's premium tax credits. To build on these gains, Congress should act to bring further stability to the market and pursue strategies to maximize young adult enrollment by making coverage easier to afford and access.

First, Congress should make clear that cost-sharing reduction payments will be made through at least the end of 2019. Up to 7.2 million young adults who are either uninsured or in the individual market could qualify for CSRs. If these payments are not made, premiums will increase 20 percent next year, hampering young

people's ability to afford coverage and potentially driving them out of the market.

Second, Congress should create a permanent reinsurance program starting with guaranteed funding through a 2-year mandatory appropriation. Reinsurance is not new or unique, nor is it an insurer bailout. National and state-level reinsurance programs have already been shown to reduce premiums, which can help increase young adult enrollment.

Third, Congress should do more to make coverage affordable for young adults by increasing their premium tax credits. Boosting premium tax credits by \$50 a month, for example, for young people would result in 900,000 more young adults gaining coverage. Another idea would be to lower the premium affordability threshold for young adults. This would lower the maximum amount low-income young people have to spend on premiums, resulting in larger premium tax credits.

Fourth, enrollment depends on consumers knowing about their options. Uninsured 19- to 34-year-olds are still the least likely group to know about the health insurance marketplaces. So the Administration's recent announcement that they would substantially cut Navigator grants and advertising goes in the exact wrong direction. Navigators help young people understand their options, qualify for financial help, and assess provider networks. Seventy-seven percent of individuals who received personal assistance ultimately enrolled in coverage, whereas 60 percent of those who did not get assistance ultimately enrolled. Studies also show a correlation between the volume of TV ads in a given area and higher rates of enrollment. I urge Congress to reverse these cuts.

Briefly, I'd like to also speak to some other ideas that we have heard that claim to make plans more affordable for young people but would, in fact, put their financial security at risk.

First and foremost, weakening the Section 1332 guardrails and allowing States to undermine consumer protections in the ACA could actually decrease rather than increase young adult enrollment. We have already seen some States propose reducing financial assistance or eliminating essential health benefits through 1332 waivers, both of which shift costs to consumers.

The top three essential health benefits that young people use are mental health services, maternity care, and preventive services. Without access to coverage for EHBs, young adults may see less value in getting covered.

Second, Congress should not authorize State or Federal high-risk pools because they are insufficient and expensive for people with pre-existing conditions. I know this to be true because when I was 20 I was diagnosed with rheumatoid arthritis. Prior to the ACA, 35 percent of 18- to 24-year-olds like me were at risk of being denied coverage because of their health status. When multiple insurers did deny me coverage, Colorado's high-risk pool was the only place I could go to get a plan. Even with the subsidy I received, my insurance through Covered Colorado was expensive, and I was subject to a 3-month exclusion period for my condition.

Finally, proposals that lead to higher deductibles or lower actuarial values expose our generation to costs they can't afford. You might be surprised to know that the law's current version of high-

deductible plans are widely unpopular among young adults. About 76 percent of young marketplace enrollees in 2015 chose a Silver-level plan or higher, with only 3 percent of young people enrolling in catastrophic coverage. So while so-called Copper plans would have lower premiums, we would not expect these plans to be much more popular for young people, and they would have significant financial downsides. Deductibles for these policies would be around \$9,000. That means the typical uninsured young person who earns a median income, again, of \$20,000 a year would have to spend nearly half of their annual income to meet their deductible.

To conclude, we know that current uncertainty is threatening the gains young people have made, and we look forward to working with Congress to continue to increase coverage for our generation.

Thank you for the opportunity to speak with you today, and I look forward to taking your questions.

[The prepared statement of Ms. Postolowski follows:]

PREPARED STATEMENT OF CHRISTINA POSTOLOWSKI

SUMMARY

Young adults have historically had higher uninsured rates than any other age group, but since passage of the Affordable Care Act (ACA), we've seen their uninsured rate nearly be cut in half. Over eight million people between the ages of 18 and 34 have received coverage through provisions in the ACA,<sup>1</sup> including 3.5 million through the health insurance marketplaces, thanks in large part to the law's financial assistance. While we've made tremendous progress, 11 million young adults remain uninsured, including 6.1 million who could be eligible for premium tax credits.<sup>2</sup> We are encouraged to see Congress work together to focus on what can be done to boost youth enrollment and further stabilize the market. Here are some of our recommendations:

**Fund cost-sharing reduction (CSR) payments through a mandatory appropriation through at least 2019.** Making CSR payments would reduce uncertainty among consumers and carriers. This funding is crucial not only for consumers currently receiving CSRs, but also for marketplace consumers whose incomes may exceed the threshold to qualify for premium tax credits. Given young adults' lower net worth and incomes, young people are less able to absorb an increase in their out-of-pocket costs or what CBO forecasts would be a 20 percent increase in premiums. If CSR payments are not funded, we could see fewer young adults able to participate in the marketplaces.

**Create a permanent reinsurance program—not high-risk pools.** National and state-level reinsurance programs have already been shown to significantly reduce premiums, which promotes market stability, insurer participation, and the enrollment of younger, healthier consumers. Reinsurance is not new or unique, nor is it an insurer bailout: for instance, Congress recognized the importance of a permanent reinsurance program when developing the Medicare Part D prescription drug program in 2003. To provide immediate stability to the market, we recommend Congress guarantee funding for reinsurance through at least a 2-year mandatory appropriation. As someone who was denied coverage for having Rheumatoid Arthritis and left no other option but to enroll through Colorado's pre-ACA high-risk pool, I saw its shortcomings first hand. I can tell you that high-risk pools are an unacceptable coverage alternative for people with pre-existing conditions.

**Maintain existing guardrails around Section 1332.** We recognize the value and importance of State flexibility in expanding access to coverage. However, amendments to Section 1332 that would change the law's guardrails would likely harm the most vulnerable young people. These guardrails are as important as ever in light of recent State waiver proposals that would decimate financial assistance for low-income young adults, like those proposed by Iowa and Oklahoma. Further-

<sup>1</sup> Erin Hemlin, What's Happened to Millennials since the ACA? Unprecedented Coverage & Improved Access to Benefits, Young Invincibles, April 2017, <http://younginvincibles.org/wp-content/uploads/2017/05/YI-Health-Care-Brief-2017.pdf>.

<sup>2</sup> Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016. Based on raw number of uninsured young adults ages 18 to 34. <http://www.census.gov/cps/data/cpsstablecreator.html>.

more, allowing States to waive essential health benefits, for example, could actually decrease rather than increase young adult enrollment, by reducing or eliminating the services that young people use and value most in their coverage.<sup>3</sup>

**Reverse cuts to marketplace enrollment promotion and consumer assistance—specifically targeting these efforts to reach young adults.** While young adults disproportionately qualify for financial assistance, their enrollment depends on them knowing about their options. Many young people remain unaware of premium tax credits or opportunities to enroll in marketplace coverage. Congress should reverse the Administration’s recent cuts to enrollment promotion and Navigator grants. These are proven strategies for helping connect people, particularly those with lower rates of health insurance literacy, to coverage.

**Provide increased financial assistance to maximize young adult and further stabilize the market.** To achieve our shared goal of boosting young adult enrollment and further stabilizing the individual market, Congress should do more to further reduce young adults’ premium costs to help more of them afford coverage. One proposal suggests a boost in financial assistance by an additional \$50 a month for young adults. This would result in an additional 900,000 insured young adults at a less than \$3.7 billion a year price tag to the Federal Government.<sup>4</sup> Another way to lower costs for young people is to lower the premium affordability threshold for young adults. This would result in greater financial assistance for young people based on their incomes and account for, as the ACA currently does, premium variation in markets across the country. Boosting young adult enrollment in the marketplaces will not only help young people, but can help reduce premiums for marketplace consumers more broadly.

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<sup>3</sup>How Millennials Use Their Health Insurance, Young Invincibles, August 2016, <http://younginvincibles.org/wp-content/uploads/2017/04/how-millennials-use-health-care.pdf>.

<sup>4</sup>C. Eibner & E. Saltzman, The Commonwealth Fund, Insuring Younger Adults Through the ACA’s Marketplaces: Options to Expand Enrollment, December 16, 2016, <http://www.commonwealthfund.org/publications/blog/2016/dec/insuring-younger-adults>.

## TESTIMONY

Thank you Chairman Alexander, Ranking Member Murray, and members of the committee for the opportunity to appear before you today. My name is Christina Postolowski, and I am the Rocky Mountain Regional Director of Young Invincibles, a non-profit, non-partisan research and advocacy organization working to expand economic opportunity for young adults ages 18 to 34. We welcome the chance to discuss ways to both improve the individual insurance market and build on the gains young adults have made under the Affordable Care Act (ACA).

The data on the impact of the ACA on young people's coverage rates, health care needs, and the financial challenges facing this generation might surprise you. Consider the following:

- Since 2010, the uninsured rate for young people has declined from 29 percent to 16 percent.<sup>1</sup> As of 2015, over eight million people between the ages of 18 and 34 received coverage through provisions in the ACA,<sup>2</sup> including 3.5 million through the health insurance marketplaces and 3.8 million through Medicaid.<sup>3</sup>
- Young adults already earn lower incomes than other age groups, but young adults who are uninsured or purchasing insurance individually earn even less. Young workers in the individual market earn a median income of \$26,000,<sup>4</sup> while uninsured young workers earn a median income of \$20,000 per year.<sup>5</sup> That means that the typical young adult enrolled in the individual market could get a benchmark plan for \$154 a month (or 7.1 percent of their annual income) in premiums.<sup>6</sup> An uninsured young person could pay \$83 a month in premiums (or 4.96 percent of their annual income) for the same policy.<sup>7</sup> In addition to these tax credits, up to 7.2 million young adults between the ages of 18 and 34 are eligible for cost-sharing reductions (CSRs).<sup>8</sup>
- Contrary to stereotypes, young adults value health insurance and want to enroll in coverage.<sup>9</sup> More than seven in n young adults say it is "very important" that they have health insurance.<sup>10</sup> And prior to the ACA, just 5 percent of young workers with an offer of employer-sponsored coverage said that they opted not to enroll in their employer's plan because they did not need the coverage, instead citing others reasons such as parental coverage or prohibitive costs.<sup>11</sup>
- A survey conducted prior to the ACA found that 60 percent of young people said that they did not get needed health care because of cost and half reported problems paying medical bills or said they were paying off medical debt over time.<sup>12</sup>

<sup>1</sup> Erin Hemlin, What's Happened to Millennials since the ACA? Unprecedented Coverage & Improved Access to Benefits", Young Invincibles, April 2017, <http://younginvincibles.org/wp-content/uploads/2017/05/YI-Health-Care-Brief-2017.pdf>

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016.

<sup>5</sup> Ibid.

<sup>6</sup> Estimated using Kaiser Health Foundation's Health Insurance Marketplace Calculator, assuming a single 26-year old non-tobacco user.

<sup>7</sup> Ibid; Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016.

<sup>8</sup> Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016.

<sup>9</sup> Kaiser Family Foundation. (2013). Kaiser Health Tracking Poll: June 2013. Princeton Survey Research Associates International. Retrieved from <http://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-june-2013/>.

<sup>10</sup> Ibid.

<sup>11</sup> S.R. Collins, The Commonwealth Foundation, Covering Young Adults Under the Affordable Care Act, August 2013, 6 [http://www.commonwealthfund.org/~media/Files/Publications/Issue percent20Brief/2013/Aug/1701 Collins covering young adults tracking brief final v4.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Issue%20percent20Brief/2013/Aug/1701%20Collins%20covering%20young%20adults%20tracking%20brief%20final%20v4.pdf).

<sup>12</sup> S.R. Collins, The Commonwealth Foundation, Young, Uninsured, and in Debt: Why Young Adults Lack Health Insurance and How the Affordable Care Act Is Helping, June 2012, 1, [http://www.commonwealthfund.org/~media/files/publications/issue\\_brief/2012/jun/1604\\_collins\\_young\\_uninsured\\_in\\_debt\\_v4.pdf](http://www.commonwealthfund.org/~media/files/publications/issue_brief/2012/jun/1604_collins_young_uninsured_in_debt_v4.pdf).

To ensure we continue to build on the ACA's coverage gains, Young Invincibles recommends that Congress take the following policy actions:

1. Swiftly fund cost-sharing reduction payments through at least 2019;
2. Create a permanent reinsurance program—not high-risk pools;
3. Maintain existing guardrails around Section 1332 waivers;
4. Reverse cuts to marketplace enrollment promotion and consumer assistance—specifically targeting these efforts to reach young adults; and
5. Provide increased financial assistance to maximize young adult enrollment and further stabilize the market.

**1. Fund cost-sharing reduction payments through at least 2019.**

First, to ensure those already benefiting from the ACA do not see their coverage jeopardized, Congress should make clear that CSR payments will be made by immediately funding the reductions through a mandatory appropriation through at least the end of 2019. Making these payments would reduce uncertainty among consumers and carriers stemming from pending litigation and statements from the Administration about whether these payments will continue to be made. Moreover, these payments are already built into the Federal budget baseline and would not require additional spending.<sup>13</sup> By immediately funding CSRs through at least 2019, Congress will avoid increasing consumers' premiums up to 20 percent next year,<sup>14</sup> spur greater competition among insurers in the individual market, and prevent the Federal Government from absorbing the additional costs associated with financing enrollee's premium tax credits. This funding is crucial not only for consumers currently receiving CSRs, but also for marketplace consumers whose incomes may exceed the threshold to qualify for premium tax credits. This is especially critical for young adults who have seen their net worth drop 56 percent in the last 25 years.<sup>15</sup> Given young adults' lower net worth and incomes, young people are less able to absorb an increase in their out-of-pocket costs or 20 percent increase in premiums. Therefore, if CSR payments are not funded, we could see fewer young adults able to participate in the marketplaces.

**2. Create a permanent reinsurance program—not high-risk pools.**

Second, to keep premiums down and make coverage more affordable, Congress should create a permanent reinsurance program. National and state-level reinsurance programs have already been shown to significantly reduce premiums, which promotes market stability, insurer participation, and the enrollment of younger, healthier consumers. Under the ACA's temporary reinsurance program, for instance, reinsurance was estimated to have reduced premiums by 10 to 14 percent in 2014.<sup>16</sup> And earlier this year, Governor Walker estimated that consumers in Alaska could see their premiums drop as much as 20 percent next year because of the state's reinsurance program.<sup>17</sup> Reinsurance is not new or unique, nor is it an insurer bailout: for instance, Congress recognized the importance of a permanent reinsurance program when developing the Medicare Part D prescription drug program in 2003.<sup>18</sup> To provide immediate stability to the individual market, we recommend Congress guarantee funding for reinsurance through at least a 2-year mandatory appropriation.

Well-funded and well-designed reinsurance programs will go a long way to helping cover high-cost consumers—a return to State or Federal high-risk pools, on the other hand, will not. Historically, high-risk pools have been woefully inadequate at providing affordable, comprehensive coverage to those who need it most and would fail to meet the needs of young people, resulting in higher uninsured rates and subjecting those with pre-existing conditions which affect up to 35 percent of 18- to 24-

<sup>13</sup>Paul N. Van de Water, "Providing an Explicit Appropriation for Cost-Sharing Reductions Wouldn't Require a Budgetary Offset," Center on Budget and Policy Priorities (CBPP) blog, April 19, 2017, <https://www.cbpp.org/blog/providing-an-explicit-appropriation-for-cost-sharing-reductions-wouldnt-require-a-budgetary>.

<sup>14</sup>Congressional Budget Office, "The Effects of Terminating Payments for Cost-Sharing Reductions," August 2017, <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

<sup>15</sup>Tom Allison, "The Financial Health of Young America: Measuring Generational Declines Between Baby Boomers & Millennials," Young Invincibles, January 2017, 11, <http://younginvincibles.org/wp-content/uploads/2017/04/FHYA-Final2017-1-1.pdf>.

<sup>16</sup>American Academy of Actuaries, *Using High-Risk Pools to Cover High-Risk Enrollees* (2017).

<sup>17</sup>Matt Buxton, Alaska's health insurance premiums to fall by 20% with new Federal funding, *The Midnight Sun*, July 11, 2017, <http://midnightsunak.com/2017/07/11/alaskas-health-insurance-premiums-fall-20%-new-federal-funding/>

<sup>18</sup>Michael Hiltzik, "As GOP Moves Toward Repeal, A Government Report Shows Obamacare is Working Well," *Los Angeles Times*(Jul. 3, 2017)

year-olds and 46 percent of 25-to 34-year-olds to a lifetime of struggling to access care.<sup>19</sup>

I know this to be true, because when I was 23, I was diagnosed with Rheumatoid Arthritis. It was 2008, and, in the midst of moving and changing jobs, I was denied coverage on the individual market by multiple insurers due to my chronic condition. The State of Colorado hired me as a contractor, without benefits. It was a great opportunity, particularly in the midst of the Great Recession, but the prospect of going without health coverage was nerve-wracking. I was still fairly early in my diagnosis and trying to figure out the appropriate medications and treatment to control my condition, to prevent more serious health challenges down the road. Colorado's state-run high-risk pool, CoverColorado, which operated prior to the ACA, was the only place I could get covered, so I enrolled. Even with the subsidy I received, my insurance through CoverColorado was expensive. By law, CoverColorado's premiums could be up to 50 percent higher than standard individual market rates.<sup>20</sup> I was also subject to a 3-month pre-existing condition exclusion period,<sup>21</sup> which meant that for one-quarter of the time that I was on the plan, I still lacked the coverage I needed. And CoverColorado had a lifetime limit of \$1 million.<sup>22</sup>

I was not alone in my experience. In 2008, about 23 percent of CoverColorado enrollees were young adults between the ages of 20 and 39.<sup>23</sup> However, there were also many Coloradans with pre-existing conditions who were left out of our State's previous high-risk pool. At its peak, CoverColorado only served about 14,000 people and accounted for only 3.5 percent of Coloradans in the individual market in 2011.<sup>24</sup> Today, it is estimated that about 753,000 non-elderly Coloradans—nearly 54 times that number, or 22 percent of Colorado's nonelderly population—have a pre-existing condition that could potentially make them eligible for a high-risk pool.<sup>25</sup>

But it is not just health care consumers that come up short under high-risk people schemes; it is the government and taxpayers as well. In a recent interview with *The Denver Post*, former Colorado insurance commissioner Marcy Morrison explained that Colorado regularly struggled to fund the pre-ACA CoverColorado program.<sup>26</sup> And the cost to operate a high-risk pool offering ACA-like coverage and subsidies—where the typical consumer spends between 8 and 10 percent of their income on coverage—would be very expensive: up to \$656 billion over 10 years.<sup>27</sup>

### 3. Maintain existing guardrails around Section 1332 waivers.

As we think about building on coverage gains made by the ACA, we recognize the value and importance of State flexibility in expanding access to coverage. For example, Colorado decided to run its own state-based marketplace and expand its Medicaid program. As a result of these efforts, Colorado has seen a reduction in its uninsured rate from 14.3 percent in 2013 to 6.7 percent in 2015, with young adults seeing the largest gains in coverage.<sup>28</sup> Section 1332 waivers are one way that States can make changes that build upon these types of successes and improve young people's access to quality, affordable health insurance.

However, amendments to Section 1332 that would change the law's guardrails would harm the most vulnerable young people. We urge Congress not to change the Section 1332 guardrails that require that any waiver proposal provide coverage to at least a comparable number of residents as the ACA, provide coverage that is at least as comprehensive and affordable as the ACA, and not increase the Federal def-

<sup>19</sup> High Risk Pool Ruse, USA Today, March 5, 2017, <https://www.usatoday.com/story/opinion/2017/03/05/high-risk-pool-ruse-editorials-debates/98681846/>; "At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans." HHS ASPE Brief. p.1. <https://aspe.hhs.gov/system/files/pdf/76376/index.pdf>.

<sup>20</sup> Robin Baker, Bell Policy Center, Non-Group Insurance: Not a Quick Fix for Health Care, Page 10, (2009).

<sup>21</sup> Blair Miller, "Despite Concerns Over Pre-existing Conditions, Rep. Mike Coffman Leaning Yes on AHCA as Vote Looms," Denver Channel (May 3, 2017).

<sup>22</sup> Ibid.

<sup>23</sup> Robin Baker, Bell Policy Center, Non-Group Insurance: Not a Quick Fix for Health Care, Page 11, (2009).

<sup>24</sup> John Ingold, "High-Risk Pools, A Centerpiece of GOP Health Care Bill, Have a History in Colorado," *The Denver Post* (May 5, 2017); Karen Pollitz, High-Risk Pools for Uninsurable Individuals, Page 4, (2017).

<sup>25</sup> Gary Claxton et al., Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA (2016).

<sup>26</sup> "High-risk pools, a centerpiece of GOP health care bill, have a history in Colorado," *The Denver Post*, May 5, 2017, <http://www.denverpost.com/2017/05/05/high-risk-pools-ahca-history-colorado/>.

<sup>27</sup> Linda Blumberg et al., High-Risk Pools Under the AHCA: How Much Could Coverage Cost Enrollees and the Federal Government?, Page 4, (2017).

<sup>28</sup> "Impacts of the Affordable Care Act," Colorado Health Institute, last updated February 21, 2017, <https://www.coloradohealthinstitute.org/research/impacts-affordable-care-act-0>.

icit.<sup>29</sup> These guardrails are as important as ever in light of recent State waiver proposals that would decimate financial assistance for low-income young adults, like those proposed by Iowa and Oklahoma.<sup>30</sup> Additionally, allowing States to waive essential health benefit requirements, for example, could actually decrease rather than increase young adult enrollment, by reducing or eliminating the services like maternity and newborn care, mental health and substance use disorder services, and preventive services—that young people use and value the most in their coverage.<sup>31</sup>

**4. Reverse cuts to marketplace enrollment promotion and consumer assistance—specifically targeting these efforts to reach young adults.**

To bring greater stability to the market and help more young people achieve the financial security associated with having coverage, we recommend boosting enrollment promotion and assistance efforts with additional funds dedicated to targeting young adults. Despite tremendous gains since the passage of the ACA, 11 million young adults remain uninsured.<sup>32</sup> About 6.1 million of these uninsured young adults have incomes that could qualify them for premium tax credits.<sup>33</sup> Of those, approximately 4.2 million of them have incomes that could qualify them for cost-sharing reductions,<sup>34</sup> including over 3 million who may be eligible for insurance plans with deductibles no larger than \$250 a year.<sup>35</sup>

Guaranteed CSR payments and a reinsurance program would help bring premiums down for even more young people, but actual enrollment depends on young adults knowing about their options. Many young people remain unaware of premium tax credits or opportunities to enroll in marketplace coverage, with historically too few resources devoted to reaching this population. For example, a report from the Commonwealth Fund found that 19-to 34-year-olds were the least likely group of uninsured adults to know about the insurance marketplaces.<sup>36</sup> This is not surprising; young people are often learning about the health coverage system for the first time in their lives.

The Administration's announcement that they would cut Navigator grants by 41 percent and paid advertising by 90 percent for this upcoming enrollment period goes in the exact wrong direction.<sup>37</sup> Congress should reverse these cuts and direct HHS to administer these resources so as not to limit enrollment,<sup>38</sup> imperil the risk pool, and discourage issuers' future participation in the marketplace. These outcomes would result in higher premiums for consumers and greater costs to the government and taxpayers in future years.

Navigators, consumer assistance programs, and marketplace call centers help bridge inequities in health insurance literacy and ensure that young people understand their options and are able to get covered. And we have seen the value of this assistance in our state-based outreach efforts. For example, recently, someone on our outreach team in Virginia recently met a student in Burke, Virginia who was weeks away from turning 26. She did not understand her options for transitioning

<sup>29</sup> 42 U.S. Code § 18052(b)(1).

<sup>30</sup> Iowa Insurance Division, Draft: Iowa Stopgap Measure, July 13, 2017, <https://iid.iowa.gov/documents/iowa-stopgap-measure>; Oklahoma State Department of Health, Oklahoma 1332 Waiver Application, Page 18, August 16, 2017.

<sup>31</sup> How Millennials Use Their Health Insurance, Young Invincibles, August 2016, <http://younginvincibles.org/wp-content/uploads/2017/04/how-millennials-use-health-care.pdf>

<sup>32</sup> Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016. Based on raw number of uninsured young adults ages 18 to 34. <http://www.census.gov/cps/data/cpstablecreator.html>

<sup>33</sup> *Ibid.*

<sup>34</sup> Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016. Based on raw number of uninsured young adults earning between 100 and 250% FPL. <http://www.census.gov/cps/data/cpstablecreator.html>.

<sup>35</sup> *Ibid.* Based on raw number of uninsured young adults earning between 100 and 250% FPL; Center for Budget & Policy Priorities, Key Facts You Need to Know: Cost-Sharing Reductions, Page 2, December 3, 2015, <http://www.healthreformbeyondthebasics.org/wp-content/uploads/2013/09/KeyFacts-Cost-Sharing-Reductions.pdf>.

<sup>36</sup> S. R. Collins, M. Z. Gunja, M. M. Doty, and S. Beutel, "Who Are the Remaining Uninsured and Why Haven't They Signed Up for Coverage?," The Commonwealth Fund, August 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/aug/who-are-the-remaining-uninsured>

<sup>37</sup> Amy Goldstein, The Washington Post, Trump officials slash advertising, grants to help Americans get Affordable Care Act insurance, August 31, 2017, [https://www.washingtonpost.com/national/health-science/trump-officials-slash-advertising-grants-to-help-americans-get-affordable-care-act-insurance/2017/08/31/e8a45386-8e8f-11e7-84c0-02cc069f2c37\\_story.html?utm\\_term=.17f5754f54d3](https://www.washingtonpost.com/national/health-science/trump-officials-slash-advertising-grants-to-help-americans-get-affordable-care-act-insurance/2017/08/31/e8a45386-8e8f-11e7-84c0-02cc069f2c37_story.html?utm_term=.17f5754f54d3).

<sup>38</sup> Pinar Karaca-Mandic, Health Affairs, The Volume Of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage, March 2017



off dependent coverage, was unaware of the 60-day special enrollment period, and had no idea she could qualify for premium tax credits. She now plans on making an appointment with Enroll Virginia as her birthday gets closer. Without this additional information, the young woman could have missed her opportunity to enroll. And she's far from alone: due to mixed messages from the Administration and uncertainty in Congress, we have seen that consumer confusion has increased. All of this calls for renewed, targeted outreach and assistance funding that helps provide accurate information to consumers and better ensures that young adults know about their coverage options.

**5. Provide increased financial assistance to maximize young adult enrollment and further stabilize the market.**

To achieve our shared goal of boosting young adult enrollment and further stabilizing the individual market, Congress should do more to further reduce young adults' premium costs to help more of them afford coverage. One proposal suggests a boost in financial assistance by an additional \$50 a month for young adults. This would result in an additional 900,000 insured young adults at a less than \$3.7 billion a year price tag to the Federal Government.<sup>39</sup>

Another way to lower costs for young people is to lower the premium affordability threshold for young adults. This would result in greater financial assistance for young people based on their incomes and account for, as the ACA currently does, premium variation in markets across the country. Boosting young adult enrollment in the marketplaces will not only help young people, but can help reduce premiums for marketplace consumers more broadly.<sup>40</sup> Lowering the affordability threshold would help make plans more accessible to the lowest income young people in the highest cost markets, ultimately bringing down costs for all consumers. We are currently analyzing the full impact on coverage, premiums, and cost that such a proposal would have.

As Congress considers ways to bring premiums down, we would caution that bringing premiums down by increasing out-of-pocket costs may do very little to help young people afford care. Very high-deductible or catastrophic plans will further expose our cash-strapped generation to financial insecurity that most cannot afford. Enrollment trends show little appetite for skinny plans, with young people opting overwhelmingly for more comprehensive coverage, not less.<sup>41</sup> In 2015, 77 percent of young adults ages 18 to 34 in Healthcare.gov States chose a Silver-level plan or higher, with only 21 percent selecting a Bronze plan and 3 percent in a catastrophic plan.<sup>42</sup> Perhaps surprising to some, a recent survey found that young adults were nearly 40 percent more likely to indicate that they would prefer a plan with a higher monthly premium and a lower deductible as compared with adults 50 and over.<sup>43</sup> This is particularly true for low-and middle-income consumers; the survey found just 39 percent of those earning under \$50,000 a year preferred a low premium, high-deductible plan, compared to 52 percent of people making over \$50,000.<sup>44</sup>

While so-called "copper plans" or similar proposals would certainly reduce premiums,<sup>45</sup> deductibles for these policies would be around \$9,000,<sup>46</sup> even while a recent analysis of consumer finance data found that, for young people, an extraordinary medical payment amounted to \$1,406.<sup>47</sup> Furthermore, the typical young adults' net worth is just \$10,900,<sup>48</sup> and the median income for an uninsured young

<sup>39</sup>C. Eibner & E. Saltzman, The Commonwealth Fund, Insuring Younger Adults Through the ACA's Marketplaces: Options to Expand Enrollment, December 16, 2016, <http://www.commonwealthfund.org/publications/blog/2016/dec/insuring-younger-adults>

<sup>40</sup>Ibid.

<sup>41</sup>ASPE Issue Brief, "Health Insurance Marketplace 2015 Open Enrollment Period: March Enrollment Report," 30-31, [https://aspe.hhs.gov/system/files/pdf/83656/ib\\_2015mar\\_enrollment.pdf](https://aspe.hhs.gov/system/files/pdf/83656/ib_2015mar_enrollment.pdf).

<sup>42</sup>Ibid.

<sup>43</sup>Jay McDonald, Bankrate, How bad is shopping for health insurance?, December 2, 2014, <http://www.bankrate.com/finance/insurance/health-insurance-poll-1114.aspx>.

<sup>44</sup>ibid.

<sup>45</sup>Caroline Pearson, Avalere Health, Avalere Analysis: "Copper Plan" Alternative Would Lower Premiums 18 percent, August 20, 2014, <http://avalere.com/expertise/managed-care/insights/avalere-analysis-copper-plan-alternative-would-lower-premiums-18>

<sup>46</sup>46 Ezra Klein, Vox.com, 7 Democrats have a plan to make Obamacare cheaper. Here's how., October 28, 2014, <https://www.vox.com/2014/10/28/7083343/obamacare-copper-plans-explained>

<sup>47</sup>Farrell, Diana and Greig, Fiona. "Coping with Medical Costs through Life." JPMorgan Chase Institute, 2017

<sup>48</sup>Tom Allison, "The Financial Health of Young America: Measuring Generational Declines Between Baby Boomers & Millennials", Young Invincibles, January 2017, Page 11, <http://younginvincibles.org/wp-content/uploads/2017/04/FHYA-Final2017-1-1.pdf>.

worker is just \$20,000 a year.<sup>49</sup> In the event of a health care emergency, these types of policies would require a young person to spend nearly all of their net worth—or half the annual income of a typical uninsured young worker to even meet their deductible. Even if such a plan were coupled with a Health Savings Account, the typical uninsured young person would have to save \$632 a month to avoid facing an extraordinary medical payment just to meet a copper plan deductible.<sup>50</sup> Young people may determine that a plan offering them such little in value is not worth the cost and forego coverage altogether.

Millions of young people are accessing coverage for the first time and millions more are benefiting from the law's benefit standards and consumer protections, enabling them to live independent, productive lives without fear of experiencing a health emergency and devastating financial loss. We hope Republicans and Democrats will follow this committee's lead and work together to bring greater stability to the health care system and make meaningful changes to the law to meet the needs of young people across the country. Thank you for the opportunity to speak with you today. I look forward to taking your questions.

The CHAIRMAN. Thank you very much.

Mr. Farmer, welcome.

**STATEMENT OF RAYMOND G. FARMER, DIRECTOR, SOUTH CAROLINA DEPARTMENT OF INSURANCE, NAIC SECRETARY-TREASURER, COLUMBIA, SC**

Mr. FARMER. Good morning, Chairman Alexander, Ranking Member Murray, and distinguished members of the committee. My name is Ray Farmer, and I am the Director of Insurance in South Carolina and Secretary-Treasurer of the National Association of Insurance Commissioners. I testify today on behalf of the membership of the NAIC, and I thank you for this opportunity.

State insurance regulators have seen firsthand the effects of the Affordable Care Act's health insurance reforms on our markets, and the results have been mixed. While the experiences of the States have differed, every State regulator is concerned that things could be worse in 2018 if the necessary actions at the Federal level are not swiftly taken.

As my fellow commissioners testified last week, there are three immediate actions Congress can and should take to stabilize the individual health insurance markets across the country.

One, ensure health insurance carriers will be reimbursed for the enhanced cost-sharing plans they offered to lower-income consumers under the law. Two, reinstate the Federal reinsurance programs. And three, amend Section 1332 to create a waiver process that is clear, timely, and flexible. These actions would help stabilize rates, encourage carriers to remain in the market, and improve consumer choice.

I know that you have heard similar recommendations from commissioners, Governors, and others over the past week, but I would like to make a few points.

First, to reimburse carriers under the cost-sharing reduction program is in no way a bailout of the industry. Under the ACA, carriers that sell on the exchange are required to offer Silver plans with lower cost-sharing requirements such as deductibles and co-insurance, but must charge the same premium as they charge for the standard version of those same Silver plans. The ACA States

<sup>49</sup> Young Invincibles' analysis of Current Population Survey, Annual Social and Economic Supplement, 2016.

<sup>50</sup> Ibid.; Farrell, Diana and Greig, Fiona. "Coping with Medical Costs through Life." JPMorgan Chase Institute, 2017

that the Secretary of HHS shall make periodic and timely payments equal to the value of the reductions in these cost-sharing requirements as compensation for these enhanced benefits to consumers. If the Federal Government fails to fulfill its reimbursement obligations, or if uncertainty over reimbursements continues, carriers will be forced to stop selling plans or increase premiums by 15 to 20 percent to offset their losses.

The best option is for the Federal Government to pay its obligations under the law. Carriers need to know what rules they will be operating under in 2018, and they must know now before rates are finalized and exchange participation contracts are signed in less than 2 weeks. Furthermore, carriers need to know payments will be made in 2019 before they start working on the 2019 rates, which will occur early 2018.

Second, uncertainty in the risk pool has also increased premiums and moved some carriers to stop selling on the exchange. The risk pool in many States is much sicker than anticipated, and the resulting claims have led to significant losses for some. To address this, the NAIC recommends that \$15 billion per year be provided to cover high claims. We believe this can be implemented quickly by the Federal Government, as is similar to the program that worked successfully in 2014 through 2016. This would not only bring greater stability to rates but also save the Federal Government billions of dollars through lower premium tax credits.

As to whether States or the Federal Government should fund and operate the reinsurance program, it would be impossible for most States to implement such a program in 2018, or even in 2019 in many States. Most States do not have the existing authority to create such a program or the existing revenue to fund it or the mechanisms to operate it. By contrast, the Federal Government can reinstate the reinsurance program quickly and impact rates in 2018.

Third, as you've heard from several witnesses, the current Section 1332 waiver process is simply too uncertain, too time-consuming, and too limited to be a real option for most States. The NAIC recommends more flexibility, clear guidance, and timely deadlines to be established.

Finally, we urge the Senate to also consider extending the moratorium on the Section 9010 annual fee on health insurance providers through 2013, thus reducing premiums, and also to provide assistance to the U.S. Territories, whose markets have been devastated under the ACA.

State regulators remain committed to working collaboratively with Congress on a non-partisan basis to address the longer-term issues related to health insurance. As your partners in government, we look forward to working with you as we all seek to make health insurance coverage more affordable and accessible.

[The prepared statement of Mr. Farmer follows:]

PREPARED STATEMENT OF RAYMOND G. FARMER

SUMMARY

While the experiences of the States have differed under the ACA, every State regulator is concerned that things could be worse in 2018 if the necessary actions at the Federal level are not swiftly taken.

Specifically, immediate action must be taken to: (1) ensure health insurance carriers will be reimbursed for the enhanced cost-sharing plans they offer to lower-income consumers under the law; and (2) reinstate the Federal reinsurance program that successfully operated in 2014 through 2016. Both of these actions would help stabilize rates, encourage carriers to remain in the market, and improve consumer choice.

To be clear, the Cost Sharing Reduction (CSR) program provides financial assistance to consumers and is in no way a “bailout” of the industry. Under the ACA, carriers that sell on the Exchange are required to offer Silver plans with lower cost sharing requirements (such as deductibles and coinsurance) but must charge the same premium as they charge for the standard version of those same Silver plans. The ACA States that the Secretary of HHS “shall make periodic and timely payments... equal to the value of the reductions” in these cost sharing requirements as compensation for these enhanced benefits to consumers.

If the Federal Government fails to fulfill its obligations to reimburse carriers, they will be forced to stop selling plans or significantly increase premiums. If carriers have to raise premiums by 15–20 percent to offset their losses due to unpaid Federal obligations, it is estimated that it will cost the Federal Government an extra \$194 billion over the next 10 years due to increased premium tax credit payments.

The risk pool in many States is much sicker than anticipated and the resulting claims have led to significant losses for some. To address this, the NAIC supports the reinstatement of the Federal Temporary Reinsurance Program. We recommend that \$15 billion per year be provided to cover high claims. It is important for the Federal Government to act because it would be impossible for most States to create and implement such a program for 2018, or even 2019.

In addition, the NAIC recommends that Congress: (1) extend the moratorium on the Section 9010 Annual Fee on Health Insurance Providers through 2019, thus reducing premiums; (2) modify the Section 1332 waiver process to give clear guidance to States and expedite the review process; and, (3) provide assistance to U.S. Territories, whose markets have been adversely treated under the ACA.

State regulators remain committed to working collaboratively with Congress on a non-partisan basis to address the longer-term issues related to health insurance. As your partners in government, we look forward to working with you as we all seek to make health insurance coverage more affordable and accessible.

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Good morning Chairman Alexander, Ranking Member Murray, and distinguished members of the committee. My name is Ray Farmer and I am the appointed Director of the South Carolina Department of Insurance and Secretary-Treasurer of the National Association of Insurance Commissioners<sup>1</sup> (NAIC). I testify today on behalf of the membership of the NAIC and I thank you for this opportunity to discuss how to immediately address an issue of critical importance to State regulators: the uncertainty and resulting lack of stability in our individual health insurance markets.

As State insurance regulators, we have seen firsthand the effects of the Affordable Care Act’s (ACA’s) health insurance reforms on our markets, and the results have been mixed. In some States, the individual market is struggling and, in a few, it is on the verge of collapse. In these States, premium increases, limited plan options, little or no competition, rising cost-sharing and more limited options have combined to create a health insurance market that fails to meet the needs of consumers and is unsustainable. However, in other States, the individual market is robust, with increased enrollment and stable premiums.

While the experiences of the States have differed, every State regulator is concerned that things could be worse in 2018 if the necessary legislative and administrative actions at the Federal level are not swiftly taken. Specifically, immediate action must be taken to: (1) ensure health insurance carriers will be reimbursed for the reduced cost-sharing plans they offer to lower-income consumers under the Cost-Sharing Reduction (CSR) program under the ACA; and 2) create a Federal reinsurance program with permanent funding similar to that which operated in 2014-2016, to spread the volatile risk in the individual market. Both of these actions would help stabilize rates, encourage carriers to remain in the market, and improve consumer choices.

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<sup>1</sup> Founded in 1871, the NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 States, the District of Columbia and the five U.S. territories. Through the NAIC, State insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

To be clear, the CSR program provides financial assistance to consumers. The reimbursement to carriers under the CSR program is in no way a “bailout” for health insurance carriers. Pursuant to Section 1402 of the ACA, issuers that sell Qualified Health Plans (QHPs) on the Exchange must offer Silver plans with lower deductibles and coinsurance—plans with a 94 percent actuarial value, an 87 percent actuarial value and a 73 percent actuarial value, depending on income—but must charge the same premium as the 70 percent actuarial value Silver plan. The ACA also clearly States that the Secretary “shall make periodic and timely payments to the issuer equal to the value of the reductions” to compensate them for Section 1402’s requirement. Fulfilling the Federal law’s requirement to reimburse health insurance carriers for benefits they are providing to lower-income consumers is not a bailout by any stretch of the definition.

If the Federal Government fails to fulfill its obligations to reimburse health insurers, insurers will have only two choices: (1) stop selling plans on the Exchange or in the individual market altogether; or (2) significantly increase premiums for all plans or just the Silver plans. If carriers have to raise premiums by 15–20 percent to offset their losses under the CSR program what will be cost to the public As estimated by the Congressional Budget Office in its August 2017 report “*The Effects of Terminating Payments for Cost-Sharing Reductions*”, increasing the Silver plan premiums will cost the Federal Government \$194 billion over the next 10 years in increase tax credit payments and there will still be more consumers in areas with no coverage options. In addition, it must be noted that while those receiving tax credits may be protected from the higher premiums, those not eligible for tax credits could be hit with significant premium increases or be forced to move to a Bronze plan that has higher cost-sharing.

The best option is for the Federal Government to pay its obligations under the law. And, assurances that these payments will be made in 2018 must be made now. On August 10th, CMS/CCIIO issued an FAQ that allowed carriers to adjust their rate filings and finalize them by September 20, 2017, while carriers must sign their contracts to sell on the Federal Exchange by September 27, 2017. Insurance carriers need to know now under what rules they will be operating in 2018, and they must know now before rates are finalized and contracts are signed.

In addition to uncertainty in the Federal funding, uncertainty in the risk pool has also increased premiums and moved some carriers to stop selling on the Exchange. The risk pool in many States is much sicker than expected and extraordinary claims have resulted in significant losses for some carriers. To address this, the NAIC supports the creation of a Federal reinsurance program to spread the risk of the small, volatile individual market to a larger pool. We recommend that \$15 billion per year be provided to cover high claims. This is a program that can be implemented quickly as it is similar to the program that work successfully in 2014–2016 under the ACA. Protecting carriers from outlier claims and spreading the risk of the individual market will stabilize rates for consumers and encourage carrier participation, giving consumers more choices.

In addition to fully funding the CSR reimbursements and creating a Federal reinsurance program, to address high risk claims, the NAIC also recommends that Congress: (1) extend the moratorium on the Section 9010 Annual Fee on Health Insurance Providers through 2019; (2) modify the Section 1332 waiver process; and, (3) provide assistance to U.S. Territories, whose markets have been adversely treated under the ACA.

Extending the moratorium on the Section 9010 premium tax would, of course, help reduce premiums. Modifying Section 1332 waiver requirements would allow more States to pursue their State-based solutions more quickly, thus returning more decision-making back to the States where they are best equipped to balance consumer and insurer needs for a strong market that offers competition, affordable options and significant consumer choice. When modifying Section 1332 requirements, Congress should consider the fact that States are hesitant to pass legislation unless it is clear that it will be approved. Without clear direction regarding what, exactly, may be waived under Section 1332, States are left looking to CMS for guidance, which often does not come. Any congressional efforts to amend Section 1332 should be very clear about what can, and cannot, be waived. Finally, providing grants to the Territories would help them repair their markets where very few, if any, carriers are currently selling individual market coverage.

We also note that several legislative proposals have been introduced under the auspices of market stabilization and increased competition that actually would have the opposite effect. For example, the Competitive Health Insurance Reform Act, H.R. 372, a bill that would repeal the health insurance exemption from Federal antitrust laws as established by the McCarran-Ferguson Act, could have far-reaching implications which could hinder competition, harm consumers and weaken the

health insurance market. States have their own antitrust and unfair competition laws. State regulators and attorneys general play complimentary and mutually supportive roles in monitoring and investigating insurers, agents, and brokers to prevent and punish activities prohibited by those State laws. Furthermore, the NAIC's fundamental concern in the 1940's—a concern that continues to define the NAIC's position on antitrust reform today—was that the competitive benefits of collectively developing loss costs and policy language would be jeopardized by the insertion of Federal antitrust authority in the insurance markets. This limited exemption allows insurers to share loss data, which promotes healthy insurance markets by increasing the level and competence of the competition.

Another legislative proposal that could adversely affect health insurance markets is the Small Business Health Fairness Act, H.R. 1101. This bill would allow a new category of federally supervised health insurance company, "Association Health Plans (AHPs)," to form and operate outside the authority of State regulators and beyond the reach of proven State consumer protections and solvency laws. State insurance regulators share the Congress's concern for the growing number of small business owners and employees who cannot afford adequate coverage. H.R. 1101, however, would do little, if anything, to address the problem and could exacerbate the problem by encouraging AHPs to "cherry-pick" healthy groups. This, in turn, would make existing State risk pools even riskier and more expensive for insurance carriers, thus making it even harder for sick groups to afford insurance. States already have the power to authorize and supervise AHPs but importantly would do so in a way that protects those consumers and ensures a level playing field. A top-down Federal approach like H.R. 1101 would only empower more Federal creep, which we vehemently oppose.

Finally, legislative proposals that would mandate interstate sales of health insurance policies, such as S. 1516 and H.R. 314, would do nothing more than undermine State insurance laws, make health insurance policies less available, make insurers less accountable, and prevent State regulators from assisting consumers in their States. Under S. 1516 and H.R. 314, insurance carriers would be allowed to choose their own regulator—their "primary state"—and sell health insurance policies in any other State without having to comply with that state's insurance regulations and laws. Naturally, insurance carriers will seek out a State with regulations that allow them to most aggressively select the healthiest risk, this would then cause risk pools with sicker enrollees to experience steep premium hikes, thus making it more difficult to increase enrollment. Consequently, as existing risk pools collapsed, insurance policies would be forced to cover less and less as insurers try to design policies that discourage the sickest consumers from signing up. Rather than being a top-down Federal mandate as they are in S. 1516 and H.R. 314, interstate sales should be conducted under voluntary agreements among States under which appropriate market rules will be set by interstate compact.

To summarize, the NAIC recommends that Congress act immediately to: 1) fully fund CSR reimbursements; 2) provide \$15 billion per year for a Federal reinsurance program; 3) extend the moratorium on Section 9010 fees; 4) modify the Section 1332 waiver requirements to provide flexibility and expedite the process; and, 5) provide grants to U.S. Territories. Doing these things now will help shore up the individual health insurance market as the Congress continues its consideration of broader reforms.

State regulators remain committed to working collaboratively with Congress on a non-partisan basis to address the longer-term issues related to health insurance. As your partners in government, we look forward to working with you as we all seek to make health insurance coverage more affordable and accessible.

The CHAIRMAN. Thank you, Mr. Farmer, and thanks to each of you.

We will now begin a 5-minute round of questions, and I will try to hold to 5 minutes for the questions and answers because we have lots of senators who want to be a part of it.

We'll start with Senator Enzi.

#### STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman.

I want to thank the witnesses of all of the panels that we've had, but I want to thank the Chair and the Ranking Member for going

into this vigorous process that seems to have brought out a lot of good ideas.

I've appreciated the comments on the invisible high-risk pool, which means that nobody knows that they're in it, and they don't pay any different premium than they were before. I think there's a way for that to be done in a rather quick manner.

I've appreciated the favorable comments on the small business health plans that allow groups of people to band together to be able to more effectively negotiate the rates. I'm always trying to figure out how to get more people insured, and I had a constituent that was paying attention to what we're doing, evidently, because the person paid a fine for not having any coverage, and she said "I've been paying for the small stuff myself. If I could get a Copper plan with catastrophic coverage, it would be more valuable than sending money to the Federal Government where I don't know where it goes."

Dr. Sethi, would you like to comment on that?

Dr. SETHI. Well, thank you so much, Senator. You know, what we—what I have seen with patients across Tennessee is that a lot of the folks who cannot obtain insurance in the individual market, it is because the premiums are simply too high, and then compounded with the fact that the deductibles are too high.

So I think allowing a catastrophic plan for all ages that could buy in would allow these patients to enter the individual market. So I believe that is a good step in providing affordable insurance coverage.

Senator ENZI. Thank you. I'm glad we have an insurer on the panel, too, because I think there's been a problem with people signing up on their way to the hospital and not being able to pay premiums, and when they get out of the hospital dropping their policy. As an insurer, do you think if we had a Copper plan that covered catastrophic so that we can encourage people to get into a plan, that would help? One suggestion that I saw was that if we drop the penalty and then after a year, after a year if people didn't have coverage for that first year, then they'd kind of be on their own for a year. But they'd have a year's grace to be able to sign up to some plan, and if they paid for at least the Copper plan for that last year they'd be covered. Is that a viable thing for bringing down costs and getting something instituted?

Mr. RUIZ-MOSS. Thank you for the question. I would agree that the way to bring more people into the market and have them maintain coverage is first to make coverage more affordable. So we see that as a critical piece in getting more people to join. Then there needs to be continuous coverage provisions. So today we have the individual mandate, that provision intended to make sure that people buy and keep coverage. The challenge I think that was stated earlier is the difference between the penalty and an insurance premium is so broad that it's losing its effect, and the fact that people can enroll specifically to come in and get services and then dis-enroll from plans is really our key contributors to destabilizing that market overall.

The Copper plan is an interesting concept. I think one of the things you have to consider is that a Copper plan is already a similar level as a Bronze plan is today. So there is an available option

that's going to be similar to a Copper plan. A big reason that the catastrophic plans are so inexpensive today relative to the other plans is that they're only available to people 30 and under, and there's no subsidy in those plans. So if you open that plan up to a broader population and assume older ages or other conditions are going to come into that plan, the premiums are going to have to reflect that expected underlying cost from the new population, thereby hurting some of the affordability that's in those plans today.

I think my colleague pointed out those plans do have much higher deductibles, co-insurance, et cetera, so they may not be the right plan for everyone. So I think all that ultimately has to be considered in offering catastrophic coverage.

Senator ENZI. Thank you. My time has almost expired. I'll try to help out.

The CHAIRMAN. Thank you, Senator Enzi.

Senator Murray.

Senator MURRAY. Well, thank you to all of our panelists. This is really a good discussion.

Ms. Postolowski, I want to start with you. Thank you for sharing your expertise and experience.

Over the last couple of weeks, this committee has spent a lot of time talking about how we can get more young people to sign up so that the pools are spread a little more across the board and lowering the cost for everyone. One theory says that if States have the ability to sell coverage with higher deductibles and fewer benefits, young people will buy that coverage because it has a lower premium. Given your experience with the health care system and your work with young people who need health care, give us your perspective on that approach.

Ms. POSTOLOWSKI. Certainly. So what I'm hearing you bring up is conversations around potential changes to essential health benefits or potential changes to cost-sharing under private insurance plans. I would start by saying that as a reminder, the essential health benefits represent 10 basic categories of services that States had a fair amount of flexibility in setting up initially in determining what plan they were going to use to determine what would be in those essential health benefits.

It might surprise members of the committee, but the health care services that young people use the most actually fall under the EHB categories. So things like mental health coverage, 7.6 million young people received treatment for a mental health condition last year. Maternity care is another big one for our generation. We know 8.7 million women received maternity care through the ACA for the first time, and preventive services.

Senator MURRAY. So making sure we provide those services is an incentive to young people to sign up?

Ms. POSTOLOWSKI. Yes. That's certainly what I hear when I talk to young people on the ground, and the presence of the out-of-pocket maximums, the lack of annual lifetime limits on the EHBs also provide important financial security for young people. Again, the average young person on the marketplace is making \$26,000 a year, so they don't have a lot of room, if they do get hit with a big medical bill, to pay for that coverage.



Senator MURRAY. OK, thank you.

Dr. Turney, let me turn to you. Marshfield's health plan you said disproportionately serves rural and low-income populations, and you testified that more of your enrollees received out-of-pocket cost reductions than other plans. Talk to us a little bit about what the uncertainty around the out-of-pocket cost reductions has had on your enrollees.

Dr. TURNEY. You know, we talked about the income of the younger adults that live in Colorado. Our average household income for a family of four in the northern half of the State of Wisconsin is \$42,000. In the State overall, it's \$66,000. So you can see that people are making very tough choices about where their money goes. And if you live in Wisconsin, you know you have to heat your house in the winter, and they're making those decisions, do I heat my house or do I actually get health care?

What we see is that the people that are in the exchange are very hard-working people. They are oftentimes self-employed or they're in a very small business. So they really have no other option for health insurance. They need to come to the exchange to make that happen.

What we've seen, the extremes that we've seen, however, is much like what others are seeing in that we have about a 30 percent drop-off in the number of people that maintain coverage at the last 3 months of a calendar year, and that's been consistent for the last 3 years.

We also know that we have a high percentage that are sicker. About 50 percent of the people in the exchange are over 50. The population tends to be sicker, and we know that about 15 percent of the people on the exchange that we serve for 30,000 patients account for about 80 percent of the cost.

So as we look at how to help the patients that we serve—and our choice is to see all patients regardless of their ability to pay—we know that without the CSRs, we know that without reinsurance, and we know that without risk adjustment, it's going to be a challenge for the health plan and the provider group that are very closely tied to really serve the population in the best way possible.

We certainly have evidence that the patients that have come onto the exchange, many who have been on the exchange all 3 years, have better outcomes. They're coming in for preventive care. They're getting the screening health care. Their chronic illnesses are better managed.

So we want to continue to serve that population, we want to serve our communities, but without the opportunity to make that happen, it's going to be a very big challenge for us.

Senator MURRAY. OK, and this committee has heard a lot about providing certainty for this program beyond 2018, so more than 1 year. How soon do you start developing your premiums for 2019?

Dr. TURNEY. We're already in the process of setting premiums. We start 18 months or more in advance looking at the population, the services they've utilized, and determining how we can provide the premiums that are going to be acceptable to the patients that we serve. We know that without the CSRs, certainly like others, our rates would go up over 20 percent this year, above what they

already are. That is just not tenable for the people that we take care of.

Senator MURRAY. OK. And really quickly, Mr. Farmer, you mentioned reinsurance helping reduce premiums in the individual market. Can you talk a little bit more about that?

Mr. FARMER. Sure. We've seen over the years that when reinsurance is paid, it stabilizes the rates on the front end. We did a survey of our carrier for the year 2014, and it showed a reduction of about 21 percent. So the Federal dollars or the reinsurance dollars certainly pay off on the front end.

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

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murray.

Senator Collins.

#### STATEMENT OF SENATOR COLLINS

Senator COLLINS. Mr. Farmer, following up on Senator Murray's question, do you think that it would be helpful if the Federal Government were to provide some initial seed money to help States establish reinsurance funds or reinsurance pools in the short term?

Mr. FARMER. Certainly in the short term, and in my opinion the longer term. You know, I know funding is tight and dollars are hard to come by, but the more the Federal Government can put in the reinsurance program to support this Federal program, the better States are going to be. We've seen reinsurance payments reduce premiums on the front end.

Senator COLLINS. Thank you.

Dr. Turney, I support giving States more flexibility in plan design, but I think you quickly get into a thorny issue, and I want to give you an example and get your reaction, and that is the interaction between certain essential health benefits that are listed under the ACA and the prohibition against lifetime or annual caps on insurance benefits. If a State chooses not to cover mental health and substance abuse treatment as an essential benefit, then doesn't that make the cap on lifetime and annual benefits irrelevant?

Dr. TURNEY. You know, that's a really good question, and I would speak to the issue of the waiver because I think that's one of the things that is certainly on the table. We would struggle understanding what the flexibility would look like if we eliminated the essential health benefits and if we didn't have the guardrails for the protection of our patients.

So if you look at the economics in health care, if you aren't serving your population and they need care, which they frequently do, someone is going to have to pay for that care, whether it's through taxes or a federally funded program. So I think it's critical as we give States flexibility in the way they design care that we continue the protections that exist today for our patients.

So then what you're really looking at is insurance design. I think it would be interesting to hear what other States are going to be doing in this realm and not just around reinsurance but how do we look at co-pays, deductibles, premium rates, and still cover the patients with the basic health care that they need.

Senator COLLINS. Thank you.

Dr. Sethi, when you told the story of the truck driver, it reminded me of a conversation that I had with a major blueberry processor in my State just yesterday. The company pays the workers in this processing plant \$14 an hour. It pays 78 percent of their health insurance premiums, so that's generous. And yet, for the average worker, the remainder of the premium constitutes 30 percent of their pre-tax income.

So he told me about a conversation that he had with some of his workers who said, you know, we're really better off not working because we can get the subsidy because of our income levels through the ACA, but because we're in an employer-sponsored plan, we are ineligible for the subsidy.

This really troubled me, because I think part of the problem with the ACA is there are numerous provisions that discourage work. We see the clips, for example, that if you make one dollar more than 400 percent of the poverty rate, you lose your subsidy.

What about allowing a low-income employee to use an ACA subsidy to help pay for his or her share of the employer-provided health insurance? What would you think of that idea?

Dr. SETHI. Thank you, Senator. I would have to study it a little bit more, but from the sound of it, I definitely think that is something that could really help folks.

You know, in my experience with patients, what I've seen is exactly what you're describing. People can't afford the insurance, and I'll just tell you this. Last night I had a patient call me who I've taken care of for about 8 years. She was involved in a major car accident with both her femurs broken, her tibia, both arms. It's amazing that she survived. Over the last 8 years her insurance has changed three times because she's on the individual market.

What she told me to tell you all is this, that it's harder right now. She would pay more for her insurance than she does for her mortgage. So I think some of those rails that we have in place between the employer-based insurance and the individual market, I think that's a great idea to allow some sort of subsidy for those folks so that they can get it. But I think at the end of the day, we really need to get premiums down. That's what we need to do.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator Casey.

#### STATEMENT OF SENATOR CASEY

Senator CASEY. Mr. Chairman, thank you. I wanted to start with a commendation of this process, to commend both the Chairman and the Ranking Member, as many have, and we should continue to say that because this hasn't happened in years, what you're seeing in the last 2 weeks.

I'd also say—I don't want to bring up bad news, but this process that they have undertaken and that we've all been participating in stands in marked contrast, dramatic contrast to not just what's been done more recently but we're hearing again about yet another bill, a big bill that will knock a lot of people off of health care, with no hearings and the kind of consideration that we're giving to much more discrete issues. But this is the way you do it. You take difficult but narrow issues and examine them like you have, and

you've brought your expertise here. The idea that you can slap together a bill with a couple of people in Washington and not have hearings and not have the benefit of outside-of-Washington expertise is really misguided, and that's a charitable way of describing it. So we're grateful that at least here we're examining difficult issues but in a very considered fashion.

I wanted to start with a question or a topic that Senator Murray asked Ms. Postolowski. I was stunned to be reminded, I guess, that when you talk about the essential health benefits, and that's a major issue that we confront, how do you balance providing good coverage and quality coverage to keep people healthy with the idea of providing incentives to get them to enroll, especially young people?

But you have cited in your testimony—I guess it's page 3—three types of services that are used most substantially by young people: No. 1, maternity and newborn care; No. 2, mental health and substance use disorder services—so that's a big category—the mental health and substance use component part being the opioid issue; and then the third area was preventive services, which probably a lot of people don't think young people avail themselves of.

I guess in light of that, and in light of the challenges of getting young people enrolled, what do you see as the main barriers? What must we focus on in terms of barriers to getting young people to enroll, thereby helping everyone by balancing the risk pool?

Ms. POSTOLOWSKI. Thank you, Senator. Well, first I think there's still a lot of work to be done around letting young people know about the marketplaces, about financial assistance, and about the type of comprehensive coverage that they can get, including free preventive care, if they sign up for a plan. As I mentioned in my testimony, 18-to 34-year-olds are still the group that's least likely to know about the marketplaces, let alone the availability of financial assistance.

So I'm deeply concerned about the Administration's recent cuts, 41 percent cut to Navigator funding, 90 percent cut to advertising. This is not the time when we want to stop telling people about the marketplaces. We know that 8 million young people have gotten covered, so the ACA in that sense is working, and we want to improve on that progress rather than stop it in its tracks.

I also think ideas around increased financial assistance to young people could be another way to incentivize young adults to enroll in coverage. We know there are still young people who feel like they can't afford coverage even with financial assistance. There are young adults who are not getting financial assistance that we'd like to bring into the marketplaces. So an additional subsidy to make plans more attractive to young people would be one way of incentivizing enrollment.

Senator CASEY. Thank you.

Dr. Turney, the reinsurance issue has been highlighted not only in discussions and hearings but even in questioning today. I guess the question I have is now that you've got a reinsurance program that expired, what's your perspective on a Federal version of that, a federally run version of that versus doing something at the State level? How do you assess that issue?

Dr. TURNEY. Well, I think the reinsurance program is important, first of all, because I do think it helps to stabilize the markets. Whether it's a Federal program or a State program I think has yet to be determined, but the funding initially is probably going to have to come from the Federal Government as seed money so that the States can set up whatever program is needed to make sure that reinsurance exists, similar to what other States are doing right now.

But it's really critical, and I think that it has helped to mitigate the rises in health insurance in our State. In 2014, increases were 20 percent, and in 2016 they were 6 percent on the exchange, so it does have an impact. And if we're going to make sure that people do get coverage, this is one way to make that happen.

Senator CASEY. Great. Thank you very much.

The CHAIRMAN. Thank you, Senator Casey.

Senator Paul.

#### STATEMENT OF SENATOR PAUL

Senator PAUL. I think the Chairman has done a great job of continuing to bring us back to where the problem is. The problem is in the individual markets, about 6 percent of the public. I think we can probably all agree that it's very sick. The individual market doesn't work very well. We can call it adverse selection. We can call it a lot of things, but it doesn't work very well. It's broken.

The problem I have with it is everybody, including the panel and everybody we bring before us, says we're going to subsidize it. Are we going to fix it or subsidize it? I haven't heard yet anybody here say they're going to fix it. We're going to subsidize it. So when we subsidize it, we give money, and if you're poor and you're in the individual market and it's too expensive, we're going to give you some money. But is that going to make the premium go down?

We've had the cost-sharing reductions for about 6 years, and all the problems with premiums in the individual market we've been talking about we've had with these subsidies. So what we're doing is that we have a broken market, the rates are going through the roof, and we're giving you some money and say, hey, it won't be so bad if we give you some money, but we're not fixing the problem of the rates going up.

The individual market is sick. It's terminal. We shouldn't subsidize it. We should give people an exit ramp out of it. We shouldn't try to fix the individual market. It's not fixable. If you guys give them the cost-sharing reductions, which it sounds like the majority want to do, we codify them, we will be back here in 2 years or 5 years because, as Senator Collins said, the prices are rising. It costs 30 percent of your salary if you make \$14 an hour.

You're not doing anything to fix that. You're going to come back here in 5 years and you're going to say we've got to double the CSRs, or triple them, or quadruple them. It's a never-ending saga.

So I don't think it works, I don't think it fixes the problem. You subsidize a problem and you leave the problem dangling out there to get worse over time. If you want to fix the problem, give people an escape ramp. Let them get free of the individual market.

The one marketplace that works is the group marketplace. Insurance companies make a ton of money in it. For the most part, peo-

ple are happy with it. If you work at Vanderbilt or a big hospital or Toyota, for the most part you don't worry about your insurance being dropped. You're not even worried about the expenses much, although expense is kind of a problem.

If you look at the expense of the insurance, what is the one marketplace that works? It's group. But within group, what is it? The ERISA plans that are large-group plans. What is unique about the large-group plans? They evade the regulations. They evade the State regulations, they evade the ACA regulations, but they still have a lot of protections. You still have pre-existing conditions protected. People are largely happy in the large-group market. But the rates have stayed down.

I meet people all the time who say, oh, the rates went up 2 percent last year in our company. I say, what kind of plan do you have? Large-group ERISA self-insured.

So what you want to do is take people in the individual market and let them get the hell out of it, let them get into the group market, empower them.

Who has all the power? The insurance companies have all the power. The equation is where the insurance companies tell everybody what to do and control the equation completely, unless you're in a group and you have some leverage with them in a group.

But I'm morally and philosophically opposed to giving them any money, all right? The definition of crony capitalism is this: you privatize your profits and you socialize your losses. You know, don't weep for me, the insurance company. They made \$6 billion a year before Obamacare. They make \$15 billion a year now. I don't get it why you guys want to give money to the middleman. In fact, I said the last time I'm more with Bernie on this than I am with the members of my party who want to subsidize it.

If you want to buy people health care, buy them health care. Don't give money to the intermediary, public money. Why would you give public money to a private company? We've got no business doing that, and you're not fixing the problem.

I promise you, they'll be back for more. It is always that way. If you don't fix the problem, if fundamentally the individual market is unsound, the insurance companies will be back for more of your money.

We say we're helping the poor, but why can't it come out of the insurance companies' profit? You know how it comes out of their profit? Let the people escape the individual market and go in the group market. What happens then? The \$15 billion in profit they make will be spread amongst more people because more people will be in the group market. Will they be able to deny those people coverage? If you let the National Restaurant Association negotiate for everybody that's a McDonald's employee, everybody that's a Burger King employee—one, many of these people don't have insurance. But if you let one person negotiate for them and you go to any big insurance and you say I've got 15 million people, do you think they're going to turn it down? They're going to have to take a contract, and they will have to negotiate.

But you get a plumber, a carpenter, a welder, even a doctor or a lawyer who has a small business, and you try to negotiate with big insurance, you have no power.

So I would say I don't want to break up big insurance. I'm not for dividing up companies. But let's empower the consumer. Let's think about a way, even if you continue to want these subsidies, let's think about a way we could also empower the consumer that actually might be a fix to the market that lets people get out of the individual market and into the group market, which is the only place that works.

I see my time has expired without a question, but I enjoyed giving a speech anyway. Thank you.

(Laughter.)

The CHAIRMAN. Thank you. You're good at it. Thank you, Senator Paul.

(Laughter.)

The CHAIRMAN. Senator Franken.

#### STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. I think that Senator Warren has someplace she has to go, so I would not give up my place in the order, but can I let Senator Warren go first?

The CHAIRMAN. Well, Senator Baldwin is next after you.

Senator FRANKEN. We discussed that.

The CHAIRMAN. That would be fine.

Senator Warren.

#### STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you very much. Thank you, Mr. Chairman, and thank you very much, Senator Franken and Senator Baldwin. I really do appreciate it.

So let me ask this. Mr. Ruiz-Moss, you're a top executive at Anthem, the second-largest health insurer in the country. When Congress was talking about taking away health insurance from over 20 million Americans, a lot of companies, including Massachusetts Blue Cross and Blue Shield, stood up to fight for the people they insured, but not Anthem. Instead, Anthem sent Congress a ransom note saying it would, quote, "begin to surgically extract" from the ACA's insurance markets if Congress didn't meet a list of your demands, including tax cuts for insurance companies and the right to collect taxpayer money for selling junk insurance plans. To show you meant business, you pulled out of insurance markets then in Ohio, Indiana and Wisconsin, and endorsed the Republican bill to repeal health care coverage for millions of Americans.

Now, when that bill failed, Anthem pulled out of more markets, claiming you just can't make it work. So I just have a couple of questions about that.

Mr. Ruiz-Moss, how much profit did Anthem make in the second quarter of this year?

Mr. RUIZ-MOSS. I'm not familiar with the profit number for the second quarter. It's a public document, so—

Senator WARREN. Yes. Yes, it is. It's \$855 million in just 3 months, just a little bit shy of a billion dollars in profits.

Now, you attack the ACA, but do you know how much of Anthem's total revenue comes from government health care programs, including Medicare and Medicaid?

Mr. RUIZ-MOSS. I do not know that off hand.

Senator WARREN. How about half? Does that sound about right to you? According to your own press release from 7 weeks ago, in fact, more than half of Anthem's revenue from the first half of this year, 54 percent, came from taxpayer-funded public insurance programs. You rake in money on Medicare Advantage plans, you rake in money on Medicare Part D prescription drug plans, you rake in money from Medicaid, on and on, buckets of taxpayer money, but you're pulling out of the ACA market. Can I ask why?

Mr. RUIZ-MOSS. Sure. So, we look at each market as its own insurance market and believe that the individual market, in order to be successful, needs to stand on its own. In fact, if we want to attract competition, if we want to bring in other carriers, there will need to be an independent, stable individual health insurance market. So when we made our decision, looking across all of our 14 States, and our CEO mentioned we're looking at this surgically, what that meant to me was I want to know by area within a State, and by State, where we can make a go of it, because anyplace we can find stability, our inclination is to participate.

Senator WARREN. Sir, I just want to make sure I'm following this. You make a lot of money off government plans elsewhere, but you want to say that the only way you're going to stay in the ACA is if you get to make more money. In fact, what you specifically said is you want to be able to sell junk insurance plans that leave families paying more, and you want a tax break, and if you can't get it, then you're telling Congress that if you don't get this kind of help you're going to quit the one market where people need you here.

So I just want to say on this, if you're curious about why a majority of Americans support Medicare for All, here's Exhibit A. I believe that Congress should ignore your threats. If you want taxpayer money, then you ought to show up in the ACA plans as well and be there, just like other companies have done, and you ought to be able to provide decent coverage. I just don't think that's too much to ask.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Warren.

Senator Scott.

Senator SCOTT. Thank you, Mr. Chairman.

Mr. Farmer, NAIC has recommended the delay of the health insurance tax, commonly referred to as the HIT. Can you explain how the HIT impacts premiums and in turn creates instability in the marketplace?

Mr. FARMER. Yes, Senator. Thank you very much.

In our calculations, the HIT tax accounts for about 3 percent of the premium. So during this moratorium piece, our citizens are saving 3 percent. If it goes back into place in 2018, that's part of the overall 31 percent rate increase that I just had to approve last week.

Senator SCOTT. That's on top of 120 percent rate increases over the last 4 years.



Mr. FARMER. That number is pretty high, but it was probably 90 something. Nevertheless, it's high, and it's too high.

Senator SCOTT. Politicians have a habit of inflating the numbers a little bit, it seems like.

Mr. FARMER. If it's your number, Senator, I'm fine.

Senator SCOTT. Thank God he's from South Carolina. He's great. (Laughter.)

Senator SCOTT. Dr. Sethi, you mentioned in your testimony the need to open up catastrophic plans to all individuals regardless of age or income status. In your experience, do you think opening up these plans to folks without subsidies will help bring some people into the market?

Dr. SETHI. Well, thank you, Senator. Meeting with patients through my travels with Healthy Tennessee and my own orthopedic trauma patients, I do believe that creating a catastrophic plan open to all ages, all incomes, I think would bring younger folks and people in general into the insurance market because I think that's the problem. You don't want to pay more for your insurance than you do for your home mortgage. I mean, when you do that, something is wrong.

Senator SCOTT. Absolutely. I was talking to some of the insured in South Carolina recently, a husband and wife, three kids, premiums over \$33,000. I sold insurance for about 8 years in my prior life, and I will tell you that the catastrophic opportunity, the catastrophic plan is an opportunity to bring more revenues into the marketplace and also provide the needed coverage for folks who are able or willing to self-insure to some extent but simply need that catastrophic exposure. So the flexibility that may be necessary in the marketplace and today is absent could provide folks with more opportunities in the health insurance space, but more premium dollars. Is that a fair assessment?

Dr. SETHI. I agree, Senator.

Senator SCOTT. One last question for you, sir. Not only is the individual mandate in direct opposition to free market principles, it is pretty clear that from all the data we can see it has not worked, particularly for those younger folks and the higher-income folks, particularly those folks under the age of 35, when only 37 percent in 2016 exchange enrollees are in that age bracket. Only 16 percent of those eligible and earning 300 percent to 400 percent of the Federal poverty level get coverage through an exchange.

So if we were to give States more flexibility through the 1332 and the elimination of the individual mandate being part of that flexibility, what would that do to our markets?

Dr. SETHI. As you mentioned, I think that it would bring more people into the insurance market. You know, as you mentioned, and has been testimony here, I think two-thirds of the folks on the individual market, they don't even qualify for a tax credit or the CSR program. Even if you look at the folks who do get subsidies, the majority of people who sign up are those people between 100 to 250 percent of the Federal poverty line. The folks beyond 250 percent, they don't enroll, and I think that's because it's just so expensive, even with a subsidy that is curtailed. They can't afford it. So I agree with you.

Senator SCOTT. Excellent. Thank you, sir.

Thank you, Chairman.

The CHAIRMAN. Thank you, Senator Scott.

Senator Franken.

Senator FRANKEN. Just quickly, Dr. Sethi, you said that two-thirds of the people in the individual market don't get a tax credit?

Dr. SETHI. Two-thirds of the people who would be eligible to be in the individual market. I believe in Tennessee that 60 percent of the folks who are actually on the individual market right now do get a tax credit. But what I'm talking about is all of those who are eligible.

Senator FRANKEN. OK. I don't quite know the relevance of what you were saying, then.

Senator Alexander and Ranking Member Murray, thank you for holding these hearings. They've been constructive and informative, and I appreciate that we are hearing new ideas, including the idea of actuarial equivalence. I hope and trust, though, that as we debate these changes, that we will explore both the opportunities and the challenges they create.

For example, if we can explore ideas that promote States to innovate around delivery system reform, I think that's great. However, I share Senator Collins' concern that we consider the unintended consequences of these policy changes, especially as regards the essential health benefits. I can't, for example, imagine what happens if we start taking out—we have policies that don't allow for mental health or addiction. I mean, I just can't understand what that would mean, and I fear that. A lot of people don't plan on having a mental health issue or having an addiction.

But I remain committed to working with you, with all of you, and simultaneously will fight to protect benefits that have helped Minnesotans and helped millions of Americans.

I'm co-chair of the Rural Health Caucus. I spend a lot of time traveling around rural Minnesota talking to folks about health care. I often hear rural consumers, including many farmers, talk about their challenges in accessing affordable health coverage, especially given that they often have to pay higher premiums, have higher cost-sharing, and have fewer provider options.

It's important to note, though, that the ACA has helped increase health insurance coverage rates in rural areas in greater Minnesota and provided more stability to rural providers and community institutions. We need to do more to help rural consumers, and sometimes that can be difficult, as folks living in rural areas tend to be higher risk than their urban counterparts.

Dr. Turney, you're a neighbor. My staff and I have been having conversations with rural health experts about how we can better serve those living in rural communities to make health insurance more affordable. Some have recommended that we include changes to the 1332 waiver process to highlight rural health needs or fund reinsurance payments to insurers that serve rural communities to increase competition in rural markets.

In your testimony, you also advocated for changes to the ACA's risk adjustment program to increase payments for rural carriers. Can you comment on how Congress could amend the 1332 waiver process, adjusting the existing risk adjustment program, or tweak

a Federal reinsurance program to improve competition in rural areas?

Mr. Farmer, please feel free to weigh in as well.

Dr. TURNEY. Thank you, Senator Franken. You know, Wisconsin is just a little bit different than other parts of the country, and we've heard about States where there's only one dominant payer. In Wisconsin we have over 30 insurance companies, and we have—about a third of them are provider sponsored plans, so working in conjunction with the providers in the community. We have 11 insurance companies on the exchange. So although Security Health Plan did go into a nominee county and rescue the nominee, one of the last two counties to be bare, we realize that, again, rural communities have very unique needs. As you mentioned, we have very few large companies in the northern half of the State of Wisconsin, so patients oftentimes find it very challenging to get insurance, and the individual market is a way that they have been able to access care.

But I think the one thing we're not talking about here that is very important is that you also have to look at the way we deliver care. Because rural health care presents unique challenges, there's a lot of investment that goes into taking care of people in these geographic disparate regions. Telemedicine and telehealth is just one example.

So as we look at this short-term fix to a relatively small group of insured, 6 percent, we have to start thinking differently about how we provide care, and actually I think the care delivery model needs to be above the payment system. Once we figure out how to take care of our communities, we can then look differently at the way we support the practices who provide those services. People don't ask to get sick. There certainly are preventable illnesses, and we've talked about that. But most people don't ask to get sick, and we need to take care of them, and we need to figure out the best way to do that.

So the challenges in rural communities are definitely unique.

Senator FRANKEN. You don't have to say anything, Mr. Farmer.

Mr. FARMER. I'm watching the Chairman.

Senator FRANKEN. That's the guy to watch.

The CHAIRMAN. If you'll be succinct, please go ahead.

Mr. FARMER. I am extremely concerned. Contrast 11 carriers in Wisconsin, Senator, and I'm down to one in all of our counties. We've had as many as four or five at a given time on the exchange. We're down to one owner and two carriers, the same owner but two carriers off the exchange. So I'm extremely concerned about all of our counties, but especially the rural counties just for the reasons that she mentioned a minute ago.

Senator FRANKEN. Thank you.

The CHAIRMAN. Thank you, Senator Franken.

Senator Murkowski.

#### STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman. I love this committee. I've loved this discussion going back and forth for the past couple of weeks. This is so important to recognize and appreciate the clear differences and distinctions in so many of our States. We

would dream to have 30 providers or carriers that would come to the State of Alaska.

We're with you in the State of South Carolina in Alaska. We're down to one, and we're just doing everything that we can to make sure that they're going to continue to stay there. But I think this is why, when we talk about flexibility, whether it's within 1332 or how we address these issues of health care, it is so important to have these very open discussions and great stakeholders that are here providing us with insight.

I've spent a lot of time over these past four hearings, and we've got three very reoccurring themes. We've got to deal with the CSRs, we have to deal with some level of flexibility within 1332—that seems like an avenue forward—and then how we're going to deal with the issue of expanding that risk pool there, making sure that enrollment stays up but also aspects of affordability, whether it's through a catastrophic, and I want to go down that road right now.

I'll ask you, Ms. Postolowski, we talk a lot about the great value that a Copper plan or a catastrophic plan can provide to young people, the invincibles. I'm hearing far too often that it's one thing to get premium support, but I may as well not even have insurance because I can't afford the deductibles, so I just might as well not even go.

There's been a lot advertised here in this committee about what Alaska has seen in how we applied for a 1332 waiver. We're going to see our rates actually going down as a State as a consequence of that. But one of the things that we learned from our state's director of insurance is that they're still doing an analysis to see how much is actually attributable to this whole backstop reinsurance and how much might be attributable to the fact that people have just deferred medical care because they can't afford to access it because they're earning, on average, \$26,000 a year. Or to your example, Dr. Sethi, you're making \$14,000 a year and you cannot afford the deductibles.

So how do we address this part of our reality, that when we're talking about affordability, premiums are just one aspect of it? I'm having far too many people that are still going to the emergency room because that's where they're going to get their level of care. So as we look at a catastrophic or a Copper plan, you're suggesting to us that you don't think that for the young people that's going to be as attractive as we might think it is. Can you speak to that?

Ms. POSTOLOWSKI. Certainly. Thank you, Senator Murkowski. Yes, that's my biggest concern with a Copper plan, that the deductible may be \$9,000. The typical uninsured young adult who we're trying to bring into the marketplace makes \$20,000. So if they were to buy a catastrophic or Copper plan and something did happen, they'll be looking at having to pay almost half of their annual income just to meet their deductible.

I also hear from young adults—for example, I heard from a young woman last month who needs mental health services but has an \$80 cost sharing. And for her, even that amount of cost sharing is unaffordable.

So I think one way we can address this is to continue to fund the cost-sharing reduction payments. We know that 7.2 million

young people rely on those subsidies so that they can access health care services. Then in the longer term looking at reducing health care costs.

Senator MURKOWSKI. Let me ask Dr. Sethi, and back to you again, Ms. Postolowski, in terms of how we're doing this outreach, we've heard the dramatic drop-off in support for the advertising for the Navigators. I think you said that with TV ads we saw increased enrollment. I've got a 24-year-old and a 26-year-old. I don't think they've watched TV in years now. Rural areas, which Alaska is all rural, what do we need to be doing better to really do the outreach, whether it's to the young people or to those in rural parts of the country if, in fact, we don't have this level of support here from the Federal Government for this level of outreach?

Dr. Sethi.

Dr. SETHI. Well, thank you, Senator. What I would tell you in terms of a model for rural outreach, we do these health screening events all across rural Tennessee, and what I have found is—we just did one 2 weeks ago near the Tennessee-Virginia border. We worked with a whole host of folks and brought them together. But I think in rural places, to be very successful, for example, to get insurance enrollment, you've really got to get on the ground with the community leaders. You've got to talk to the county mayor. You've got to talk to the State representative, talk to the local Chamber of Commerce. That's what we do, and I think that really starts a conversation where people say maybe we should listen to these people.

I'll just give you an example. Do you know what the most powerful source of getting people to our health event was 2 weeks ago? It was the Sneedville Shopper, this paper we put an advertisement in and it goes out once every 2 weeks. So literally this paper—I asked all these folks who came to our event. They said, oh, I heard about it in the Sneedville Shopper. So I would have never known this, you know?

So I think that is one very powerful way that in rural communities you could really be effective, but you've got to know that community. I think this one-size-fits-all idea, like you're saying, and if we just really advance the ball and give it to local communities, I think they could do a more effective job.

Ms. POSTOLOWSKI. I think you also bring up a really good point about meeting young people where they are, right? So if young people are not watching TV, meeting them online, meeting them on their smart phones, thinking about reaching out to young adults in different ways.

For example, in Colorado this year I ran a pilot in rural areas using Facebook advertising to tell young people about preventive care, and actually we had very early signs of success from that pilot where we saw young adults clicking on the ads at higher than average rates, and we saw young people who are disproportionately uninsured still, so Hispanic young adults and young white men engaging with the ads at higher rates than other younger people.

So I think more innovation like that would be good. I also would add that Navigators play a really important role in outreach. So—

The CHAIRMAN. We're running out of time on this question.

Ms. POSTOLOWSKI. OK. Can I have one sentence?

The CHAIRMAN. Sure.

Ms. POSTOLOWSKI. Tabling at community colleges, for example, is a way to reach underserved young people, what Navigators do.

Thank you, Senator.

Senator MURKOWSKI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Murkowski.

Senator Bennet.

Senator BENNET. Thank you, Mr. Chairman. I think I speak for the committee when I say we'd all like to have a copy of the Sneedville Shopper distributed to us, to each of us.

(Laughter.)

The CHAIRMAN. Well, if you approve something good, I'll get you a subscription.

(Laughter.)

Senator BENNET. Ms. Postolowski, thank you again for testifying today. We deeply appreciate your being here. In your written testimony you describe your perspective as a patient who saw firsthand the effect of high-risk pools. In Covered Colorado, our high-risk pool has had waiting periods for care, and the premiums failed to cover health care costs.

Based on your testimony, it sounds like you're in favor of a reinsurance program. As you already know, our Department of Insurance in Colorado is currently working with actuaries to study the reinsurance program for the individual market. I wonder if you could expand a little bit for the panel on your experience with high-risk pools in Colorado, what the benefits are from your perspective of reinsurance versus high-risk pools and what parameters we ought to keep in mind if we're thinking about designing a Federal reinsurance program.

Ms. POSTOLOWSKI. Great. Thank you, Senator Bennet, and thank you for the introduction earlier.

I think one of the biggest benefits of reinsurance programs over high-risk pools is that they are less expensive because you have everyone in the same risk pool and you have healthy people who can offset some of the costs of the high-risk pool.

Covered Colorado was our state's previous high-risk pool before the ACA. It was an option that was available. I was grateful that I had at least some backstop, but it was expensive. Premiums could be over 50 percent higher by law in Covered Colorado. Other State high-risk pools had premiums up to 250 percent higher than other plans in the individual market. As you mentioned, there was also a waiting period, as well as an annual lifetime limit, and that was because it was hard for Colorado to find the money to fund the high-risk pool, whereas reinsurance programs are more affordable.

I know the Colorado Division of Insurance has been having stakeholder meetings on setting up a reinsurance program in our State and is committed to doing so but would be unable to do so next year given that we need legislative approval for that process. We also need a mechanism set up because we repealed the high-risk pool in our State to administer a State reinsurance program.

So one thing that I'd like to ask the committee to do would be to fund Federal reinsurance for at least the next 2 years to give

States the opportunity to set up their own programs if they want, but really immediate funding for reinsurance is the only thing at the Federal level that's going to be able to keep rates down next year.

Senator BENNET. Thank you for that answer.

Mr. Ruiz-Moss, as we consider policies to stabilize the individual market, I often think about what the Chairman has said multiple times, which is that we're dealing with 6 percent of the people that are insured when we're focused on that. The individual market also represents 6 percent of Coloradans.

In your testimony you talk about managing the total cost of care as a long-term goal. You said that Anthem now pays nearly 60 percent of reimbursement value-based care models. I wonder if you could expand on the steps Anthem has taken to achieve that goal, what outcomes you've seen, and what do we need to do to better realign incentives in the system more broadly to try to capture the kind of value you've done both in Colorado and in California.

Mr. RUIZ-MOSS. Great, thank you. Certainly, we have been innovative in value-based plan designs. Working with accountable care organizations, we're seeing the physician community willing to accept more of the insurance risk, which is able to help us manage both quality and cost better. Initiatives that we're working on as an industry, and really with CMS around payment innovation continue, I think, to help us bend that cost curve. So support for those kinds of initiatives and continued support for transparency. We use Castlight, where we have much greater transparency now toward both quality and cost, and those both play into the decision. It's not just a cost-based decision for people when they're looking to get care.

The promotion of all those types of programs we believe will help to bend that—

Senator BENNET. Before I let you go—I only have 30 seconds left—can you describe with a little more precision the kind of transparency you're talking about, what that looks like?

Mr. RUIZ-MOSS. Sure. So, a person, let's say they're going in for a knee replacement, is able to look at the average cost of that kind of procedure from a variety of physician hospitals in their area, and they can look across and see which they think is the best fit for them specifically.

Senator BENNET. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

I'll ask my questions now.

Mr. Ruiz-Moss and Mr. Farmer, since you're regulators and insurance companies, let me direct this to you.

The Section 1332 innovation waiver that's already in the Affordable Care Act expressly says that you may not, in approving plans in a State, you may not approve plans that don't include what we call the patient protections or patient protection guardrails, which are pre-existing conditions, lifetime limits, age 26, guaranteed issue, all that. In at least the suggestions I've made—I've not heard anybody else make a suggestion—no one is suggesting we change that. That's in the law.

Also in Section 1332 it says you may waive the essential health benefits in the Affordable Care Act—that's what it expressly says—as a part of the innovation waiver. You may not waive the patient protections; you may waive the essential health benefits in the existing law as long as the result is a comprehensive policy, one that's affordable and covers the same number of people, basically.

What does that mean? What kind of policy is that? I mean, what does that say to you? If you're designing a plan, what does that say to you about plan design, Mr. Ruiz-Moss? What flexibility do you have under the existing Section 1332 if you were designing a plan?

Mr. RUIZ-MOSS. So when we think about this, we think about both essential health benefits, what are the benefits that have to be covered in a plan, and then we think about a metal level which says how much of the medical cost should be covered by the insurance company versus the population of people in total, and I think those always have to be—they should come in tandem, those conversations should come in tandem, and we certainly believe we support those portions of the law that you talked about that you're not talking about changing.

The CHAIRMAN. Right. In essence, it says you may waive the essential health benefits if you create the plan. What does that mean to you?

Mr. RUIZ-MOSS. Right. Well, right now it would mean the State would have to allow, or a regulator would have to allow for a change in essential health benefits. We're not a proponent of blowing up essential health benefits. I think there's some flexibility that could be—

The CHAIRMAN. So the State would have that decision—I interrupted you—but you're not a proponent of creating plans that don't include them. Is that what you're saying?

Mr. RUIZ-MOSS. We're not a proponent of blowing up essential health benefits and starting from scratch. We think there needs to be a minimum level of benefit. There are some programs under the current arrangement that we're not able to offer the individual market that we offer in the group market. So there's some wellness incentives. There's reference-based pricing, which we worked with CalPERS on, and now if you're looking for knee and hip replacement—

The CHAIRMAN. So you can do that in the group market, but you're not allowed to do it in the individual market because it's too rigid?

Mr. RUIZ-MOSS. Because the law, the way the rules are currently written, wouldn't allow that. We couldn't design a plan around—

The CHAIRMAN. So you can design a plan that encouraged, say, wellness more, as an example.

Mr. RUIZ-MOSS. There are limitations on how much a patient can be rewarded for certain types of behaviors.

The CHAIRMAN. Mr. Farmer, what about you? You see different plans. What does it mean to you when it says that a plan under Section 1332, if someone came forward with a plan that would have to have pre-existing condition, et cetera, but the Federal law says you may waive the essential health benefits as long as the result is what I read, what does that mean to you? What could you approve? What flexibility do you have?



Mr. FARMER. Senator, we at our department and most departments, especially under the Affordable Care Act, we are an effective rate review State, so we have the authority to review rates and the forms. We would have some flexibility. But, Senator, every day we go to our office with—to protect the consumer. If a plan is submitted that does not offer those essential benefits to the consumer that we think they need, it wouldn't be approved. If there's some flexibility in there that—

The CHAIRMAN. Even though the Federal Government doesn't require it according to the current law, you might require it anyway? The essential health benefits I mean.

Mr. FARMER. Yes, sir. Our number-one goal is going to be protecting the consumer. Each filing, each case would be looked at—

The CHAIRMAN. As you read the law that says you may waive it, do you think the law says that a State may waive essential health benefits but that the same section of law would say but you can't do it?

Mr. FARMER. I don't think that section says I have to do it.

The CHAIRMAN. OK. Well, my time is up.

Senator Baldwin.

Senator BALDWIN. Thank you, Mr. Chairman.

Ms. Postolowski, I'm wanting to start with a question for you, but I also wanted to appreciate the fact that you shared your own personal health story with us in your testimony as a young adult with a diagnosis that led you to be labeled as a young adult with a pre-existing condition. I, too, actually after a childhood illness, bore that label of being a child with a pre-existing condition and remember the struggles that my family had in obtaining insurance coverage for me during my youth.

Over the course of our bipartisan hearings, of course we've been hearing so much about the importance of having young and healthy people in our insurance pools to make it work. So I know our staffs have been talking to one another. I'm interested in your proposal to look at financial assistance, particularly for young adults, to help increase the enrollment, and look forward to continuing those discussions.

I wonder if you could say why is the young adult population specifically in need of this boost in order to better afford coverage, and how could we do this without impinging on quality or raising costs for other enrollees?

Ms. POSTOLOWSKI. Thank you, Senator Baldwin. I do appreciate and look forward to future conversations with your staff about how to increase young adult enrollment in the marketplaces.

As you mentioned, we all share the goal of making sure that more young people can get covered, which we know will have positive impacts on the risk pool and the cost for everyone else in the health insurance market.

So one way that I'd like to see this done is by perhaps lowering the affordability threshold for young adults, which would in turn increase their premium tax credits or their financial assistance. So the median income for a young person in the marketplace is \$26,000 a year, which means that their affordability threshold right now is about 7.1 percent of income that they have to pay toward health insurance. A 26-year-old's premium at this median in-

come in Milwaukee, Wisconsin, for example, is \$154 a month for coverage. Whereas if we lowered that threshold by 2.5 percentage points, for example, so their affordability threshold would change to 4.6 percent, their monthly premium would drop to just under \$100 a month, which would save them about \$650 a year.

One good thing about looking at changing the affordability thresholds is the additional financial help adjusts based on the prices of plans in your market, as well as your income level.

Senator BALDWIN. Dr. Turney, I am heartened that Security Health Plan expanded to serve the nominee county. After a national insurer left the marketplace, it was the only insurer providing service to the nominee county prior to that. Can you discuss why you made the decision to fill that gap and to ensure our rural residents have an option, and specifically why a Federal reinsurance program is critical to helping you maintain Security's ability to serve Wisconsin in the longer term?

Dr. TURNEY. Thank you. As I mentioned, we have about 30,000 people that are enrolled on the exchange with Security Health Plan. The advantage of having the insurance plan, as well as the provider group, I do think creates opportunity that an independent insurance company might not have.

The reason we got into the exchange is to make sure that our patients not only had care, because they were getting care, they were also getting coverage for that care. So we realized that even if the health plan loses money, the patient benefits and the practice does get some reimbursement for what would otherwise be provided, and oftentimes be provided at an appropriate time, not when they, for example, have oral pain, have something wrong with their teeth, go to the emergency room and get opioids. So you can kind of see the cycle that starts to build.

So we are here to enrich lives. We take care of patients regardless of their ability to pay, and we know that our responsibility is to the patients at least in the northern half of the State even though we see patients from all 72 counties. We will continue to do that and do what's best to make sure that happens. I think we've been successful with our model. We've been around 100 years, and I hope we're here another hundred.

Senator BALDWIN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Murphy.

#### STATEMENT OF SENATOR MURPHY

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

Thank you all for being here.

Yesterday in Connecticut, the new rates were announced for the two insurers, Anthem included, who offer on our exchanges. There was an announcement of a 17 percent increase attributable only to the uncertainty around cost-sharing reduction payments, an additional 6 to 8 percent increase due to the uncertainty around the individual mandate. So you're looking at a 20 percent increase to Connecticut consumers based only upon the uncertainty that this Administration is inserting into the marketplace commands our attention.

I actually wanted to essentially re-ask the question that Senator Alexander asked because I think it is probably the most important question, especially as we try to sort through how we provide some more regulatory certainty to States. I'll just ask it a little different way.

I think what Senator Alexander is saying is that because you have the ability under existing law to change these minimum benefits, we're searching for what the existing standard is, how a State would be guided in doing that today, what would be allowed and what wouldn't be allowed, and whether we need to amend that standard or clarify that standard, because it's already permissible but there's some uncertainty as to how you would be guided.

So let me maybe ask this question to Dr. Turney, but I'll ask anybody to comment on it. If the standard is simple actuarial value of the overall benefit plan, then theoretically that would allow a State or a plan to get rid of, let's say, mental health benefits and maternity benefits, the things that young people use, so long as they loaded up on hospitalization or on cardiac services.

I'd be interested as to what the upsides and downsides are to a model in which actuarial value is the simple measure of whether or not you can seek that kind of waiver, whether that's the right way or whether there's some peril to providers and to patients if you can essentially move around benefits at will, so long as in the end the amount of money you're providing to an average beneficiary remains the same. Does that make sense as a question?

Dr. TURNEY. I believe the question makes sense, but I might take it a different direction I think than you were heading, and that is as a physician, I'm here to serve our patients, and when we think about serving our patients across our geography, it's very important that we take care of the whole patient throughout the continuum of life. So we are committed to our patients in our communities and making sure that patients do get preventive care, that they get appropriate screening health care, that they get taken care of during their acute episode of care as well as for their chronic illnesses.

Our focus is to make sure that they do have comprehensive benefits because we know that if they do, they're more likely to come in at the appropriate time, seek care in the office, not in the emergency room, make sure that if a woman has a breast lump she comes in to be seen and doesn't wait until her skin is eroding because the tumor has advanced.

I think we think about it more probably from the provider side where we understand that the patients need care. If they have coverage, they will seek care. We know that outcomes are better with that care.

Senator MURPHY. You'd be worried, then, about flexibility that would allow you to get a really robust hospitalization benefit at the expense of any coverage for, for instance, mental health or addiction.

Dr. TURNEY. Yes, we're worried about it for two reasons. One, if you have, for example, a catastrophic plan, we're very worried that, first of all, patients wouldn't come in for other care because all they have is a catastrophic plan; and if they do need to seek care,

there's a good chance that they're not going to be able to afford that care. So that's the one issue.

Actuarially, yes, we have to look at balancing the business and making sure that we can run our business, but we want to make sure that people do have the most comprehensive benefits they can get, and we're not going to—I mean, can you carve out benefits? Absolutely. Can people choose to do that? Certainly. Not all of our patients are insured by Security Health Plan. So we do have to deal with a number of different options. But our philosophy is to take care of the whole patient.

Senator MURPHY. I will stipulate that it's hard to figure out what the measurement would be other than actuarial value, but therein lies the problem. If it is, then you potentially provide some significant gaps, and you get rid of the certainty of products that was part of the reason that we put it in, so that when you bought insurance you knew what it is.

But I think this is a true conundrum. If it's not actuarial value, then it's kind of hard to figure out what the substitute standard is.

Dr. TURNEY. Right.

Senator MURPHY. Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Murphy. That's very helpful.  
Senator Kaine.

#### STATEMENT OF SENATOR Kaine

Senator Kaine. Thank you, Mr. Chair, and thanks to the witnesses.

One of the things these four hearings has shown is that reinsurance is a really popular idea. I have a bill with Senator Carper, who is here, to do a Federal reinsurance program. There's a cost to it, but it's not a bailout of insurance companies. What reinsurance does is it brings down premiums for most people. By bringing down premiums, it allows some people to buy insurance who weren't going to do it otherwise. By bringing down premiums, it reduces the Federal Government's payment of subsidies based on those premiums. It provides a backstop that enables high-risk or high-claim individuals to get insurance, and it provides certainty to a number of insurers to stay in the market. There are five definite benefits to reinsurance, and that's why every witness in the four hearings has asked for it.

Mr. Ruiz-Moss, I want to talk to you about Anthem in Virginia, just using it as an example. Anthem was the largest provider of care through the individual marketplace, 330,000 Virginians, and Anthem recently announced it would no longer provide coverage on the individual market. I am right, am I not, that Anthem still does a lot of business in Virginia with group plans and finds Virginia and Virginians in that market very good customers; correct?

Mr. RUIZ-MOSS. Yes, that's absolutely correct.

Senator Kaine. So in the group market, Anthem finds Virginia to be profitable and stable, but the individual market you found not to be profitable and definitely not stable; correct?

Mr. RUIZ-MOSS. Correct.

Senator Kaine. I don't think it's unfair for Anthem to deliver a message to Congress, or for insurers generally, that we would like

some stability. So in the individual market, if you don't know whether the mandate is going to be enforced, if you don't know whether CSR payments are going to be made, if you don't know whether marketing is going to be done or whether open enrollment is going to be vigorous or narrow, that creates an awful lot of instability for a company like Anthem, and I don't think it's unfair for you or other insurers to say to us give us some stability. If we don't give you stable answers, then you take actions. I get that, and I hope we can provide stability.

But I want to turn it around and give you a message about an action that we're likely to take. Anthem coming out of Virginia, combined with others, could lead about 60 to 65 counties in Virginia to be without an insurer writing on the exchange. We have 134 cities and counties, so that would be half of our counties, not half of our population, because this is overwhelmingly rural. It's depriving people in rural Virginia of opportunities. I think people ought to be able to buy into Medicare. This is the Tim Kaine view, if I had a magic wand. People under Medicare-eligible age, I think they should just be able to pay a premium that's actuarially sound and buy in, and I don't have the votes for that right now, but I will get the votes for it if there are bare counties in Virginia or elsewhere.

So just as you've communicated to us a desire for stability, which is fair, I just want to communicate to all insurance companies there is no way, none, that Congress is going to tolerate a situation where persistently there are counties in this country where people cannot buy insurance on the individual market. We just won't tolerate it. The pressure will build, and then we will create a solution for it, and the solution will be, if there's no private companies that will provide insurance, the solution will be something like Medicare that people can buy into.

When that day comes, we won't just allow them to buy in if insurance companies don't cover their county. We won't just allow somebody to buy into Medicare if insurance companies have said they're too old or too poor or too sick. We will provide a vigorous public option to allow anybody to buy into Medicare because we want to have a broad risk pool with some young and healthy people, just like you would want to have one.

So in some ways, the bare county phenomenon, I view it bluntly that the insurance companies have to worry about holding a knife up to their own throat. The bare county phenomenon is going to create incredible pressure for us to provide a solution so that people can have health insurance. At the end of the day, that solution I think is going to be one that is going to work directly contrary—you know, you're worried about profitability and stability, as you should be. You're a company, you need to worry about that. But if you're thinking about that in the short term and you're missing the long term, we can't have bare counties. I'm not going to tolerate one. I'm going to find a solution for the one. If we can't find a solution through private insurance, we're going to find a solution.

So just as you're communicating to us that we owe you stability, and we do, I want to communicate to private insurance companies that we're not going to tolerate bare counties and we will provide

an option, and it will be an option that will be very, very challenging to the insurance industry as we know it.

So, with that, Mr. Chair, that's all I have. Thanks.

The CHAIRMAN. Thank you, Senator Kaine.  
Senator Hassan.

#### STATEMENT OF SENATOR HASSAN

Senator HASSAN. Well, thank you, Mr. Chair and Ranking Member Murray, for this hearing, as well as the last three that we've had, and thank you to all the witnesses not only for being here today but for what you do. It's incredibly important.

Most of the questions I had have been asked. Ms. Postolowski, I wanted to follow-up with you on the issue of Copper plans because you've talked a little bit about how high the deductible would be in relationship to the median income of young invincibles, but one of the other things that I noticed in your testimony is that you also talked about the idea that those Copper plans or catastrophic plans could be supplemented by HSAs, and I think in your testimony you said in order for a young invincible to make up that deductible difference through an HSA, they'd have to save something like \$632 a month. Is that right?

Ms. POSTOLOWSKI. I know it would be \$9,000 for the deductible.

Senator HASSAN. So you'd need a young person whose median income, according to your testimony, is around \$20,000 a year to be able to save \$632 a month to make up that deductible over the course of a year. The reason I point that out is that I think it's really critical that as we have this discussion about health care, we understand how things actually would play out on the ground for the people we're trying to serve.

The founding principle of this country is that every single person counts. That's why what we just heard from Senator Kaine is so real, that we're not going to tolerate people in our States not being able to get health care. Every single person counts. That's the basic foundational principle of our democracy, and that means every single person has to be able to get health care.

So as we look at the debate we're having, I also think it's really important that we understand that health care is not like any other consumer product. I can choose not to go to a restaurant or have the most expensive thing on the menu. I can choose not to take vacation and save money that way. But nobody plans to get sick, and we don't say, 'Oh, gee, that essential benefit has been waived by my State, so I just won't get mental illness.? Nobody plans to get substance use disorder, but people in my State are being ravaged by it. And, boy, has the fact that substance use disorder is an essential health benefit been absolutely critical to our capacity to try to address this terrible epidemic.

So as we move forward, I think it's really critical for us to think about that. I think it's very critical for us to think about, as compelling as Senator Paul's remarks about the group plans were, every group plan I know relies on employers paying an awful lot of the cost of the premium that actually plays out, which is why when people terminate their employment in a group plan, they often can't afford the cost of COBRA, because that's the actual cost of the plan that the employer was helping to subsidize.

We have to understand how this plays out, and ultimately we have to figure out a way to make the innovations and discoveries that have made 21st-century health care in this country so remarkable available to people. We have to provide incentives, as we try to do in New Hampshire, through transparency of cost and outcomes so that people can understand that sometimes lower costs can actually be aligned with better health outcomes, something that I do not think is intuitive for most people who think if you say to them, hey, please go use the lower cost provider, that they're somehow going to get worse care.

Ultimately, in my State the business community came together, for instance, and supported Medicaid expansion under the Affordable Care Act and convinced a Republican legislature to reauthorize it because they know that when people don't have the access to get the health care they need at the front end, ultimately they end up in emergency rooms in great crisis. They get the care because we're the United States of America. We are going to give our citizens in health care crisis care because everybody counts, but ultimately that cost gets shifted somewhere else, and the private insured through their employers end up paying greater health care costs.

So I hope as we work to stabilize the markets right now with cost-sharing reductions, with, I hope, federally at least seeded reinsurance plans, I hope that we also then move on to a discussion about how we continue to get our country healthier, lowering costs, so that all of us can thrive together, that we can have a workforce that is competitive in the 21st century economy, and that we can make sure that all Americans have the opportunity to enjoy the quality of life that we'd all like to have as healthy citizens.

Thank you all very much.

The CHAIRMAN. Thank you, Senator Hassan.

I want to acknowledge Senator Carper, who is in the back. He's come to—he's not a member of the committee, but if it were the 3d grade, he'd get perfect attendance, I think.

(Laughter.)

The CHAIRMAN. So, thank you for your interest in what we're doing, and we welcome your ideas.

Senator Whitehouse.

#### STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thanks, Chairman. As I think I've done in each one of these hearings, let me thank you and Ranking Member Murray for the bipartisan way in which this has proceeded and what I think has been an optimistic launch platform this has made for good work going forward.

I wanted just to check in with Ms. Postolowski. As I understood your testimony, your dissatisfaction with the Colorado high-risk pool that you were put into had to do with the waiting period that you were subjected to and with the cost of the premium. Is that a fair description of what you said?

Ms. POSTOLOWSKI. That's correct.

Senator WHITEHOUSE. So you were here when Senator Kaine talked about the prospect of, say, a Medicare program that somebody could buy into at a reasonable rate. Would you have the same

hesitation about that, or would you feel comfortable going into a Medicare for people who had diseases, as opposed to Medicare for people who were over a certain age?

Ms. POSTOLOWSKI. I certainly think a public option that has a robust risk pool would be the most attractive option both for taxpayers and consumers. The idea of buying into a public option is not something that I would be opposed to, though.

Senator WHITEHOUSE. As the co-author with Sherrod Brown of the public option that we nearly got into the Affordable Care Act, I appreciate you saying that. We came very close. We missed by a very small margin of votes. And I think had we succeeded, we would not be having the competition problem and the bare counties problem that we are facing right now. But this is Congress, and you have to have the votes. We were close, but no cigar.

Mr. Farmer, I wanted to ask you a question. I was the State insurance commissioner for a while in Rhode Island as well, and in the health insurance market I wanted to get your comment on if a health insurance provider was to come and propose to do business in either your State or, speaking for the National Association of Insurance Commissioners, more generally, how important would it be for that insurer to show that they had a robust and legitimate provider network in your state?

Mr. FARMER. Thank you, Senator. First, we welcome competition in our State, and no regulator would say anything different.

Senator WHITEHOUSE. Correct.

Mr. FARMER. It's important for that new provider or that provider to have a workable and extensive provider network. The Affordable Care Act in some instances has produced more narrow networks. We've got to get beyond that.

Senator WHITEHOUSE. An insurance company that was proposing to do business in your State and had made no effort to establish a network of doctors and hospitals, a provider network, would be viewed with disfavor, correct?

Mr. FARMER. That company is not going to do business in our State.

Senator WHITEHOUSE. And that would be true for most or all insurance commissioners as well?

Mr. FARMER. They'd have to speak for themselves, but I doubt anyone would. If you're not going to come in and provide the basic services and the networks that you're there to do, you're going to have issues, I don't care what State you're in.

Senator WHITEHOUSE. So let me ask all of you, if you wouldn't mind, a question for the record. It's the same question that I have asked all of the witnesses, all the panels so far. Many witnesses have urged, and the Chairman has expressed interest in, continuing this bipartisan conversation beyond just market stability and going into the areas of cost and quality of care that I think provide immense bipartisan opportunities. There are five that I have asked people to focus on.

One is patient safety, hospital-acquired infections, that arena of concern. It is a very significant cost of casualties among the American public.



The second is learning from the variations in cost and outcomes that show themselves among different States, and using those differences to learn what best practices are.

The third is trying to reduce administrative overhead. One of my particular favorites is warfare between insurance companies trying to deny payment to providers, and providers having to staff up to try to fight their way through that barrier, and the whole enterprise contributing zero health care value and it's just ridiculous administrative bureaucratic warfare that we all have to pay for.

The fourth is making sure that people's wishes as to what care they will receive at the end of life are properly documented early on so that they can be honored when it's game day and things are going badly.

The final one is looking at payment reform as an opportunity to redirect care so that doctors have the incentive to intervene earlier in the process with prevention and so forth and not be condemned to receive no compensation unless and until somebody is sick enough to require a procedure or a prescription.

If you'd all be kind enough to respond on those fronts what you think our opportunities are here for bipartisan action in this committee, I'd be grateful to you, and I'm grateful to the Chairman and the Ranking Member.

The CHAIRMAN. Thank you, Senator Whitehouse, for your participation.

Senator Murray, do you have any closing questions or comments?

Senator MURRAY. I have some closing comments, and I do want to thank everyone here and all of our witnesses who are joining us. I especially want to, again, express my appreciation to you, Chairman Alexander, for your leadership in holding these hearings. I think we all agree it hasn't been an easy 2017. There's been a lot of partisanship and disagreement, some unfortunate acrimony and sniping, but I want to thank you for the work we've done here in the past few weeks. I think this is the way things ought to go. This is the work that we should be doing here in the Senate, Democrats and Republicans coming together focused on common ground and working to find results for our constituents. And from the beginning you've agreed and we have worked together to organize these hearings in a bipartisan way. We've had great conversations in our committee coffees that you've organized, in our hearings, and outside them as well.

We've heard from really great witnesses who have laid out some really good ideas for helping us to move forward and engaged in productive negotiations, which we are ongoing with and I'm very hopeful about so we can find common ground and get something done.

As all of you know, Chairman Alexander, you and I have worked together in this committee to get some really important things done that were not easy, but I think the Every Student Succeeds Act, the 21st Century Cures Act, and mental health reform are great examples, and I'm confident that this committee can do it again because we know this isn't about us, it's not about partisanship, it's not about politics. It is about getting results for the people we serve, and no committee that I serve on does it better than this,

and I really appreciate that and all of our committee members who worked together and your leadership on this.

So as we wrap up this last hearing today, I'm really glad we've had these. I'm glad for the open and frank discussions and, as I mentioned, taken together, all the perspectives we have heard make it very clear that there is common ground on the key goal that we do want to meet together, which is stabilizing our markets and lowering costs for families in the near term.

Certainly, there are some differences to be resolved, but I feel very optimistic that there's a lot more that we agree on than we disagree on with respect to that goal, and I'm hopeful and confident we can get that done. And then we hopefully can use that as a base to continue doing what this committee does, which is get results.

So thank you, Chairman Alexander, and thank you to all our committee members and everybody who has participated for all that we've been doing here.

The CHAIRMAN. Thank you, Senator Murray.

I subscribe to everything she just said. We have shown in this committee on actually issues that are larger and more difficult than this one should be that we know how to take very contentious and difficult issues and get a result. And the advantage of that is that once we get it, whether it's fixing No Child Left Behind or the 21st Century Cures bill, or the first reorganization of our mental health laws in 10 years, then the law is settled for a while. People can count on it. It's durable. There's a consensus.

When one party does it at the expense of the other, why then we just keep fighting like the Hatfields and the McCoys. The result of that over the last 7 years is that we've really spent, as important as it is to every single American, we spent too much time on insurance and not enough time on the cost of health care. You can't have lower cost insurance if you have higher cost health care, and we need to get into the issues that many of you have mentioned, having to do, for example, with wellness and other provisions.

There's been a lot of suggestion that if we just had a little more money for this or for that, it would solve the problem. Well, we have a Federal Government that this week became \$20 trillion in debt. So there's not any money up here to give to anybody, really. We just have to borrow it from somebody's grandchildren. So that's the reality of what we're faced with.

I have one question I'd like to ask Mr. Ruiz-Moss. Would you say again—Senator Murphy, I thought, put it pretty well. We're trying to figure out what Section 1332 really means when it says you may waive this but you may not. You said that you offered a wellness provision in the group market, but there was something too rigid about the individual market to permit you to offer it. Could you explain that?

Mr. RUIZ-MOSS. There are innovations that are in the employer market, and a lot of times they will relate to if a consumer makes this kind of a decision, can they be rewarded for that financially.

The CHAIRMAN. Right.

Mr. RUIZ-MOSS. That, with the way plans and rates are developed in the individual market, is just virtually impossible to design. So it sort of comes from the rules that exist today without it looking like a premium rebate or some adjustment from that—

The CHAIRMAN. It has to do with plan design or benefit?

Mr. RUIZ-MOSS. Probably as we get deeper into it, I can have some of my team follow-up in more detail with you on the specifics of that, but it will relate somewhere between plan design and rate development, premium rate development.

The CHAIRMAN. Thank you very much. I would be interested if you could follow-up with that.

Mr. RUIZ-MOSS. Absolutely.

The CHAIRMAN. And as Senator Murray said, we've had a very good 2 weeks, and we're really a long way toward a consensus. Always sometimes the last decisions are the hardest decisions, and she and I will visit over the next few days and consult with members both on and off the committee, and we'll see if next week we can come to some consensus that we can offer to Senator McConnell and Senator Schumer, ask them to present it to the Senate before the end of the month so we can pass it, send it to the House, and hopefully the President will sign it.

If we do that, I'm convinced that we can limit the increase in premiums in the year 2018 and put in place some improved flexibility for States that will mean lower premiums in the future.

Senator Murkowski is still here. All of us are very interested in what Alaska has done, what Minnesota is trying to do, Iowa and Maine as well, which is basically to take some of the available money, create a reinsurance plan with some State funds and lower rates by 20 percent in those States.

So State innovation is a part of our solution, and I look forward to working with Senator Murray. As I said yesterday, when Senator Murray decides that we're going to get a result, we usually do, and we've been both working in that way for the last 2 weeks, and I hope we succeed.

My last comment will be that I heard a Supreme Court justice in the summer who was asked how can members of the Supreme Court get along as well when they have such different points of view, and the answer was that we try to remember that the institution is more important than our own opinion, and I think that's a good lesson for the U.S. Senate as well.

The record will be open for 10 days for comments and questions. We'd like to have your additional suggestions, though, in the next three or 4 days because we're trying to come to a consensus quickly. We've heard from a variety of witnesses including Governors, insurance companies, providers, actuaries, insurers. We thank them and you especially for your time.

The last 10 days mark a modest first step in our efforts to stabilize the market for 2018 and beyond. But if we can take one modest first step, we believe it will make it a lot easier to take step 2 and step 3 and step 4.

The committee will stand adjourned.

[Whereupon, at 12:32 p.m., the hearing was adjourned.]

[Additional Material follows.]

## ADDITIONAL MATERIAL

### STATEMENT FOR THE RECORD AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians (ACP) applauds Chairman Alexander and Ranking Member Murray for convening a series of bipartisan hearings to improve and strengthen the individual insurance market to ensure that millions of patients continue to have access to critical health coverage into the future. We also appreciate the HELP Committee inviting input from the physician community during the legislative process and we support the adherence to regular order which provides a valuable opportunity for analysis, review and input by organizations and other stakeholders, by members of the Senate, and by independent and nonpartisan analysts.

ACP is the largest medical specialty organization and the second largest physician group in the United States, representing 152,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

ACP is pleased to offer the following recommendations on market stabilization with the strong belief that any reforms should *first, do no harm* to patients and actually result in improving access and quality of care.

#### ENSURING COST SHARING REDUCTION PAYMENTS

ACP believes that Congress must make a clear, immediate and unambiguous commitment to preserve the ACA's cost-sharing reduction (CSR) payments to insurers at least through 2019, and better yet, for the long-term. In 2016, about 6 million enrollees relied on CSR payments to help reduce the burden of co-payments, deductibles, and co-insurance. Without a guarantee that the CSR payments will be continued, many insurers will have no choice but to leave the exchanges or to raise premiums by up to 23 percent to make up the shortfall according to preliminary insurer rate filings for plan year 2018.<sup>1</sup> Insurers are deciding now whether they will be able to offer insurance through the exchanges for the 2018 enrollment cycle and several have already announced substantial premium increases because of the uncertainty over whether the CSR payments will continue. The Congressional Budget Office (CBO) has determined that gross silver plan premiums would increase by 20 percent in 2018 and 25 percent in 2020 compared to the March 2016 baseline if CSRs are not continued after 2017.<sup>2</sup> While enrollees who receive premium tax credits would be largely insulated from rate fluctuations, individuals who do not qualify for subsidized plans would be forced to pay the higher premiums or switch to less-expensive, off-marketplace plans. However, eliminating CSR payments would in fact cost the Federal Government \$194 billion more over 10 years according to the CBO.<sup>3</sup> Therefore, it is imperative that CSRs be preserved into the future.

#### ENCOURAGE REINSURANCE AND OTHER STABILIZATION EFFORTS THROUGH STATE WAIVERS

The College believes that the Department of Health and Human Services' (HHS) *March 13, 2017 letter* encouraging States to seek Section 1332 waivers for reinsurance programs was a step in the right direction. There is ample evidence that reinsurance can help to ensure that patients retain the coverage they have while protecting insurers from high costs. The ACA's temporary reinsurance pool ended in 2016 and was proven to be effective by HHS' June 30, 2017 report on transitional reinsurance payments and risk adjustment transfers for plan year 2016. That report showed that the ACA's transitional reinsurance program stabilized insurers with a substantial amount of high-cost enrollees, and, in concert with the risk adjustment program, reduced the risk of adverse selection.<sup>4</sup> Alaska's reinsurance program has

<sup>1</sup> <http://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>.

<sup>2</sup> <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

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

<sup>4</sup> Centers for Medicare and Medicaid Services. *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year*. June 30, 2017. Accessed at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf> on July 6, 2017.

successfully reduced premium costs,<sup>5</sup> containing premium hikes to just 7 percent, down from a projected 42 percent increase. Minnesota has also applied for a section 1332 waiver to help finance its reinsurance program. Congress can also embrace initiatives that have proven effective in the Medicare Part D program by establishing permanent reinsurance and risk corridor programs as well as emergency fallback protections to provide coverage when no plans are available in an area.<sup>6</sup>

Congress should consider additional policies to encourage State innovation and bring more choice and competition into insurance markets without rolling back current coverage, benefits and other consumer protections guaranteed by the ACA and other Federal laws and regulations. Provided that coverage and benefits available in a particular State would be no less than under current law, Congress should encourage the use of existing section 1332 waiver authority to allow States to adopt their own innovative programs to ensure coverage and access. Section 1332 waivers offer States the opportunity to test innovative ways to expand insurance coverage while ensuring that patients have access to comprehensive insurance options. However, ACP believes that Congress should not weaken or eliminate the current-law guardrails that ensure patients have access to comprehensive Essential Health Benefits and are protected from excessive co-payments and deductibles. If existing requirements were removed (e.g. that waivers provide comprehensive, affordable coverage that covers a comparable number of people as would be covered under current law), a backdoor would emerge for insurers to offer less generous coverage to fewer people and to make coverage unaffordable for patients with preexisting conditions. As long as a State's waiver program meets the ACA's standard of comprehensiveness at the same cost and level of enrollment, it can test a more market-based approach, or make other, more targeted revisions to continue existing State initiatives.

#### ENHANCE ENROLLMENT THROUGH PROMOTION AND ENGAGEMENT

ACP supports robust outreach to patients to encourage patient enrollment in health coverage. Congress should support and properly fund this outreach and other education efforts to avert declining enrollment that could lead to higher premiums and market destabilization. The administration's recent actions to cut marketing funding for advertising by 90 percent and cut navigator program grant funding by about 41 percent are steps in the wrong direction and are counter to the available evidence. Distressingly, the administration has also interrupted the current funding for the navigator program and it is unclear when the funding will resume.<sup>7</sup> With open enrollment starting November 1st and the administration already stating that the funding will not be retroactive, Congress must step in with its oversight authority to properly ensure that the navigator programs are properly funded.

ACP strongly believes that more intensive outreach and enrollment efforts will be needed because the open enrollment period for 2018 was considerably shortened. Many uninsured people remain unaware of marketplace-based coverage options and subsidies<sup>8</sup> and in 2017 marketplace enrollment declined after HHS prematurely ended its open enrollment publicity and outreach campaign. Evidence suggests that efforts such as enhanced television advertising can increase enrollment.<sup>9</sup> Curtailing funding for such advertising, as the administration is planning to do, will not only reduce overall enrollment, leading to more uninsured persons, but also lead to adverse selection (and higher premiums and Federal premium subsidies) if younger and healthier persons do not get the information needed to encourage and help them enroll. Therefore Congress must encourage the administration to redouble efforts to promote marketplace awareness and attract more people to shop and purchase the right coverage for them.

<sup>5</sup> Alaska Department of Commerce, Community, and Economic Development Division of Insurance. Alaska 1332 Waiver Application. December 7, 2016. Accessed at <https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=106061>.

<sup>6</sup> <http://www.commonwealthfund.org/publications/blog/2017/apr/shoring-up-the-health-insurance-marketplaces>.

<sup>7</sup> Cliff, Sarah. "This is the most brazen act of Obamacare sabotage yet." Vox, September 8, 2017. Accessed at <https://www.vox.com/platform/amp/policy-and-politics/2017/9/8/16268572/trump-obamacare-navigators>

<sup>8</sup> <http://www.commonwealthfund.org/publications/blog/2016/jan/better-outreach-critical-to-aca-enrollment-particularly-for-latinos>

<sup>9</sup> Karaca-Mandic P, Wilcock A, Baum L, Barry CL, Fowler EF, Niederdeppe J, Gollust SE. The Volume of TV Advertisements During The ACA's First Enrollment Period Was Associated With Increased Insurance Coverage. *Health Affairs*. 2017; 36(4):747-754. Accessed at <http://content.healthaffairs.org/content/36/4/747> on June 13, 2017.

## ENFORCE CURRENT-LAW REQUIREMENT TO PURCHASE A QUALIFIED HEALTH-PLAN

Not enforcing the insurance mandate penalty will lead directly to enrollment rates dropping among healthy enrollees who may be less inclined to purchase health insurance. Insurers would need to increase premiums to compensate for the resulting sicker risk pool. Insurance companies have already anticipated lax individual-mandate enforcement by the administration. For instance, the 2018 Maryland individual market rate filing for CareFirst stated that, “we have assumed that the coverage mandate introduced by ACA will not be enforced in 2018 and that this will have the same impact as repeal. Based on industry and government estimates as well as actuarial judgment, we have projected that this will cause morbidity to increase by an additional 20 percent”.<sup>10</sup> The CBO predicts that while premiums are rising, tax credits that insulate enrollees from rising costs as well as the individual mandate “are anticipated to cause sufficient demand for insurance by enough people, including people with low health care expenditures, for the market to be stable in most areas.” CBO also States that insurers withdraw from the market due to a variety of factors including, “substantial uncertainty about enforcement of the individual mandate and about future payments of the cost-sharing subsidies to reduce out-of-pocket payments for people who enroll in non-group coverage through the marketplaces established by the ACA.”<sup>11</sup>

Congress should avail itself of its oversight authority so that the administration effectively enforces the individual mandate under current law. Maintaining effective adherence helps balance the market’s risk pool, attract healthier enrollees, and avoid dramatic premium rate increases. In addition, Congress should not enact any legislation to weaken or repeal the individual insurance requirement absent an alternative that will be equally or more effective. For example, automatic enrollment in a qualified health plan has been suggested by former CMS Administrator Andy Slavitt and former Majority Leader Bill Frist as an alternative to the individual insurance mandate; further analysis needs to be done by non-partisan experts, including the CBO, to determine if automatic enrollment is a viable alternative.

ACP supports consideration by Congress of additional steps and incentives to encourage younger and healthier persons to enroll, such as targeted outreach and education programs, as long as they do not increase premiums and out of pocket costs for older and sicker persons or erode current law essential benefits and consumer protections.

## ENACT LEGISLATION TO EXPAND INDIVIDUAL CHOICE IN THE MARKETPLACES

Currently, some exchanges have difficulty attracting enough insurers and some patients may have only one insurer from which to obtain coverage. Congress should enact a public option that would provide more options and increase competition. Several avenues exist to achieve a range of public options including a buy-in program for traditional Medicare and Medicare Advantage, Medicaid, and other publicly funded health programs to offer real competition to private insurers in the marketplaces.

For instance, ACP supports the development of a Medicare buy-in option for people age 55–64. Older adults would have the opportunity to enroll in the popular Medicare program while potentially improving both the Medicare and ACA marketplace risk pools and driving down premiums. Specifically, ACP recommends that: 1) a Medicare Buy-in Program must include financing that assures that premiums and any subsidies are sufficient to fully cover expenses without further undermining the solvency of the Medicare trust funds; 2) a Medicare Buy-in Program should include subsidies for lower-income beneficiaries to participate; 3) Eligibility for a Medicare Buy-in Program should include adults age 55–64 regardless of their insurance status; 4) Enrollment in a Medicare Buy-in program should be optional for eligible beneficiaries and should include the full range and responsibilities of Medicare benefits (Parts A, B, Medicare Advantage and Part D); and 5) Reimbursement for services, including evaluation and management services, should be no less than under the traditional Medicare reimbursement rates.

The benefits of a Medicare Buy-in program, according to the American Academy of Actuaries, may expand patient access to providers and enhance the continuity of

<sup>10</sup>CareFirst Blue Cross Blue Shield. Part III Actuarial Memorandum. Accessed <http://www.healthrates.mdinsurance.state.md.us/AllNewRateReq.aspx>.

<sup>11</sup>Congressional Budget Office. Cost Estimate of H.R. 1628 Better Care Reconciliation Act of 2017. June 26, 2017. Accessed at <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf>.

care for individuals changing over to Medicare while at the same time helping to reduce premiums for individuals in the marketplace exchanges.<sup>12</sup>

USE EXISTING STATUTORY AUTHORITY TO ALLOW SALE OF INSURANCE ACROSS STATE LINES

ACP supports States using authority under existing law to permit the sale of insurance across State lines among States that have agreed to enter into a regulatory compact to protect patients. Without a robust regulatory structure that ensures that such plans meet existing essential benefit, community-rating, network adequacy standards, prompt claims payment and other consumer protections, the current evidence strongly suggests that selling insurance across State lines would not likely result in significant cost-savings while at the same could cause a “race to the bottom.” Instead of pursuing new laws to sell insurance across State lines without such protections for patients, Congress should strongly encourage the administration to work with States to promote and support the development of interstate health insurance compacts as already authorized under Section 1333 of the ACA. While these compacts could potentially broaden choice of insurance options for patients while still maintaining crucial insurance regulations, benefit requirements, and other protections that characterize health plans under current law, it is unclear if many States or insurers are willing and able to sell insurance across State lines, and create the necessary regulatory compact structure to allow such sales. One limitation is that insurers typically negotiate market-specific contracts with physicians, hospitals and other providers of health care services; insurers located outside of a specific market would face challenges in having the relationships needed to negotiate effective contractual arrangements. Therefore, some caution is appropriate in considering the likely impact that selling insurance across State lines, under existing statutory authorities, will have on patient choice, access to care, and premiums.

BIPARTISAN PROPOSALS AT THE STATE LEVEL

ACP is encouraged by the broad discourse about the individual insurance market at both the State and Federal level. Several bipartisan proposals, including those put forth by Gov. John Kasich (R-OH) and Gov. John Hickenlooper (D-CO) along with other State Governors and the Bipartisan Policy Center can further the discussion and contain some promising ideas. While ACP continues to study these proposals more closely, the College agrees that maintaining CSR payments and creating reinsurance programs should be the first steps in stabilizing the individual market. ACP also supports the overall concept of State innovation through Section 1332 waivers, including Congress possibly adding structural or procedural improvements to shorten the waiver process, as well as offering a public option, as described above. We also agree that funding for outreach and enrollment must be strengthened. However, ACP strongly believes that Essential Health Benefits and other consumer protections (guaranteed issue and renewability, modified community rating) must be maintained at the Federal level and would be concerned about efforts to give States the ability to modify or reduce these benefits.

CONCLUSION

The College would again like to sincerely thank Chairman Alexander and Ranking Member Murray for convening this hearing and for your shared bipartisan commitment to stabilizing the individual insurance market. We greatly appreciate the committee inviting input from the physician community and the opportunity to provide recommendations on strengthening the health insurance market, and stand ready to work with the committee on the development of any reforms where our experience and expertise could be of value. Our hope is that the information shared today will provide the committee with a clinician perspective and we welcome the opportunity to continue to work with you as you advance healthcare reforms through the 115th Congress. Please contact Jared Frost at [jfrost@acponline.org](mailto:jfrost@acponline.org) with any questions or if additional information is needed.

<sup>12</sup> <http://election2016.actuary.org/sites/default/files/Medicare-Buy-In-Option.pdf>.

## HABILITATION BENEFITS COALITION

Hon. LAMAR ALEXANDER,  
 Hon. PATTY MURRAY,  
*United States Senate,*  
*Washington DC, 20510.*

CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY Thank you for the opportunity to submit testimony for the written record on behalf of the Habilitation Benefits (HAB) Coalition on the issue of preserving habilitative benefits in connection with your hearing entitled, “Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Flexibility.” The undersigned organizations are writing as members of the Habilitation Benefits (HAB) Coalition to continue to express our deep concern about repealing key provisions of the Affordable Care Act (ACA) that would limit access to habilitation services and devices for children and adults under Medicaid expansion and in ACA insurance plans. The HAB Coalition is a group of national nonprofit consumer and clinical organizations focused on securing appropriate access to, and coverage of, habilitation benefits within the statutory Essential Health Benefits (EHB) category known as “rehabilitative and habilitative services and devices” under Section 1302 of the ACA.

We last wrote to Congress on April 6, 2017 expressing the importance of maintaining access to habilitation services and devices in any ACA repeal and replace bill that advanced in the House and Senate. The HAB Coalition continues to have significant concerns with ongoing efforts to modify the ACA in ways that could decrease access to habilitation benefits. One proposed reform would waive Federal EHB requirements entirely and delegate to States the determination of the scope of Essential Health Benefits. There is little doubt under this scenario that access to habilitation services and devices will suffer in many areas of the country. Americans needing habilitation services and devices rely on their health care coverage to acquire skills and functions never developed due to disability, as well as assist in maintaining their health and function, and living as independently as possible. Often skills acquired through habilitation services and devices lead to breakthroughs in functional abilities that would have been impossible without access to timely and appropriate habilitation benefits. This reduces long-term disability and dependency costs to society.

For these reasons, the HAB Coalition strongly urges Congress to maintain the Federal standard for EHB coverage, specifically, coverage of rehabilitative and habilitative services and devices, in any ACA repeal and replace or ACA stabilization bill that is advanced in the future.

## DEFINITION OF HABILITATION SERVICES AND DEVICES

The ACA created in statute the EHB category of “rehabilitative and habilitative services and devices.” ACA, Section 1302 (b). In the February 2015 Benefit and Payment Parameters Final Rule, the Centers for Medicare and Medicaid Services (CMS) defined “habilitation services and devices” using the definition of “habilitation services” from the National Association of Insurance Commissioners’ *Glossary of Health Coverage and Medical Terms*<sup>1</sup> plus explicitly adding habilitation devices, as follows:

“Habilitation services and devices—Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.”<sup>2</sup>

This definition is a floor for individual insurance plans sold under the ACA exchanges. In addition, all States that opted to expand their Medicaid program must cover Essential Health Benefits at a minimum. For the first time, this definition established a uniform, understandable Federal definition of habilitation services and devices that became a standard for national insurance coverage. We stress that this definition is a floor for coverage and includes both habilitative *services* and habilitative *devices*. The services and devices covered by the habilitation benefit should not be limited to the therapies enumerated in the Federal regulation which are listed as *examples* of covered benefits.

In addition to the regulatory definition cited above, examples of these types of services typically provided under this benefit include rehabilitation medicine, behavioral health services, recreational therapy, developmental pediatrics, psychiatric re-

<sup>1</sup> <https://www.cms.gov/CCIIO/resources/files/downloads/uniform-glossary-final.pdf>.

<sup>2</sup> <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>, at 10871.



habilitation, and psycho-social services provided in a variety of inpatient and/or outpatient settings. These services should be provided based on the individual's needs, prescribed in consultation with a clinician, and based on the assessment of an interdisciplinary team and resulting care plan.

The HAB Coalition supports the preservation of the EHB category of "rehabilitative and habilitative services and devices," and the subsequent regulatory definition and related interpretations duly promulgated, as a Federal standard of coverage for habilitation under any future ACA-related legislation. The HAB Coalition believes that adopting the uniform Federal definition of habilitation services and devices minimizes the variability in benefits across States and uncertainty in coverage for children and adults in need of habilitation.

#### OTHER HHS REFORMS POSITIVE TO HABILITATION COVERAGE

The HAB Coalition also supports other regulatory changes that have had a positive impact on habilitation coverage, and advises this committee to strive to preserve the effectiveness of such regulations in future ACA legislative approaches. First, the Department of Health and Human Services (HHS) adopted in the regulation defining "habilitation services and devices" that exchange plans cannot impose limits on coverage of *habilitative* services and devices that are less favorable than any such limits imposed on coverage of *rehabilitative* services and devices. Further, for plan years beginning on or after January 1, 2017, exchange plans cannot impose combined limits on habilitative and rehabilitative services and devices. Both of these regulatory provisions are strong indicators of a habilitation benefit that is designed to meet the needs of individuals who require habilitation benefits.

#### PRESERVING HABILITATION IS COST-EFFECTIVE

Removing coverage protections for habilitative services and devices will not significantly save the taxpayers' money. While some believe that Essential Health Benefits (EHBs) significantly increase premiums, evidence suggests that this is not the case, and that other factors such as community rating has a greater impact on premiums. To illustrate this, Milliman estimated that the total cost of providing selected hearing services, speech-language therapy, and hearing supplies, devices, and related professional services, in a commercial employer group population, noting a utilization rate of approximately one per thousand, resulted in PMPM (per member per month) claim costs of approximately \$1.48 for 2014. Additionally, an *analysis* from the Urban Institute and the Robert Wood Johnson Foundation indicates EHBs covered under the ACA, if removed, will not significantly reduce the cost of monthly premiums. Instead, this would merely add considerable costs for beneficiaries. According to the analysis, habilitative and rehabilitative care represent only 2 percent of nongroup premiums in 2017.

#### VIGNETTES

The following vignettes help to demonstrate the value of habilitation. We ask HELP Committee members and staff to seriously consider these illustrations of habilitation services and devices before taking legislative action on the Affordable Care Act:

##### 1. HABILITATION SERVICES FOR INFANTS AND CHILDREN

###### *Hearing Screening*

Consistent with the State mandate for infant hearing screening, Gavin received a newborn hearing screening test in the hospital 48 hours after he was born. The newborn hearing screening indicated a possible hearing loss, and according to the State protocol, he was referred for a repeat outpatient hearing screening. The results of the outpatient screening indicated the need for further testing. Therefore, he was referred to a pediatric audiologist for a comprehensive diagnostic evaluation. The results of the evaluation confirmed a moderate sensorineural hearing loss in both ears. The family chose an auditory/oral approach for speech and language development for Gavin. He was fitted with binaural hearing aids at 3 months of age and referred to the State Early Intervention (EI) program. The initial recommendations from EI were biweekly early intervention services provided by an audiologist and speech-language pathologist (SLP) in the home, beginning at 4 months of age that focus on parent education, auditory/listening skills, and language development. After 3 years of consistent hearing aid use and regular habilitation treatment services, Gavin entered preschool with normal receptive and expressive language, on par with his hearing peers. Hearing aids, speech-language pathology and audiology serv-

ices are often covered under the EHB category of rehabilitative and habilitative services and devices.

#### *Cochlear Implants (CI)*

Olivia was identified with a permanent, sensorineural severe-to-profound hearing loss at 6 months of age and currently wears hearing aids in both ears. Her family chose an auditory/oral communication approach. Olivia received a cochlear implant evaluation from an interdisciplinary team—including a surgeon, an audiologist, a speech-language pathologist (SLP), and a social worker—at a hospital 3 hours away from her home. An SLP has been providing habilitation services in the home since Olivia's hearing loss was diagnosed. The audiologist and SLP have been collaborating with the cochlear implant team on habilitative treatment and will continue to provide services locally to Olivia and her family following the cochlear implantation. This professional collaboration will help Olivia develop speech and language skills post-cochlear implantation and will help the audiologist in programming the cochlear implant to maximize the hearing benefit. Without Essential Health Benefits and insurance protections to ensure coverage of pre-existing conditions, far too many children would go without access to cochlear implantation.

#### *Cleft Palate*

Jessica is a 2-year old child with a bilateral cleft palate that was surgically repaired at 11 months of age. She presented with speech sound production errors and excessive nasality that impaired her ability to communicate. Jessica's care is coordinated by a cleft palate/craniofacial team that includes a plastic surgeon, an orthodontist, an SLP, a pediatrician, and additional providers. The SLP assesses articulation, language, voice, and resonance and determines the presence of articulation deficits and nasal emission that requires speech-language treatment weekly. Treatment goals focus on correct articulatory placement to address sound errors, nasality of speech, and oral airflow. With appropriate speech language treatment, Jessica will learn techniques to improve her speech intelligibility, allowing her to communicate with others at an age-appropriate level. Professional collaboration with the craniofacial team and a coordinated care plan ensure that Jessica achieves maximum functional communication. Without habilitation coverage, it would be difficult for Jessica to access services to treat her condition.

#### *Muscular Dystrophy*

Adam is a 14-year-old boy with Duchenne Muscular Dystrophy. He has recently experienced a significant decrease in his trunk and arm strength. After conducting an occupational profile and evaluating Adam's current performance skills, the occupational therapist adapted Adam's computer keyboard in order for him to be able to continue to use the computer and keyboard for schoolwork and entertainment. She teaches Adam compensatory strategies and modifies his silverware so that he may continue to feed himself without assistance, and teaches him and his family strategies for dressing with minimal assistance from his caregivers. The occupational therapist also teaches Adam stretches for his shoulders and upper arms to help maintain flexibility and prevent the development of muscle contractures. Finally, she teaches Adam new strategies for relieving pressure on his buttocks in his wheelchair, as he can no longer perform wheelchair pushups. She works with Adam to build these techniques into his daily routine so he does not forget, since forgetting could result in the development of additional pressure sores.

#### *Down Syndrome*

Jill is a 5-month-old girl with Down syndrome (DS). Jill's parents were aware of the diagnosis before her birth and they have always sought optimal care for her. She is scheduled for surgical repair of a congenital heart defect in the near future. Jill has had difficulty drinking from a bottle, and her physical therapist has worked with other health professionals to assist the parents with a feeding program best suited for her. She is seen at home by several health care professionals. The pediatric physical therapist has helped the family learn how to teach Jill to hold her head upright when she is supported when sitting, and how to teach Jill to roll over from her stomach to her back and from her back to her stomach. The physical therapist includes games and toys with bright colors to stimulate Jill's interest, play, and hand skills. The therapist incorporates words and pictures with the treatment sessions to help Jill's language development.

The family has already asked for information about starting an infant treadmill walking program as soon as Jill has recovered from her surgery and can put weight on her feet to stand. The therapist is using a large ball to encourage Jill to take some weight on her feet now. As Jill continues to develop during her early years of life, the physical therapist will encourage progression of motor activities such as

crawling, walking, climbing stairs, and running. An orthotics (braces for the foot and ankle) assessment will be completed once Jill begins to initiate weight-bearing activities at 7–9 months. Infants with DS are at high risk for delayed standing due to low muscle tone and joint instability, which may result in foot deformity and life-long mobility impairments. An orthotics assessment is beneficial, in the first year of life, to prevent misalignment.

## 2. HABILITATION SERVICES FOR ADULTS

### *Multiple Sclerosis*

A 47-year-old female with Multiple Sclerosis was referred to occupational therapy for self-management, specifically management of fall risk and fatigue. She reported having difficulty with household chores, specifically cleaning and ironing. She also reported becoming easily fatigued during the day. Intervention focused on identifying adaptive and compensatory strategies to assist her to learn how to self-pace her daily routines between demanding and non-demanding activities to conserve energy. She was able to continue her daily routines with improved energy and satisfaction.

### *Cochlear Implants*

Raul was diagnosed with congenital hearing loss as a young child, but did not have access to hearing aids until age ten. He attended a school for the deaf and hard of hearing, and his primary language is American Sign Language. As an adult, Raul decided to undergo cochlear implant surgery and learn spoken language. He works with an audiologist and SLP on open-set speech recognition with amplification. The prognosis from the interdisciplinary cochlear implant team—based on Raul's motivation, progress in therapy, and use of lip-reading and technology—is fair for receptive language abilities. His cochlear implant and related new skills will assist him with communication in the workplace and community.

## CONCLUSION

Habilitation services and devices maximize the health, function, and independence of children and adults with disabilities. Each vignette outlined above is a real-life example of habilitation services and devices being used to address the needs of individuals who require habilitation. The Steering Committee of the HAB Coalition firmly believes that any Federal legislation to modify the Affordable Care Act must preserve access to habilitative services and devices in order to continue to meet the needs of children and adults with disabilities and chronic, progressive conditions.

Thank you for your willingness to consider our views. Should you have further questions regarding this information, please contact Peter Thomas, [Peter.Thomas@powerslaw.com](mailto:Peter.Thomas@powerslaw.com) Steve Postal, [Steve.Postal@powerslaw.com](mailto:Steve.Postal@powerslaw.com). HAB Coalition coordinators.

Habilitation Benefits Coalition  
<https://Habcoalition.wordpress.com>.

Melanie Dolak, American Academy Of Physical Medicine And Rehabilitation; Stephanie Mohl, American Heart Association/American Stroke Association; Chuck Willmarth, American Occupational Therapy Association; Tim Nanoff, American Speech-Language-Hearing Association; Julie Utano, American Therapeutic Recreation Association; Julie Ward, The Arc Of The United States; Jan Kaplan, Children's Hospital Association

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AMERICAN ACADEMY OF FAMILY PHYSICIANS; AMERICAN ACADEMY OF PEDIATRICS; AMERICAN COLLEGE OF PHYSICIANS; AMERICAN CONGRESS OF OBSTETRICIANS; AND GYNECOLOGISTS AMERICAN OSTEOPATHIC ASSOCIATION AMERICAN PSYCHIATRIC ASSOCIATION

## JOINT STATEMENT FOR THE RECORD

SEPTEMBER 14, 2017

On behalf of the more than 560,000 physicians and medical students represented by the combined memberships of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Congress of Obstetricians and Gynecologists, the American Osteopathic Association, and the American Psychiatric Association, we appreciate this opportunity to submit a statement for the record outlining our recommendations to stabilize the health insurance market and ensure our patients have access to a wide variety of

affordable and comprehensive coverage options. Our members are the front-line physicians who care for patients in rural, urban, wealthy and low-income communities, and are the foundation of the American health care system.

We applaud the committee's efforts to develop bipartisan solutions to strengthen and improve the health insurance market. Millions of Americans rely on the coverage offered through health insurance exchanges (also known as marketplaces) and it is imperative that we work together so that insurance is available and affordable to all. We submit the following recommendations, as reflected in our *joint principles*:

#### PROVIDE LONG-TERM COST-SHARING REDUCTION FUNDING

Our coalition's joint principles State that policymakers must ensure that premium and cost-sharing subsidies are sufficient to make coverage affordable and accessible, especially for vulnerable patients like children and adults with special health care needs, older adults, and low-income individuals and families. Stakeholders as diverse as the National Association of Insurance Commissioners and Governors from both parties have called for predictable long-term cost-sharing reduction funding.<sup>1,2</sup>

Congress should make an immediate commitment to fund cost-sharing reduction payments at least through 2019 and, preferably, for the long term. Failing to do so could result in higher premiums, reduced insurer confidence in the sustainability of the marketplace risk pool, and a larger Federal deficit. Preliminary insurer rate filings for plan year 2018 indicate that insurers are requesting additional premium increases of up to 23 percent because of uncertainty related to cost-sharing reduction payments.<sup>3</sup> According to the Congressional Budget Office, gross silver plan premiums would increase by 20 percent in 2018 and 25 percent in 2020 compared to the March 2016 baseline if cost-sharing reductions are not continued after 2017.<sup>4</sup> Although many enrollees would receive premium tax credits that would insulate them from rate fluctuations to some effect, those who do not qualify for the tax credits may be forced to pay higher premiums or shop for cheaper off-marketplace plans that lack the consumer protections of marketplace plans.

#### CONTINUE REINSURANCE AND OTHER PREMIUM STABILIZATION PROGRAMS

Reinsurance and other risk stabilization programs have been an effective tool to offset the cost of insuring high-risk individuals and curbing excessive premiums. The Affordable Care Act's (ACA) temporary reinsurance pool ended in 2016 and the Centers for Medicare and Medicaid Services (CMS) has since encouraged States to develop reinsurance programs through the § 1332 waiver process.

Alaska's reinsurance program successfully limited premium hikes to a manageable 7 percent, down from a projected 42 percent increase had the State not intervened.<sup>5</sup> A recent CMS report indicated that the transitional reinsurance and permanent risk adjustment programs successfully prevented exorbitant premium spikes, which kept enrollees in the individual marketplace.<sup>6</sup> We encourage Congress to develop and sufficiently fund long-term premium stabilization programs to enhance the availability of affordable premiums and encourage insurer participation.

#### ENHANCE OUTREACH AND EDUCATION EFFORTS

Millions of Americans remain unaware of premium tax credits, community-based Navigator and outreach programs and other assistance that can help them afford and enroll in comprehensive health insurance coverage. A 2016 Commonwealth Fund report on the uninsured found that 38 percent of survey participants were unaware of the Healthcare.gov website or their state's health insurance exchange/marketplace.<sup>7</sup> The report also found that adults who visited the exchange and received personal assistance from a navigator, broker or other assister were much more likely to enroll in coverage than the unassisted. More intensive outreach and enrollment efforts will be vital since the open enrollment period for plan year 2018 has been

<sup>1</sup>[http://www.naic.org/documents/government\\_relations\\_170517\\_letter\\_omb\\_costsharing\\_reduction.pdf](http://www.naic.org/documents/government_relations_170517_letter_omb_costsharing_reduction.pdf).

<sup>2</sup><http://Governor.ohio.gov/Portals/0/pdf/Bipartisan%20Governors%20Blueprint.pdf?ver=2017-08-31-094757-317>

<sup>3</sup><http://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>.

<sup>4</sup><https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

<sup>5</sup><https://aws.state.ak.us/OnlinePublicNotices/Notices/Attachment.aspx?id=106061>.

<sup>6</sup><https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf>.

<sup>7</sup><http://www.commonwealthfund.org/publications/issue-briefs/2016/aug/who-are-the-remaining-uninsured>

shortened to only a month and a half. In 2017, marketplace enrollment declined after the Department of Health and Human Services prematurely ended its open enrollment publicity and outreach campaign. CMS has reduced funding for open enrollment advertising by 90 percent and cut navigator program grant funding by about half, despite evidence of effectiveness and promises of enhanced outreach efforts to increase awareness of the compressed open enrollment period. Congress should adequately fund outreach and education efforts to encourage a better risk pool and prevent low enrollment, higher premiums, and market destabilization.

#### ENFORCE CURRENT-LAW CONSUMER PROTECTIONS

Our coalition's joint principles call for the protection of the ACA's patient-centered insurance reforms, including the preservation of current coverage of Essential Health Benefits (EHBs). As Congress deliberates creative ways to stabilize the individual market and reduce costs, it must do so without jeopardizing the coverage our patients have today. All marketplace plans must retain EHBs, including maternity coverage and mental health and substance use disorder treatment services. An estimated 8.7 million Americans gained maternity coverage under the ACA, righting a wrong in our health care system and ensuring that insured pregnant women have access to prenatal care, leading to healthier pregnancies and healthier babies. An estimated 4.8 million Americans gained coverage for substance use disorder treatment, and 2.3 million Americans gained mental health coverage at parity with medical and surgical benefits (10). Over time, untreated serious mental illness and substance use disorders intensify and increase the number of comorbid medical conditions in individuals with those conditions, which in the long run increases total individual insurance coverage spending.

We believe the expanded § 1332 waiver authority proposed in the latest ACA repeal effort is the wrong approach, as it significantly lowers the standard by which these waivers are approved. While we understand that the impact of this waiver authority would vary amongst the States and recognize the need to ensure adequate participation in the individual insurance market, we do not believe that pregnant women or people with a serious mental illness or substance use disorder should be denied coverage simply because they live in a State that waived vital consumer protections. Efforts to increase State flexibility should not come at the expense of coverage of this essential coverage. Congress must ensure that these consumer protections are preserved.

#### ENFORCE CURRENT-LAW REQUIREMENT TO PURCHASE COVERAGE OR OTHERWISE ENSURE INCENTIVES FOR YOUNG ADULTS TO BUY COVERAGE AND PARTICIPATE IN INSURANCE POOLS

Without the current law's requirement that individuals purchase insurance, many healthy individuals would choose to delay or decide not to purchase insurance, creating a risk pool comprised primarily of sick enrollees, increasing the cost of coverage and further destabilizing the insurance market. If the insurance mandate penalty is not adequately enforced enrollment rates will drop among healthy enrollees who may be less inclined to purchase health insurance, leading insurers to increase premiums to compensate for the sicker risk pool.

Through its oversight authority, Congress should urge the administration to enforce the individual mandate to balance the market's risk pool, attract healthier enrollees, and avoid dramatic premium rate increases. Congress should also explore other appropriate incentives for young, healthy individuals to buy coverage so as to ensure a balanced risk pool, provided that such incentives do not result in increased premiums and out-of-pocket costs for older and sicker patients or erosion of current law essential benefits and consumer protections.

#### EXPAND COMPETITION AND CONSUMER CHOICE BY OFFERING A PUBLIC INSURANCE OPTION IN ALL EXCHANGE MARKETS

Many patients shopping for exchange-based coverage face a dwindling number of insurance plans from which to choose. To broaden consumer choice and invigorate market competition, Congress should establish a public option. Possible approaches might include a buy-in program for traditional Medicare or Medicare Advantage, Medicaid, or other public health programs to compete with private exchange-based plans. For example, depending on how it is constructed, a Medicare buy-in program limited to individuals age 50–64 could help expand access to physicians and other health care professionals and improve continuity of care for those transitioning to Medicare and reduce premiums for individual market exchange-based plans, accord-

ing to the American Academy of Actuaries.<sup>8</sup> Whatever the policy option adopted, Congress must ensure that reimbursement for physicians' office and hospital visits and other evaluation and management services are no less than the rates paid under traditional Medicare for comparable services.

We appreciate the opportunity to provide recommendations on strengthening the health insurance market, and stand ready to work with the committee on the development of any reforms where our experience and expertise could be of value.

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THE AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS,  
WOMEN'S HEALTH CARE PHYSICIANS,  
WASHINGTON DC,

*August 2, 2017.*

Hon. LAMAR ALEXANDER, *Chair,*  
*Health, Education, Labor and Pensions Committee,*  
*U.S. Senate,*  
*Washington, DC 20510.*

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

DEAR CHAIRMAN ALEXANDER and RANKING MEMBER MURRAY: The American Congress of Obstetricians and Gynecologists (ACOG), representing more than 58,000 physicians and partners dedicated to improving women's health, thanks you for your leadership and commitment to finding sensible bipartisan solutions to improve our Nation's health care system. We are eager to work with you and appreciate your approach, including transparency and opportunity for public input.

ACOG is the leading authority on women's health. For more than 65 years, the US Congress has sought out our moderate voice and our commitment to ensuring public policy based on facts, science, and evidence-based medicine. We are devoted to ensuring the patients our members serve have access to affordable, high-quality, evidence-based care.

We welcome continued reform of our health care system. The Affordable Care Act is responsible for landmark women's health gains that are now part of the fabric of our society. Reform efforts must not result in a loss of coverage or turn back the clock on women's health. The goal of any health reform effort must be to continue and expand access to safe, affordable, quality care, and reduce health care costs.

Thank you for putting partisan politics aside to seek real solutions for the benefit of your constituents, and our patients. We look forward to working closely with you and invite you to contact me or ACOG Federal Affairs Director, Rachel Tetlow at [rtetlow@acog.org](mailto:rtetlow@acog.org), or 202-863-2534, at anytime.

Sincerely,

HAYWOOD L. BROWN, MD, FACOG,  
*President.*

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TESTIMONY BY MARGARET MURRAY, CEO, ACAP

Chairman Alexander, Ranking Member Murray, and Members of the committee: The Association for Community Affiliated Plans (ACAP) thanks you for the opportunity to comment on the committee's efforts to stabilize the Marketplaces. ACAP is an association of 60 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 States. Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, CHIP, Medicare Special Needs Plans for dually eligible individuals, and the Marketplaces. In 2017, 17 of ACAP's SNHPs offered qualified health plans (QHPs) to over 700,000 enrollees in the Marketplaces.

Looking to 2018, ACAP's SNHPs are in an untenable position of facing significant uncertainty. As historically Medicaid-focused plans working to improve the health and well-being of lower-income and vulnerable populations, ACAP's plans are committed to remaining in the Marketplaces wherever possible. Many ACAP plans are part of integrated delivery systems with robust safety net provider networks including public hospitals, children's hospitals, and community health centers. As such, SNHPs are uniquely situated to manage care for Marketplace enrollees—many of

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<sup>8</sup><http://election2016.actuary.org/sites/default/files/Medicare-Buy-In-Option.pdf>.

whom churn between Medicaid and the Marketplaces as income levels fluctuate. ACAP members have also stepped up to fill the bare counties in at least two States.

However, because of the significant uncertainty facing the Marketplaces, three ACAP plans have announced plans to withdraw their QHP products altogether. Still others are waiting to see what happens in Washington before signing their final QHP agreements on September 27th, 2017. Their final decision will likely be determined by the outcome of this committee's efforts as well as ongoing guidance from the Administration. To date, the constant uncertainty around rules moving forward is the single biggest hindrance to plan participation, and those that have left the Marketplaces have stated they would like to re-enter in the future, once there is greater stability. As Medicaid plans owned in many cases by safety-net parent companies, the risk posed by current instability is simply greater than they can take on without endangering their Medicaid lines of business.

Accordingly, ACAP has developed the following set of recommendations to stabilize the individual market for the committee's consideration.

#### FUND COST-SHARING REDUCTIONS

It will come as no surprise to Members of the committee that SNHP's single greatest source of concern at present is the lack of certainty surrounding repayment of cost-sharing reductions (CSRs) to plans. 3 in 5 of ACAP plans' Marketplace enrollees receive CSRs, which totaled nearly \$130 million in 2015. Cost-sharing reductions are simply a pass through to low-income consumers to enable them to afford coverage, yet CSR payments account for approximately 5 to 10 percent of Marketplace plan premiums, and ten to 15 percent of premiums for Safety Net Health Plans in particular.<sup>1</sup> Issuers designed plans and contracts for 2017 with the understanding that CSR payments would be made. Without congressional action to fund CSRs for the rest of 2017, issuers will be forced to reevaluate their ability to participate in the Marketplace for the rest of year as well as future years.

A mid-year loss of CSR funding would likely result in mid-year market withdrawals by issuers that cannot sustain such losses. Additionally, looking to 2018, ACAP plans have estimated they would need to raise rates an additional 13 to 23 percent to compensate for a loss of CSRs. In addition, the Congressional Budget Office (CBO) has estimated that the increased rate burden on silver-level plans in particular will lead to approximately \$6 billion in increased Federal spending on Advanced Premium Tax Credits (APTC) in 2018 alone, with \$194 billion in increased Federal spending by 2026.<sup>2</sup>

Given that *House v. Price* is likely to remain unresolved in the near future, and the month-by-month outlook of the Administration on whether to continue funding the payments, we call on Congress to take action to guarantee an extension of CSR funding prior to the September 27th 2018 QHP agreement deadline.

#### ENFORCE THE INDIVIDUAL MANDATE OR ADOPT AN EQUALLY STRONG COVERAGE INCENTIVE

It is no secret that the individual mandate has been the least-popular provision of the Affordable Care Act. However, it is also the lynchpin that makes the popular market-rule protections feasible. Popular market rules, such as the prohibition on pre-existing condition exclusions and guaranteed issue require robust consumer participation to ensure a stable Marketplace. The individual mandate or other equally compelling incentives must be present in order to prevent adverse selection, where consumers wait until they become sick to purchase coverage. This would force insurers to raise prices or leave the market—ultimately leading to a death spiral.

ACAP recently contracted with an actuarial firm, the Wakely Consulting Group, to evaluate alternatives to the individual mandate and determine what other options might have a similar impact on the risk pool as the mandate. The Wakely Consulting Group evaluated a variety of options, including late enrollment penalties, escalating penalties, waiting periods, underwriting, auto-enrollment, increased outreach, and increased subsidies and concluded that without a combination of other policies and increased financial contributions from the Federal Government, there is no actuarial equivalent to the individual mandate as far as balancing the risk pool. (See Appendix A for the report from the Wakely Consulting Group.)

<sup>1</sup>Milliman, 2017. Cost-Sharing Reduction Plan Payments Under the ACA <http://zz4d3fkhud1nejc8ukrnazz-upengine.netdna-ssl.com/wp-content/uploads/2017/02/CSR-Funding-White-Paper.pdf>.

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

Accordingly, we call on Congress to work with the Administration to enforce the current individual mandate until and if at any point in time another equally strong alternative is developed.

#### ELIMINATE NON-COMPLIANT COVERAGE OPTIONS

The proliferation of non-compliant plans, such as grandmothers, grandfathered, and short-term limited-duration plans has had a significant effect on the risk pool; the existence of these plans has served to remove healthy enrollees from the single Marketplace risk pool, raising premiums for everyone who seeks to purchase coverage through the Marketplaces.

In addition to the dilatory impact on the risk pool, short-term, limited-duration plans and many grandmothers and grandfathered “transitional” plans do not offer adequate coverage for consumers. While they may be cheaper for some consumers, we remain concerned about medical underwriting, coverage for pre-existing conditions, and a slim benefit package.

We believe that efforts from some Senators to expand short-term, limited-duration plans would have a truly catastrophic impact on the individual market risk pool. These coverage options simply pull healthy consumers from the Marketplaces, thus making the risk pool sicker and driving up QHP premiums, with the ultimate effect of a death spiral and additional issuer exits from the Marketplaces.

#### ENSURE COMPREHENSIVE, AFFORDABLE COVERAGE

ACAP’s member plans are dedicated to ensuring that coverage in the individual market is both comprehensive and affordable. Some recent proposals would advance this aim, where others would not. Specifically, ACAP supports changing the age rating bands from 3:1 to 5:1, which will allow issuers to offer lower priced options to young enrollees, thus improving the risk pool.

However, this change must be coupled with tax credits structured by both age and income so as not to adversely impact older, poorer adults. Likewise, we believe coverage should truly be meaningful. Proposals that would limit benefits significantly—such as a complete repeal of Essential Health Benefits or greater move to catastrophic coverage options—would do little to provide comprehensive coverage for those who need it. Accordingly, these changes may not be appropriate for a short-term stabilization package impacting plan year 2018, but rather for future consideration.

#### IMPROVE RISK ADJUSTMENT TRANSFER FORMULA

An additional change that ACAP would recommend that may also be more appropriate over the longer-term would be to improve the risk adjustment program. While CMS has made great strides working to improve the program administratively, however, ensuring that the program works well and does not unduly advantage particular issuers is key to ensuring a stable Marketplace. Accordingly, ACAP believes that Congress should consider a statutory change that would permit States to adjust the geographic risk adjustment areas, rather than requiring a statewide risk pool. This way, plans’ risk adjustment transfer formula would assess charges or payments across competitors in the same market area—rather than statewide. ACAP believes that States are best able to determine appropriate geographic market areas for risk pooling and whether or not a statewide risk pool is appropriate.

#### STATE DETERMINATION OF APPROPRIATE GRACE PERIODS

As is the case for many other insurers, a large portion of SNHP enrollees are enrolled for less than the full 12-month period. Owing to the statutory requirement that enrollees be provided coverage even if they don’t pay their premiums, some enrollees game the system by simply not paying a full year’s worth of premiums. Enrollees may front-load their care and then not pay their premiums for the balance of the year (sometimes even just for the last 90 days of the year), only to sign up again at the next open enrollment period—effectively having coverage if needed but without paying premiums if coverage is not needed. This impacts a QHP’s risk score, drives up premiums, and creates significant hardships on QHPs, particularly small health plans. While CMS has worked to mitigate this problem by tightening Special Enrollment Periods (SEPs) and increasing SEP verification, ACAP urges Congress to permit States to determine a more appropriate grace period timeframe than 90 days.



## CONCLUSION

In conclusion, ACAP thanks you for the opportunity to provide feedback to the committee and for your efforts to stabilize the health insurance Marketplaces. ACAP and its member plans are dedicated to serving Marketplace enrollees and we appreciate the committee's support in doing so. We are particularly pleased by the bipartisan nature of this effort and look forward to providing Senators with additional feedback or guidance. Please contact Heather Foster, Vice President of Marketplace Policy ([hfoster@communityplans.net](mailto:hfoster@communityplans.net), or 202-204-7510) with any questions or for additional information.

## APPENDIX A

## WAKELY

## ASSOCIATION FOR COMMUNITY AFFILIATED PLANS

## EVALUATION OF ALTERNATIVES TO THE INDIVIDUAL MANDATE

## EXECUTIVE SUMMARY

Wakely was retained by the Association for Community Affiliated Plans (ACAP) to develop an educational paper describing approaches to mitigating adverse selection in the individual health insurance market.<sup>3</sup> Other uses may be inappropriate.

The Affordable Care Act (ACA) enacted large changes to the health insurance market, particularly the individual market. The changes to the individual market included three intertwined policies or pillars. The first pillar outlawed discrimination against individuals on the basis of health. For the first time, in every State, individuals with pre-existing conditions could purchase insurance at the same rates as those who do not. The second pillar consisted of subsidies to help low-income enrollees afford the coverage. The final pillar was a requirement for all Americans who can afford coverage to purchase coverage (the "mandate"). If individuals had the option to only purchase coverage when they got sick, the individual market would become prohibitively expensive. In a world of guaranteed issue, a mechanism to ensure sufficient people enroll in coverage to prevent adverse selection is necessary.

Since the beginning, the mandate has been among the least popular and most controversial aspects of the Affordable Care Act. This has created a conundrum. The ban on discriminating against pre-existing conditions, which is among the most popular aspects of the ACA, is only possible if a policy like the mandate exists. This paper will examine the mandate from an actuarial and policy perspective. It will then examine alternatives to the mandate and their relative effectiveness at minimizing market destabilization and premium spikes. A number of policies have been put forth as alternatives to the individual mandate that could potentially maintain or improve the current level of adverse selection in the individual market. These policies can broadly be categorized into different forms of sticks (late enrollment penalties, delayed enrollment, etc.) and carrots (better outreach or larger subsidies). This paper evaluates multiple potential alternatives to the individual mandate.

Our review of historical experiences and literature for related programs and policies shows that to date no alternative has been found to be both as effective as the individual mandate and costs less to the government. Policy makers thinking about repealing or changing the individual mandate must consider the ramifications to the risk pool and to premiums. **It is likely only a combination of policies and greater government expenses could produce similar risk pool effects to the current mandate.**

<sup>3</sup> If this paper is distributed to outside parties, the paper should be distributed in its entirety. Anyone receiving this paper should retain their own experts in interpreting its contents. The opinions expressed in this paper are those of the authors and do not necessarily reflect those of Wakely.

TABLE 1

## SUMMARY OF ALTERNATIVES W/ PRIMARY ADVANTAGE(S) AND DISADVANTAGE(S)

Policy Options	Description	Advantage	Disadvantage
Late Enrollment Penalties .....	Premium surcharge for non-continuous coverage.	Provides incentives to maintain continuous coverage.	Higher premiums may be a barrier for entry into risk pool if coverage is lost
Escalating Enrollment Penalties.	Premium surcharges for non-continuous coverage increase relative to amount of time without coverage.	Provides escalating incentives to maintain continuous coverage.	Escalating higher premiums may be barrier for entry into risk pool if coverage is lost
Enrollment Delay .....	Individuals with non-continuous coverage would be barred for a period of time from purchasing coverage.	Provides incentives for continuous coverage..	Likely not strong enough to prevent deterioration entirely. Policy concerns with preventing those with life threatening disease from gaining coverage
Underwriting .....	Individuals with non-continuous coverage only eligible for non-ACA-compliant plans that require medical underwriting.	Provides incentives for sick individuals to maintain coverage in ACA-compliant plans.	May destabilize ACA-compliant market. Complex and expensive.
Auto-Enrollment .....	Individuals automatically enrolled in coverage.	Increases coverage as individuals need to act to forego coverage.	Logistical hurdles to implementation. Effectiveness unclear.
Increased Outreach .....	Provide greater funding for advertising and other outreach activities.	Increases awareness and enrollment.	Requires Federal or State funding
Increased Subsidies .....	Provide subsidies to enrollees to reduce premium costs.	Improves affordability of coverage which increases enrollment.	Requires Federal or State funding

## INTRODUCTION

The market reform rules were a key lynchpin in the success of the ACA. These rules prevent insurance companies from denying coverage or charging more to individuals with pre-existing conditions. In this environment, healthy individuals may decide not to purchase or delay purchase of insurance unless there is a requirement or incentive to do so; delaying coverage would not yield any penalties and paying premiums without medical needs has a cost. In effect, it would be rational for healthy individuals to delay purchasing insurance.

If that were to happen, the risk pool would contain a greater proportion of sick people (also known as adverse selection). As adverse selection increases, premiums will proportionately increase to cover the increase in average claims costs. The increased premiums in turn make it less likely that healthy individuals will enroll and stay enrolled, which creates a feedback loop of higher premiums, causing greater adverse selection, which in turn again leads to higher premiums.

The Congressional Budget Office (CBO) estimated that if the individual mandate were to be repealed, individual market enrollment would decrease by 6 million and premiums would increase by 20 percent.<sup>4</sup> Greater adverse selection begets higher premiums, which begets even greater risk selection. The extreme form of this cycle of adverse selection and higher premiums is known as a “death spiral” since it results in market collapse. Accordingly, Congress instituted the individual mandate as a key provision of the ACA to help ensure sufficient enrollment to mitigate the potential for such adverse selection.

## HISTORICAL EXPERIENCE: THE CASE OF WASHINGTON

The State of Washington’s individual market experience belies the idea that a death spiral scenario is purely theoretical. Washington’s individual market experi-

<sup>4</sup><https://www.cbo.gov/budget-options/2016/52232>.

ence in the 1990s demonstrates that an individual market with guaranteed issue, but without a mechanism for incentivizing healthy individuals to enroll, is at risk for catastrophic deterioration. In the early 1990s, Washington passed a bill that not only allowed any individual to purchase coverage (in ACA terms it required guaranteed issue), it also prohibited underwriting (rating based on health). The original bill also included a requirement to purchase insurance; however, the law was amended to drop the requirement to purchase insurance.

The result of not including the mandate was disastrous for the state. Within 3 years, 17 of the 19 issuers had exited the market. Premera, one of the largest issuers in the state, raised premiums over 75 percent within 3 years.<sup>5</sup> Within 5 years of repealing the mandate without a replacement, it was not possible to purchase a new individual market policy as every issuer had pulled out.<sup>6</sup> In the case of Washington, the mandate-less individual market produced a legitimate death spiral. Washington was not unique. In the 1990s, eight States<sup>7</sup> experimented with individual markets that had guaranteed issue but did not require insurance coverage. Without fail, each of the States experienced severe premium spikes. While the ACA market subsidy structure provides insulation from the worst of the Washington experience, there is every reason to believe that a mandate-less individual market would have markedly higher premiums and lower enrollment than today's individual market.

#### INDIVIDUAL MANDATE IN THE ACA

To combat the potential for adverse selection, an individual responsibility requirement, often referred to as the individual mandate, was included as part of the ACA. The requirement has a tax penalty (assessed the following year) for individuals that can afford insurance but choose not to purchase coverage. The penalty was phased in between 2014 and 2016. In 2016, the penalty was the greater of a flat amount, for adults that was \$695, or 2.5 percent of a person's household income above the tax return filing threshold for his/her filing status. That amount is pro-rated for each month without insurance (for each month without insurance the penalty is 1/12th of the total amount). The result of the policy is that incentives exist for healthy individuals to enroll. For coverage relating to the 2015 benefit year approximately 6.6 million people paid about \$3 billion in individual responsibility payments or about \$457 per tax household.<sup>8</sup> While data from penalties associated with the 2016 coverage year (i.e., the first year the mandate was fully implemented) are not yet available, there has been criticism of the mandate both from those objecting that it is overly prescriptive and from those advocating that the current mandate is insufficient to induce enough healthy individuals to purchase health insurance.

One simple potential solution to improving risk selection and reducing the number of uninsured is to increase the mandate penalty. The effects of the mandate should increase as the size or scope of the penalty increases. The American Academy Actuaries recently testified that "a larger financial penalty would increase the incentives for individuals to enroll, especially as the amount of the penalty approaches the amount of the premium."<sup>9</sup> Individuals that are uninsured for multiple years could have higher penalties than individuals that are uninsured for a shorter period. In this scenario, someone that is uninsured for 2 years would have penalties in excess of today's thresholds. Alternatively, exceptions to the mandate could be reduced. In 2015, approximately 12 million people claimed an exemption to avoid paying the mandate penalty.<sup>10</sup> One way of reducing the number of people eligible for exemptions is to shorten the length of time individuals can be uninsured before being affected by the mandate. Individuals are currently exempt from the mandate if they are uninsured for only one or 2 months. This could be constricted such that an individual is only exempt if they are uninsured for one month or less. This re-

<sup>5</sup> [https://www.washingtonpost.com/blogs/ezra-klein/post/health-reform-without-a-mandate-lessons-from-washington-state/2012/06/16/gJQAosKghV\\_blog.html?utm\\_term=.13ffb15dd29](https://www.washingtonpost.com/blogs/ezra-klein/post/health-reform-without-a-mandate-lessons-from-washington-state/2012/06/16/gJQAosKghV_blog.html?utm_term=.13ffb15dd29).

<sup>6</sup> <http://www.seattletimes.com/seattle-news/politics/dismantling-of-states-health-reforms-in-1993-may-offer-lesson-for-obamacare-repeal/>.

<sup>7</sup> Kentucky, Maine, Massachusetts, New Hampshire, New Jersey, New York, Vermont, and Washington all adopted guaranteed issue and community rating in the 1990s. <http://www.statecoverage.org/files/Updated-Milliman-Report-GI-and-Comm-Rating-March-2012.pdf>.

<sup>8</sup> <https://www.irs.gov/pub/irs-soi/17sprbul.pdf>.

<sup>9</sup> [http://www.actuary.org/files/publications/Ways\\_and\\_Means\\_submitted](http://www.actuary.org/files/publications/Ways_and_Means_submitted)

<sup>10</sup> [http://www.actuary.org/files/publications/Ways\\_and\\_Means\\_submitted](http://www.actuary.org/files/publications/Ways_and_Means_submitted)

<sup>10</sup> <https://www.cnbc.com/2015/07/20/irs-more-paid-obamacare-fine-than-expected.html>.

striction may increase take-up among individuals that lose employer-based coverage and thereby increase continuity of coverage.<sup>11</sup>

The drawback of this approach is that the individual mandate has consistently been the least popular portion of the Affordable Care Act.<sup>12</sup> Increasing penalties or reducing exemptions for life events may be politically unpalatable. This problem is currently exacerbated by the current lack of choices in issuers. While in the long term larger mandate penalties may improve risk selection and mitigate premium increases, the delay in seeing the effects may ultimately mean this is not a current potential policy avenue. The next section will discuss some of the potential alternatives alongside their benefits and potential pitfalls.

#### ALTERNATIVE POLICIES

##### LATE ENROLLMENT PENALTIES

In the recent debates on replacing the ACA, the idea of a continuous coverage requirement was considered as an alternative to the individual mandate. The idea, similar to the individual mandate, was that individuals would be required to have continuous coverage of health insurance. The difference is that rather than a tax penalty, individuals would be assessed a penalty in the form of higher premiums should they eventually buy insurance. The American Health Care Act<sup>13</sup> included a provision in which individuals that could not demonstrate continuous coverage (defined as gaps of more than 63 days) would be charged 30 percent higher premiums if and when they ultimately enrolled. The threat of higher premiums in the future is thought to incentivize purchase of insurance immediately. The problem is that individuals with shorter decisionmaking time horizons may discount the future penalties as part of the immediate decisionmaking. Younger or healthier individuals, in particular, may think that the chances they need healthcare are low enough that the concept of future higher premiums may be insufficient to induce immediate action. Furthermore, lower-income individuals may not have the means to maintain continuous coverage.

Another problem that may arise is that when those individuals ultimately wish to purchase insurance, the higher premiums may, at that point, provide a disincentive from enrolling. This would be especially true for healthier individuals—further perpetuating the cycle. When the CBO modeled the continuous coverage provision, this counter-intuitive phenomenon is exactly what their modeling predicted. The continuous coverage provision increased coverage in the immediate-term by one million enrollees, as individuals moved to avoid the potential of higher premiums. However, over the long term, the continuous coverage provision actually reduced enrollment (by 2 million) as the higher surcharge proved to be a barrier to enrollment. CBO noted that those that would be deterred would be relatively healthier.<sup>14</sup> The continuous coverage provision, over the long term, was estimated to have a deleterious effect on the risk pool relative to no mandate.

##### ESCALATING ENROLLMENT PENALTIES

Another alternative is escalating the penalties based on length of non-coverage. For example, individuals that would be uninsured for 2 years would face a higher penalty than those that are uninsured for 1 year. Escalating penalties could incentivize individuals from being uninsured for longer periods. However, the same dynamic for a surcharge for 1 year would apply to the escalating surcharges. The American Academy of Actuaries noted that penalties for lack of continuous coverage would need to be sufficiently high to induce compliance, but not too high to dissuade healthy enrollees from purchasing coverage. Escalating penalties can create too high of a barrier for healthy individuals to ultimately enroll.<sup>15</sup>

<sup>11</sup> For example, in 2014 Jonathan Graves and Pranita Mishra found that individuals that those that transitioned off employer coverage were no more likely to take up coverage than before the mandate existed in 2013. <https://www.milbank.org/quarterly/articles/evolving-dynamics-employer-sponsored-health-insurance-implications-for-workers-employers-affordable-care-act/>.

<sup>12</sup> <http://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-march-2015/>.

<sup>13</sup> <https://www.gpo.gov/fdsys/pkg/BILLS-115hr1628rh/pdf/BILLS-115hr1628rh.pdf>.

<sup>14</sup> <https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf>.

<sup>15</sup> [http://www.actuary.org/files/publications/Sustainable\\_Health\\_Insurance\\_Marketplace\\_042417.pdf](http://www.actuary.org/files/publications/Sustainable_Health_Insurance_Marketplace_042417.pdf).

## ENROLLMENT DELAY

Instead of monetary penalties for late enrollment, another alternative is delayed enrollment. This policy proposal would bar individuals that do not maintain continuous coverage from enrolling in coverage until after a waiting period. For example, those that go without insurance for a year could not sign up for insurance for 6 months, even during open enrollment. This continuous coverage requirement was a part of the recent Senate health care bill (BCRA).<sup>16</sup> The benefit to the risk pool from this proposal is that uninsured individuals that have high utilization needs would be barred from purchasing insurance for a defined period of time. Individuals, regardless of their willingness to pay higher premiums, would be unable to enter the individual market.

However, similar selection effects would occur with delayed enrollment as could occur due to late enrollment penalties. Healthier and younger individuals that place less value on having insurance ('I'm healthy why should I pay premiums') would also be less likely to value maintaining coverage. Many such consumers who are uninsured have already made a conscious decision that they can wait until the next open enrollment to purchase coverage. It is unlikely that adding an additional 6 months (or however long) to that timeframe would change such a calculus for a healthy consumer who has already made the decision to abstain from coverage rather than paying premiums. The end result is that healthy consumers will be forced to remain out of the risk pool for an even longer time. Sick consumers who are uninsured would also be kept out of the risk pool, which, while it might help in the short term, would lead to an even worse risk pool if they delay care until the waiting period ends and then are permitted sign up for coverage.

A final consideration is the consequences of barring sick individuals from access to health insurance. The Commonwealth Fund estimated as many as 21 million individuals, including newborn or adopted children, could be locked out of coverage.<sup>17</sup> For both political reasons (refusing insurance to individuals with cancer, for example) and for economic reasons (uncompensated care costs would increase), locking individuals that are sick out of insurance may not be a political bridge that policy-makers want to cross.

## UNDERWRITING

Another idea recently put forward as an alternative to the individual mandate is to allow a return to underwriting for individuals that do not maintain continuous coverage. Individuals that cannot prove that they had insurance throughout the year would be unable to purchase ACA-compliant coverage (likely for a defined period of time). Instead they would only be able to purchase underwritten insurance products that are priced according to individuals' health status. Individuals would have an incentive to maintain coverage rather than risk having higher premiums or be restricted to purchasing coverage with fewer benefits than ACA-compliant coverage. A second, non-compliant market would develop, consisting of plans that do not protect individuals with pre-existing conditions. The plans would be designed to have fewer benefits, higher cost-sharing, or premiums based on health status (i.e., underwriting). By limiting benefits for individuals with pre-existing conditions or by discouraging those with pre-existing conditions with higher rates, the non-ACA plans would essentially be designed to attract healthy enrollees—as they were in the pre-ACA individual market.

Similar to higher premium surcharges or delayed enrollment for those without continuous coverage, this potential "penalty" could initially increase ACA-compliant coverage purchase among a subset of individuals. However, one significant drawback of this approach is that the incentives for healthy and sick individuals diverge. Underwritten plans could offer lower premiums (relative to ACA-compliant plan premiums) for healthy consumers. In such an event, healthy individuals without continuous coverage would choose the non-compliant plans due to lower premiums. Conversely, consumers with pre-existing conditions or who are high-utilizers would choose ACA-compliant plans with more robust benefits that cover their conditions. For example, someone who is thinking about becoming pregnant will choose a plan that provides maternity coverage. Conversely, someone for whom maternity coverage is not necessary will avoid such a plan, since it will be cheaper. The differences in benefits and premiums between the two types of plans will directly lead to adverse selection issues and increased premiums in ACA-compliant plans.

<sup>16</sup> <http://www.beckershospitalreview.com/hospital-management-administration/republicans-add-continuous-coverage-provision-to-bcra.html>.

<sup>17</sup> <http://www.commonwealthfund.org/publications/blog/2017/jun/waiting-period-under-senate-aca-repeal-bill>.

An additional concern is that healthy individuals who currently have ACA-compliant insurance may purposefully attempt to gain underwritten insurance, since those premiums would be cheaper. Both AHIP and the Blue Cross Association have noted that the existence of short-term, limited-duration plans, which do not have to comply with ACA regulations, may have hurt the risk pool.<sup>18</sup> This scenario could lead to bifurcation of the market with healthy individuals enrolled in underwritten plans and unhealthy individuals in ACA-compliant plans. The American Academy of Actuaries recently wrote that the existence of two risk pools, one for ACA-compliant plans and one without, would destabilize the ACA-compliant pool.<sup>19</sup> Individuals with pre-existing conditions could face prohibitively high premiums. Matt Fiedler, a health policy expert at the Brookings Institute, wrote: "Creating parallel insurance markets that operated under very different rules would, as other analysts have noted, cause individual market enrollees to sort themselves across the two markets by health status."<sup>20</sup> Such sorting would inevitably lead to much higher premiums in the ACA-compliant market as healthier individuals without the protection of subsidies would exit the ACA-compliant risk pool. Underwritten or non-ACA-compliant products competing with ACA-compliant products would inevitably produce higher premiums and less enrollment in ACA-compliant plans. The effect of this bifurcation could ultimately lead to only subsidized enrollees being able to afford coverage in the ACA-compliant individual market.

#### AUTO-ENROLLMENT

Another alternative to the individual mandate is auto-enrollment. Auto-enrollment was discussed in Republican Senate working groups and among liberal advocates.<sup>21</sup> Auto-enrollment would automatically enroll individuals into coverage and require individuals to take action to be dis-enrolled. By putting the default status as enrolled in coverage, healthier and younger individuals that have so far avoided signing up for coverage would be more likely to be enrolled. Auto-enrollment has been used for Medicare. For example, low income individuals are automatically enrolled in Medicare Part D. Within 6 months of implementation, 74 percent of the population was enrolled.<sup>22</sup> Auto-enrollment has also increased participation in programs such as 401(k) pensions. Research has found that auto-enrollment increased participation in defined contribution plans by over 50 percent.<sup>23</sup> By relying on inaction rather than penalties, enrollment, especially among younger or healthier individuals, may be improved.

However, there are some potential pitfalls with the auto-enrollment policy, including operational constraints. There is no existing, reliable data base of those currently uninsured. Therefore, identifying the uninsured may prove difficult. Individuals' coverage status can also rapidly change, which can result in duplicate coverage. This is further complicated by dependents. A large number of the uninsured have or are dependents. For example, a family unit could have one spouse with insurance and one without. Attempting to create policies that ensure that families are on the same policy or, alternatively, that avoid double billing a family would be a monumental operational challenge. States and plans, in particular, will need to work to develop data bases and systems to address these operational constraints, which will take significant time, policy consideration, and operational work. Policy-makers would also need to address a host of additional considerations, such as how to decide who would be enrolled with which insurance companies and into plans with which benefit designs, metal levels, and premiums.

As the American Academy of Actuaries stated: "Auto-enrollment, successful in increasing participation in retirement savings plans, has the potential to achieve high participation rates if logistical hurdles such as how to identify eligible enrollees could be overcome. The residual and transitional nature of the individual market could make those efforts especially difficult, however."<sup>24</sup>

Beyond operational issues, there are theoretical reasons that auto-enrollment may be less effective for the uninsured population than a Medicare population. Medicare

<sup>18</sup> <https://www.bna.com/shortterm-health-plans-n57982082031/>.

<sup>19</sup> <http://www.actuary.org/files/publications/RiskPoolingFAQ071417.pdf>.

<sup>20</sup> [https://www.brookings.edu/blog/up-front/2017/07/12/sen-cruzs-proposed-change-to-senate-health-care-bill-would-undermine-protections\\_for-enrollees-with-significant-health-care-needs/](https://www.brookings.edu/blog/up-front/2017/07/12/sen-cruzs-proposed-change-to-senate-health-care-bill-would-undermine-protections_for-enrollees-with-significant-health-care-needs/).

<sup>21</sup> <https://www.vox.com/policy-and-politics/2017/5/22/15655782/automatic-enrollment-health-insurance-gop>.

<sup>22</sup> *ibid*.

<sup>23</sup> Fidelity Investments, "Fidelity Perspectives: Evaluating Auto Solutions" (2009).

<sup>24</sup> [http://www.actuary.org/files/publications/Sustainable\\_Health\\_Insurance\\_Marketplace\\_042417.pdf](http://www.actuary.org/files/publications/Sustainable_Health_Insurance_Marketplace_042417.pdf).

Part D premiums generally represent a smaller percentage of income than premiums would generally be for ACA-compliant coverage. High costs, as measured by a percent of an individual's income, make it less likely for a person to maintain coverage. Therefore, people may be more likely to opt out under ACA auto-enrollment than the Medicare Part D experience showed.<sup>25</sup> Jonathan Gruber estimated that the ACA with auto-enrollment would have approximately eight million more uninsured over the long term than the ACA with the mandate.<sup>26</sup>

#### INCREASED OUTREACH

Ultimately the goal of the mandate and other alternative policies is to improve the risk mix and increase the number of individuals in the market. The Commonwealth Fund studied 2016 Open Enrollment to better understand what factors were most important in maximizing enrollment.<sup>27</sup> Their research found that "in-person outreach and enrollment assistance were critical to facilitating sign-ups." The Urban Institute noted that in 2016 there were approximately 6.9 million uninsured individuals that were eligible for Exchange tax credits and of that total, 3.2 million uninsured individuals were eligible for both tax credits and significant cost-sharing reductions.<sup>28</sup>

Enrollment of even a portion of these remaining uninsured would have a positive effect on the risk pool and put downward pressure on premiums. Urban posits that additional outreach and enrollment efforts would be the most successful for these individuals. Increasing funding for outreach could ultimately provide a cost-effective way of improving the risk pool.

Additional research had found a direct causal relationship between increased outreach and enrollment. Ben Sommers' et al analysis of State policies among low income enrollees found that application assistance was the strongest predictor of enrollment.<sup>29</sup> In 2017, state-based marketplaces maintained or increased outreach efforts while the federally facilitated marketplaces reduced outreach efforts. State-based marketplaces, relative to their Federal counterparts, had more success increasing enrollment. As the Commonwealth Fund stated "Maintaining stable marketplaces with affordable premiums will likely require continued outreach by Federal and State authorities."<sup>30</sup>

Recently, HHS announced a 72 percent cut in outreach spending, impacting both advertising and navigators.<sup>31</sup> Given the ample statistical evidence on the relationship between outreach spending and enrollment gain, the reduction in outreach funding is likely to result in decreased enrollment and a worse risk pool. To compensate for decreased outreach, other policy levers to improve the risk pool may become more important.

#### INCREASED SUBSIDIES

Finally, increasing the number of individuals eligible for subsidies would likely increase enrollment. According to the Urban Institute, approximately 12.5 percent of the remaining uninsured (over 3 million individuals) are ineligible for subsidies solely because their income is too high. The current tax credit subsidy has a steep cliff in its structure. Households with incomes above 400 FPL are not eligible for any subsidy. Additionally, given income fluctuations, there may be disincentives for individuals with incomes near the threshold from accessing premium tax credits because if they earn more than expected, they may ultimately have large tax liabilities. Increased subsidies would provide a "carrot" to enroll more individuals.

As the American Academy of Actuaries noted, weaker sticks could be compensated by having stronger carrots.<sup>32</sup> They note that increased subsidies, specifically targeting younger enrollees, could have benefits to the risk pool. Lower premiums for moderate and middle income families could be achieved by expanding tax credit eli-

<sup>25</sup> [https://www.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/gruber\\_mandate.pdf](https://www.americanprogress.org/wp-content/uploads/issues/2011/02/pdf/gruber_mandate.pdf).

<sup>26</sup> *ibid.*

<sup>27</sup> <http://www.commonwealthfund.org/publications/issue-briefs/2016/jul/insurance-enrollment-aca-state-marketplaces>.

<sup>28</sup> [http://www.urban.org/sites/default/files/publication/79051/2000691-Who-Are-The-Remaining-Uninsured-And-What-Do-Their-Characteristics-Tell-Us-About\\_How-To\\_Reach\\_Them.pdf](http://www.urban.org/sites/default/files/publication/79051/2000691-Who-Are-The-Remaining-Uninsured-And-What-Do-Their-Characteristics-Tell-Us-About_How-To_Reach_Them.pdf).

<sup>29</sup> <http://content.healthaffairs.org/content/34/6/1010.short>.

<sup>30</sup> <http://www.commonwealthfund.org/publications/blog/2017/may/2017-Federal-state-marketplace-trends-show-value-of-outreach>.

<sup>31</sup> <https://www.vox.com/2017/8/31/16236280/trump-obamacare-outreach-ads>.

<sup>32</sup> [http://www.actuary.org/files/publications/Sustainable\\_Health\\_Insurance\\_Marketplace0\\_42417.pdf](http://www.actuary.org/files/publications/Sustainable_Health_Insurance_Marketplace0_42417.pdf).

gibility. For example, the Century Foundation proposed a fixed dollar tax credit to individuals that do not meet the current subsidy eligibility requirement as one of the key fixes to the ACA.<sup>33</sup> By reducing premiums for a larger pool of individuals, it would provide incentives for the previously uninsured individuals to enroll in coverage. The major drawback of increased subsidies is that such policies potentially create higher Federal costs than currently budgeted for.

#### CONCLUSION

The individual mandate was included as part of the Affordable Care Act to prevent the individual market from the destabilization that characterized some State markets in the 1990s that attempted to have an individual market with guaranteed issue without a mandate. If policymakers wish to have an individual market that does not discriminate against those with pre-existing conditions, then policies are needed to incentivize healthy individuals to enroll in plans. Historical experience, such as Washington's experience in the 1990s, has demonstrated the damage that can be done to the individual market if the mandate were to be repealed without an effective replacement or if the mandate is not enforced moving forward. Alternative policies in the form of penalties for individuals that lack continuous coverage, from higher premiums to delayed enrollment, have some benefits but ultimately may not incentivize healthier individuals to enroll and, paradoxically, may actually serve as a barrier to enrollment. Auto-enrollment has the potential to increase participation, but significant operational shortcomings may be difficult, if not impossible to overcome. Escalating mandate penalties would be more effective than the current mandate penalty; however, the political environment may not accommodate such ideas. Spending in the forms of better outreach or subsidies for middle income households may provide the appropriate "carrot" for individuals to enroll but would require additional budget resources.

Finally, the alternatives considered are not mutually exclusive. While further modeling is needed, it is possible that a combination of delayed enrollment penalties, increased tax credits for middle income individuals, and better outreach can produce similar risk pool outcomes to that of the individual mandate. Ultimately, the individual mandate appears to be the most cost effective way, from a Federal budget perspective, to maintain a stable risk pool. However, policymakers may decide that greater flexibility is needed. To avoid replicating mistakes of the past and ensure a strong risk pool, a combination of policies may ultimately be required if the mandate is to be replaced.

October 19, 2017.

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

DEAR CHAIRMAN ALEXANDER: I am writing to submit responses to questions posed by Senator Whitehouse for the record of the September 14th Hearing on Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018.

Thank you for the opportunity to elaborate on our testimony and provide the following response:

**Question 1. Which of these areas should be a priority for the HELP Committee going forward?**

Answer 1. Of the five areas noted, Marshfield Clinic Health System believes the following should be considered the top two:

1. Advancing payment reform to encourage prevention and primary care.
2. Addressing the dramatic variations in care quality and outcomes across States.

In addition to the areas noted above, the committee should also look at adding a priority around supporting site of care innovation. Marshfield Clinic Health System is innovating in moving care out of expensive places of service, such as a hospital, to lower cost places of service that save health care costs while maintaining quality and improving patient experience.

**Question 2. What strategies would you suggest to lower costs and improve quality in these areas?**

Answer 2. Fee for service is deeply entrenched in the medical reimbursement methodology in the U. S. It's been said that the medical system's addiction to fee for service is as bad as or worse than the opioid epidemic. Some newer payment

<sup>33</sup> <https://tcf.org/content/report/key-proposals-to-strengthen-the-aca/>.



methodologies fall short, but they are beginning the process of linking quality to services. To be successful, payment methodologies need to inextricably link quality of care and efficiency of care to the reimbursement that is provided.

**Question 3. Is there innovative work in your States and communities that you would like to highlight?**

Answer 3. There are many innovations happening throughout Wisconsin that deserve being highlighted. Wisconsin is an incredibly competitive State both on care delivery and health insurance. To that end, below are two internal programs to highlight and one external program that show how, even in a competitive environment, organizations can come together to positively impact patient outcomes.

**Pay for performance models:** Security Health Plan and Marshfield Clinic have entered into several innovative pay for performance models that have improved the quality and reduced the cost of care for our shared consumers. Our Medicare Advantage pay for performance model incentivizes improvements in quality and has helped Security Health Plan maintain our 4.5 star status as measured by the Centers for Medicare and Medicaid Services. Few plans across the United States achieve a 4.5 or 5 star rating, but Security Health Plan has maintained this status for 7 years. The 4.5 star rating would not be possible without the aligned incentive created through our innovative payment arrangements.

**Comfort and recovery suites:** MCHS expanded its ambulatory surgery centers in Marshfield, Eau Claire and Wausau, Wisconsin to include comfort and recovery suites for post-surgical procedures performed in their ambulatory surgical centers. The comfort and recovery suites offer the same high quality, post-operative care received in a hospital but at a considerably lower cost. This approach has saved the MCHS insurance subsidiary, Security Health Plan, more than \$3 million in just under 2 years and patient satisfaction is extremely high with an average rating between 4.5 and 5 on a 5-point scale.

**Wisconsin Health Informatics Organization:** The Wisconsin Health Information Organization (WHIO) is a non-profit organization dedicated to improving the quality, affordability, safety and efficiency of health care in Wisconsin. With its unique All-Payer Claims Data base, WHIO makes high quality, reliable, integrated data available to all stakeholders seeking to transform healthcare.

WHIO's goals are to:

- Aggregate health care data to create a comprehensive, reliable data source to be used by multiple stakeholders to decrease unwarranted variations in efficiency, quality, safety and cost;
- Improve the quality, cost, safety and efficiency of health care in Wisconsin by partnering with providers, purchasers and consumers;
- Inform and support provider, payer and purchaser quality improvement and value-based initiatives; and
- Encourage consumer engagement by publishing usable information.

Marshfield Clinic and Security Health Plan apply advanced analytics to the WHIO information to lower costs and improve quality through collaborative solutions that minimize unwarranted variations in health care resource use.

**Home Hospitalization:** Marshfield Clinic is submitting a proposal for a Physician-Focused Payment Model entitled "Home Hospitalization: An Alternative Model for Delivering Acute Care in the Home" for Physician-Focused Payment Model Technical Advisory Committee (PTAC) review. In the model physicians could provide hospital level care delivery to Medicare fee-for-service beneficiaries in their homes for a meaningful number of medical and surgical conditions. In a hospital at home model that we presently are involved in for commercial and Medicare advantage patients we have already demonstrated success through high quality care focused on superior outcomes, excellence in patient experience and lower health care costs.

I considered it an honor to appear before the committee and would welcome the opportunity to serve as a resource for you and the committee at your discretion.

Thank you for the opportunity to share our views. Please contact Brent Miller, Director of Federal Government Relations (202 756-5027) with any questions.

Sincerely

SUSAN L. TURNEY MD, MS, FACP, FACMPE,  
*Chief Executive Officer, Marshfield Clinic Health System, Inc.*

RESPONSES BY MANNY K. SETHI, M.D. TO QUESTIONS OF SENATOR  
WHITEHOUSE

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

I believe the following areas are ripe for bipartisan collaboration:

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

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

*Answer.* Senator Whitehouse, thank you so much for the question. I agree with you that each of the issues that you raise are critical to solving our crisis of rising costs. I feel that the encouragement of prevention (e) is the most important to address cost and improve the quality of care. For too long, we have focused on treating disease rather than encouraging or promoting health. It is time that we shift our healthcare investments to get on the front side of major health problems before it's too late. For example, each dollar we invest in education of diabetic patients saves roughly ten dollars on the back end in preventing hospitalizations and associated costs.

We must spend more time as a Nation educating patients about the benefits of pursuing a healthy lifestyle and helping our citizens to better understand how simple lifestyle decisions can dictate their health in the long term. Currently, healthcare in America is much too focused on disease.

As you have suggested, if we shift our payment models to place a stronger focus on primary care, we could better align incentives with the direction we must take our healthcare.

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RESPONSES BY RAYMOND G. FARMER TO QUESTIONS OF SENATOR  
WHITEHOUSE

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

I believe the following areas are ripe for bipartisan collaboration:

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

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

*Answer.* Thank you, Senator. I completely agree that the next step for Congress must be to address the cost of health care. While stabilizing the markets is important to ensure there is access to coverage options for consumers, the biggest challenge facing the country is the ever-growing cost of health care. Reforming health insurance will not solve the underlying cost issue. It is long past time for serious, bipartisan discussions on how to improve health, enhance quality, and lower the cost of care.

As to your specific suggestions, below please find my responses on behalf of the membership of the National Association of Insurance Commissioners:

- a. States, large employers, and insurance carriers are experimenting with payment models to encourage patient safety and prevent medical errors. These include penalties for re-admission, better reimbursement for prevention programs, and increased oversight of care providers. Medicare and Medicaid can play a major role in leading in this area, and have in many cases.
- b. Enhanced data collection—including data from Federal programs—and sharing of that data can improve care quality and outcomes across the country. We must also ensure those that are educating and training the providers also have access to the latest data and have the resources to use it to improve provider practices.
- c. States have been working to address issues like balance billing disputes and fair compensation. According to a recent report by The Commonwealth Fund, at least 21 States have enacted some protections from balance billing, but more work needs to be done. State regulators also remain concerned about the administrative burdens placed on carriers as these lead to increased costs for consumers. And we need to also look at the regulatory burdens placed on providers. As the NAIC has said in several comment letters, coordinating Federal and State oversight would go a long way in this area.
- d. End of life legislation has been adopted in States like CA, WA, OR and VT, but this is an extremely personal and sensitive subject that should be reviewed carefully and with compassion and consideration to those on all sides of the issue.
- e. The most successful insurance companies and employer plans have developed creative payment systems that encourage prevention, primary care, and consumer education and shopping. Federal programs have also been part of this effort. Congressional review of the successes, and failures, could help spur further improvements.

The NAIC is in the process of surveying States to gather information on programs that effectively reduce health care costs and improve quality of care. We would be happy to share that information with you and the committee when it is completed.

I hope Congress will act quickly to stabilize the markets, which will then allow us to focus our attention on what must really be done to ensure the long-term viability of our health care system: bending the cost curve.

The NAIC and I look forward to working with you on this all-important task.

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#### QUESTIONS FOR THE RECORD FROM CHRISTINA POSTOLOWSKI

Thankfully, the Affordable Care Act (ACA) has resulted in significant progress in reducing the uninsured rate among young people, cutting it from 28.8 percent to 14.6 percent as of 2016.<sup>1</sup> But more can be done to ensure younger, healthier people can get covered. As I stated in my testimony, we need bipartisan efforts to further stabilize the individual health insurance markets by making clear that cost-sharing reduction payments will be made, creating a permanent reinsurance program, and reversing cuts to enrollment promotion and assistance.

But health insurance, although a big part, is only one piece of the puzzle in making sure that our health care system works for all young people, as well as their parents, grandparents, and children. For example, in 2013, 17.1 percent of the nation's gross domestic product went toward health care,<sup>2</sup> nearly 50 percent more than the second highest spending Nation, France.<sup>3</sup> Health care costs can have a significant impact on the lives of young people and their families, both directly and indirectly.

Directly, young people need health care services, but may have to forego this care because of cost. Despite being thought of as “young invincibles,” young adults spend about \$174 billion on health expenses every year, making up 12 percent of all health

<sup>1</sup>Data derived from US Census Bureau, American Community Survey 1-year Estimates for 2010-2016, using American FactFinder, <https://factfinder.census.gov/faces/nav/jsf/pages/index.xhtml>.

<sup>2</sup>D. Squires and C. Anderson, U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries (Washington, DC: The Commonwealth Fund, 2015), <http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective>.

<sup>3</sup>Ibid.

care expenses nationally.<sup>4</sup> The most common expenses are for treatment for mental health conditions, followed by trauma-related disorders, chronic obstructive pulmonary disease/asthma, and childbirth.<sup>5</sup> By far, childbirth accounts for the highest costs, \$34 billion a year, for young adults.<sup>6</sup> Even for those who do not need routine treatment or care, unexpected health care costs can be devastating. Without health insurance, for instance, non-surgical treatment for a broken arm can cost up to \$2,500 or more while a typical appendectomy costs over \$33,000.<sup>7</sup> When the average young worker's income is \$30,000 per year,<sup>8</sup> even a routine injury can be financially devastating.

High health care costs also have major indirect effects on our generation. According to AARP, nearly one-in-four Millennials are family caretakers,<sup>9</sup> many of whom care for aging parents who cannot afford long-term care, in-home assistance, or prescription drug costs even with Medicare or Medicaid. As costs go up, so too does economic hardship for young people who are working to support their loved ones and themselves. More generally, resources spent on health care are funds that cannot go toward other investments in our future such as higher education and workforce training.

Given these issues, I very much agree with the need to further address the cost of health care and improve the quality of our system. Doing so will ultimately help reduce premiums (which will help more young people enroll in health insurance) and result in lower out-of-pocket costs (which will help more young people access the health care they need). Addressing underlying health care costs will also reduce Federal spending and save taxpayers money. I look forward to continuing to work with you and your staff to advance efforts to address health care costs and modernize our health care system in a way that reflects the needs of young adults across the country. With respect to the specific questions you have posed, I offer the following comments.

a. **Improving patient safety by preventing medical errors and healthcare-acquired infections (HAIs).** I urge Congress to build upon the progress that has already been made in this area under the ACA, which established the Hospital-Acquired Condition Reduction Program (HACRP), the Hospital Readmission Reduction Program (HRRP). These programs have shown early signs of success by incentivizing hospitals to reduce their HAI and readmission rates.<sup>10</sup> The ACA's Prevention and Public Health Fund also provided funding in 15 States for 1 year to reduce hospital bloodstream infections. A study in the American Journal of Public Health found that the funding was associated with a 33 percent reduction in standardized infection ratios for bloodstream infections in the States that received funding, and that the return on investment from the funding was \$1.10 to \$11.20 per \$1 invested.<sup>11</sup> The study also found that the reduction in infections stopped after the funding ended.<sup>12</sup> Reducing HAIs and excess readmissions is critical: although many HAIs are preventable, they affect thousands of patients and cost tens of thousands of dollars to treat.<sup>13</sup> Although there is no "silver bullet" to address this issue, I urge

<sup>4</sup>Tom Allison, *How Millennials Use Their Health Insurance*, (Washington, DC: Young Invincibles, 2016), <http://younginvincibles.org/wp-content/uploads/2017/04/how-millennials-use-health-are.pdf>.

<sup>5</sup>Ibid.

<sup>6</sup>Ibid.

<sup>7</sup>Cost Helper Health, *How Much Does a Broken Arm Cost?*, <http://health.costhelper.com/broken-arm.html>; Renee Hsia MD, *Health Care as a "Market Good?" Appendicitis as a Case Study*, (Chicago, IL: Journal of American Medicine Association, 2012), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/1151669>.

<sup>8</sup>Young Invincibles' analysis of 2016 Current Population Survey, Annual Social and Economic Supplement, Median person income for 18-34 year-old, 2016.

<sup>9</sup>Amy Goyer, *Report: Millennials Now Almost 25% of Family Caregivers*, (Washington, DC: AARP, 2015), <http://blog.aarp.org/2015/06/05/amy-goyer-caregiving-in-the-us-2015/>.

<sup>10</sup>Cristina Boccuti and Giselle Casillas, *Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program* (Washington, DC: The Henry J. Kaiser Family Foundation [KFF], 2017), <https://www.kff.org/Medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-Medicare-hospital-readmission-reduction-program/>; "Hospital-Acquired Conditions (HAC) Reduction Program," Eloquest Marketing, last updated June 9, 2017, <https://www.eloquesthealthcare.com/hospital-acquired-conditions-hac-reduction-program/>.

<sup>11</sup>Melanie D. Whittington, Cathy J. Bradley, Adam J. Atherly, Jonathan D. Campbell, Richard C. Lindrooth, "Value of Public Health Funding in Preventing Hospital Bloodstream Infections in the United States," *American Journal of Public Health* 107, no. 11 (November 1, 2017): pp. 1764-1769.

<sup>12</sup>Ibid.

<sup>13</sup>Understanding the Hospital-Acquired Condition (HAC) Reduction Program, Cook Medical, 2017, <https://www.cookmedical.com/interventional-radiology/understanding-the-hospital-acquired-condition-hac-reduction-program/>.

Congress to build on the ACA's progress in this area to improve patient safety and reduce preventable dangers, such as HAIs.

**b. Addressing the dramatic variations in care quality and outcomes across States.** Young adults should have access to the same quality health insurance and health care no matter who they are or where they live. Yet, there is often dramatic variation in health care quality, costs, and outcomes across States and even within a state. There are also significant regional disparities in health care access and outcomes for low-income people specifically.<sup>14</sup> Studies show that low-income and Latinx individuals are more likely to be uninsured or underinsured than those with higher incomes and are thus less likely to have a usual source of or receive recommended care.<sup>15</sup>

The ACA provides a strong foundation upon which to continue to address these challenges, but more can and should be done. Research shows, for instance, that States that expanded their Medicaid program made some of the most significant gains in ensuring that their residents are able to get the health care they need.<sup>16</sup> And people on Medicaid are happy with their coverage and access to care. In my State of Colorado, a recent statewide survey found that "81.0 percent of Medicaid clients say their family's needs are being met by the health care system, higher than any insurance type, including employer-sponsored insurance."<sup>17</sup> Beyond Medicaid expansion, there is a need to strengthen primary care, reduce reliance on emergency services, and improve care for individuals with chronic disease. To make real progress, these efforts should be targeted to low-income and other underserved communities to help improve population health.

Continued data collection and measurement on quality, cost, and access is critical to understanding why these variations exist and how to develop solutions to address this issue. Thus, I support continued research, evaluation, and analysis of health care access and value by Federal agencies such as the Agency for Healthcare Research and Quality, the Center for Medicare and Medicaid Innovation, and the Centers for Medicare and Medicaid Services.

**c. Identifying ways to reduce administrative overhead and dispute, specifically the bureaucratic warfare between insurance companies and providers over reimbursement.** Unnecessary administrative overhead and lengthy dispute processes hurt all consumers through higher premiums. No consumers, including young adults, should be put in the middle of a dispute between an insurance company and a provider over reimbursement or any other issue. Unfortunately, this happens far too often, especially in the context of surprise medical billing, which has affected nearly one-third of privately insured Americans.<sup>18</sup> This can occur even when a consumer has done due diligence by checking to see if their hospital or doctor is in-network only to find that someone who saw them during the course of treatment, such as a specialist at the hospital or an anesthesiologist during surgery, was out-of-network, resulting in higher than expected bills. In Colorado, for example, State regulated insurance companies cannot require consumers to pay out-of-network rates if they go to an in-network facility but unexpectedly see an out-of-network provider. However, Colorado law does not prevent providers from sending a bill for the out-of-network costs to consumers, resulting in confusion and leading some con-

<sup>14</sup>C. Schoen et al, *Health Care in the Two Americas: Findings from the Scorecard on State Health System Performance for Low-Income Populations, 2013*, (Washington, DC: The Commonwealth Fund, 2013), <http://www.commonwealthfund.org/publications/press-releases/2013/sep/first-ever-scorecard-evaluates-how-well-state-health-care-systems>

<sup>15</sup>Ibid; S. R. Collins et al, *Who Are the Remaining Uninsured and Why Haven't They Signed Up for Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, February-April 2016*, (Washington, DC: Commonwealth Fund, 2016) <http://www.commonwealthfund.org/publications/issue-briefs/2016/aug/who-are-the-remaining-uninsured>.

<sup>16</sup>M. Mahon, *New State Health Care Scorecard Finds Improvements in Access and Quality nationwide Following ACA's Major Coverage Expansions; States That Expanded Medicaid Saw Some of the Biggest Gains*, (Washington, DC: Commonwealth Fund, 2017), <http://www.commonwealthfund.org/publications/press-releases/2017/mar/state-scorecard-release>.

<sup>17</sup>"2017 Colorado Health Access Survey: The New Normal," Colorado Health Institute, last updated September 18, 2017, <https://www.coloradohealthinstitute.org/research/colorado-health-access-survey>.

<sup>18</sup>Consumer Reports survey finds nearly one third of privately insured Americans hit with surprise medical bills, (Washington, DC: Consumer Reports, 2015), <https://consumersunion.org/news/consumer-reports-survey-finds-nearly-one-third-of-privately-insured-americans-hit-with-surprise-medical-bills/>.

sumers paying higher bills that they are not required to pay.<sup>19</sup> In addition, self-funded employer plans, which cover roughly 100 million people nationally, are exempt from these types of State regulation.<sup>20</sup> To address this issue, Congress should consider policies that better hold consumers harmless from high unexpected out-of-pocket demands from providers. I also support continued efforts begun under the ACA to address overhead and consumer disputes. These include a strong medical loss ratio for insurers and new internal and external appeals standards that allow consumers to contest a claims denial.

**d. Ensuring that a patient's wishes are honored at the end of his or her life.** As noted above, nearly one in four Millennials are caretakers for an older family member.<sup>21</sup> As a result, end-of-life care is an unexpected, but critical, issue for young adults as well as their parents and grandparents. The lack of a clear, unambiguous understanding of someone's final wishes can result in the provision of costly and, in some cases, inappropriate health care and a reduced quality of life. Because most people are covered under Medicare at the end of their life, roughly one-quarter of traditional Medicare spending on health care is for services provided in the last year of a Medicare beneficiary's life.<sup>22</sup> For these reasons, it is important for everyone to talk to their family members and providers about the quality of life they want to have and the type and extent of the medical treatment they are willing to get to prolong their life.

Although I do not make specific policy recommendations at this time, I encourage Congress to help make sure that appropriate at-home end-of-life care is available to all who need it and to consider the recommendations on end-of-life care that were issued by the Institute of Medicine in 2014 in its report, *Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*.<sup>23</sup>

**e. Advancing payment reform to encourage prevention and primary care.** The ACA made significant advances in encouraging the use of primary and preventive care by, for instance, requiring plans to cover annual physicals, screenings, and other preventive care without cost-sharing. This has resulted in a significant benefit to young adults who value these services and are motivated to get the preventive care they need because it is now covered at no extra cost. For example, a study in the *American Journal of Public Health* found that the ACA resulted in increased use by young adults of routine and preventive care, and decreases in the number of young adults forgoing care and experiencing delays in care as a result of high costs.<sup>24</sup> Other studies cited by the *American Journal of Public Health* have also shown an increase in the percentage of young adults who sought routine health care.<sup>25</sup> The nonprofit that I work for, *Young Invincibles*, has conducted focus groups and trainings with young adults across the country on

Unfortunately, like many Americans, young adults are affected by an ongoing primary care physician shortage, especially in rural areas of the country.<sup>26</sup> This is particularly true in States that have not expanded their Medicaid program.<sup>27</sup> To address this, I urge Congress to consider policies that would incentivize primary care, particularly in rural areas. This may include reauthorizing and increasing invest-

<sup>19</sup>"A Consumer Guide to Surprise Medical Bills," The Colorado Consumer Health Initiative, accessed October 17, 2017, <http://cohealthinitiative.org/surprise-medical-bills>.

<sup>20</sup>Loren Adler, et al., "Stopping Surprise Medical Bills: Federal Action Is Needed," *Health Affairs Blog*, February 1, 2017, <http://healthaffairs.org/blog/2017/02/01/stopping-surprise-medical-bills-Federal-action-is-needed/>.

<sup>21</sup>Amy Goyer, Report: Millennials Now Almost 25 percent of Family Caregivers, (Washington, DC: AARP, 2015), <http://blog.aarp.org/2015/06/05/amy-goyer-caregiving-in-the-us-2015/>.

<sup>22</sup>10 FAQs: Medicare's Role in End-of-Life Care, Kaiser Family Foundation, 2016, <https://www.kff.org/Medicare/fact-sheet/10-faqs-Medicare-role-in-end-of-life-care/>.

<sup>23</sup>*Dying in America: Improving Quality and Honoring Individual Preferences Near the End of Life*, The Institute of Medicine, 2014, <http://www.nationalacademies.org/hmd/Reports/2014/Dying-In-America-Improving-Quality-and-Honoring-Individual-Preferences-Near-the-End-of-Life.aspx>.

<sup>24</sup>Charlene Wong et al, Changes in Young Adult Primary Care Under the Affordable Care Act, *American Journal of Public Health*, 2015, <http://ajph.aphapublications.org/doi/10.2105/AJPH.2015.302770>.

<sup>25</sup>Ibid. covered preventive services. What we have found, anecdotally, is that the fact that these services are now free with a health plan is the No. 1 motivating factor for young adults to get preventive care, followed by the piece of mind a preventive check-up can provide.

<sup>26</sup>Graves, John A., PhD et al, "Role of Geography and Nurse Practitioner Scope-of-Practice in Efforts to Expand Primary Care System Capacity: Health Reform and the Primary Care Workforce, *Medical Care*, 2016, [http://journals.lww.com/lww-medicalcare/Abstract/2016/01000/Role\\_of\\_Geography\\_and\\_Nurse\\_Practitioner.13.aspx](http://journals.lww.com/lww-medicalcare/Abstract/2016/01000/Role_of_Geography_and_Nurse_Practitioner.13.aspx).

<sup>27</sup>Ibid, 83.

ments in the National Health Service Corps,<sup>28</sup> increases in Medicaid fees for primary care as was done temporarily under the ACA,<sup>29</sup> and further addressing emerging models of primary care such as telemedicine and direct primary care. Additionally, many young adults rely heavily on safety net providers, such as federally Qualified Health Centers, community health centers, and local Planned Parenthood affiliates. Continued access to and funding for these types of primary care providers should also be a key consideration for Congress moving forward.

[Whereupon, at 12:22 p.m., the hearing was adjourned.]



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<sup>28</sup>Sebastian Negrusa et al, National Health Service Corps—An Extended Analysis, Assistant Secretary for Planning and Evaluation, US Department of Health & Human Services, 2016, <https://aspe.hhs.gov/system/files/pdf/255496/NHSCanalysis.pdf>.

<sup>29</sup>Stephen Zuckerman et al, Medicaid Physician Fees after the ACA Primary Care Fee Bump, (Washington, DC: Urban Institute, 2017), <https://www.urban.org/research/publication/Medicaid-physician-fees-after-aca-primary-care-fee-bump>