

**HEALTH CARE: ISSUES IMPACTING
COST AND COVERAGE**

HEARING

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

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SEPTEMBER 12, 2017
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HEALTH CARE: ISSUES IMPACTING COST AND COVERAGE

TUESDAY, SEPTEMBER 12, 2017

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC

The hearing was convened, pursuant to notice, at 10:05 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Roberts, Cornyn, Thune, Burr, Portman, Toomey, Heller, Cassidy, Wyden, Stabenow, Cantwell, Carper, Cardin, Brown, Bennet, Casey, Warner, and McCaskill.

Also present: Republican Staff: Jennifer Kuskowski, Chief Health Policy Director; Preston Rutledge, Senior Tax and Benefits Counsel; and Martin Pippins, Detailee. Democratic Staff: Joshua Sheinkman, Staff Director; Michael Evans, General Counsel; Ann Dwyer, Senior Health Counsel; Elizabeth Jurinka, Chief Health Policy Advisor; and Arielle Woronoff, Senior Health Counsel.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

Before we begin, I would like to pause for a moment to say a few words regarding the traumatic events that have recently impacted so many of our fellow citizens. The damage and destruction we have seen with relation to Hurricanes Harvey and Irma have been devastating, but I will say that the acts of heroism we have seen over the last few weeks have been awe-inspiring.

I think I speak for everyone here when I say that our thoughts and our prayers go out to all of these individuals and friends and family who have been affected by these disasters and that we urge all those who are able to provide assistance to do what they can to help the relief efforts currently underway.

With that, I want to thank everyone present for attending today's hearing on health-care costs and coverage.

Health care is always an important topic, as it impacts literally everyone. Health care has also, since the passing of the so-called Affordable Care Act, become a rather contentious topic as well. The divisiveness that surrounds the health-care debate is unfortunate in my mind because it has far too often allowed politics and partisanship to cloud our judgment. Now, this is true for those on both sides of the aisle.

We have discussed these issues at length many times before today. This is at least the 37th health-care hearing we have had

in the Finance Committee since final pieces of Obamacare were signed into law. However, recent events have spurred us to re-evaluate the current situation.

And while I welcome the opportunity to reset parts of the health-care debate, the problems plaguing our health-care system remain pretty much the same as they were prior to the passage of Obamacare, and in some regards, I would argue that they have become worse.

Costs are continuing to skyrocket. According to a recent report from CMS, because increasing health-care costs are still outpacing the growth of our economy, they are projected to consume 20 percent of our total GDP in just 8 years. Now, that is one-fifth of the economy, and that is if we are lucky.

No one should say that we do not spend enough on health care in this country. Currently, health-care expenditures in the U.S. amount to nearly \$10,000 per person. That is more per-capita spending than any other industrialized country and, according to OECD data, 20 percent higher than the next highest spending country and nearly double the overall average among OECD member countries.

From 2011 to 2016, the average health premium for employer-sponsored family coverage increased by 20 percent in comparison to a wage increase of only 11 percent during that same period. A recent study from the PWC Health Research Institute found that medical costs are projected to grow between 6 and 7 percent between 2016 and 2018. Unsurprisingly, this trend in health-care costs has forced families to divert their spending on other items and necessities, things like food and housing, to pay for growing health-care costs.

Of course, these general growth trends pale in comparison to those in the Obamacare exchanges, where the average premium has more than doubled in just the last 4 years.

One of the chief assumptions underlying the Affordable Care Act was that if the government forced people to purchase health insurance, more young, healthy people would enter the insurance market, which was supposed to offset the increased costs imposed by all of the law's mandates and ensuing regulations.

Instead, the law imposes a legal requirement for people to purchase insurance while also making insurance unaffordable for millions of Americans. This, as I have noted in the past, is the ultimate irony of Obamacare.

Supporters of the law like to tout coverage numbers in order to claim that the system has actually succeeded, but those numbers warrant a closer look. True enough, from 2014 to 2016, insurance coverage in the United States increased by about 15.7 million people; however, the vast majority of those newly insured people, around 14 million, were added through either Medicaid or CHIP.

As we will hear from some of our witnesses today, enrollment in the individual market may be reaching a tipping point where those who previously had insurance are being priced out of the market and actually becoming uninsured since the enactment of Obamacare.

None of this is surprising. Most of this was predicted at the time Obamacare was being debated. And now with virtually every night-

mare scenario for the fate of Obamacare, they are coming true. We are hearing calls for bipartisan fixes to shore up the failing system.

Let me be clear. I want to find a bipartisan path forward through this mess. At this point, it is pretty clear that the parties will need to work together if any of this is going to improve.

That said, I am concerned that many of the proposals for a bipartisan solution would amount to little more than a bailout of the current system. This, in my view, would be a mistake. If we simply throw money into the system to maintain cost-sharing subsidies or make payments to insurers without fixing any of the underlying problems, we would just be setting up another cliff and likely another partisan showdown in the future.

Even worse, we would not be helping to reduce premiums or increase insurance options for the vast majority of middle-class families, whether they get their plans through the exchanges or elsewhere.

Of course, I am neither naive nor oblivious. I do not want to simply watch health-care costs increase and choices diminish even further while purists in Congress demand the unattainable.

We will likely have to act at some point, maybe even this year, to protect American families from the failures of the current system. Once again, I want to find a bipartisan path forward to address these problems.

But let me be clear. In my view, an Obamacare bailout that is not accompanied by real reforms would be inadvisable. We cannot simply invest more resources into a broken system and hope that it fixes itself over time. The status quo under Obamacare is not improving. I do not believe we should spend more energy to prop up a system that is already hurting millions of Americans.

And while I may sound like a naysayer here this morning, that is far from the truth. I am an optimist and always have been.

We had a hearing last week on the CHIP program, which demonstrated that we are more than capable of working together to address health-care needs. Hopefully, we can do the same when we talk about the broader effort to bring down costs and maintain coverage for the health-care system.

For instance, both Senators Cornyn and Wyden each have a bill to repeal the Independent Payment Advisory Board included in Obamacare. Just last Congress, many of us worked together in a bipartisan fashion to delay the HIT for 1 year and the Cadillac tax for 2 years. We also imposed a 2-year moratorium on the device tax.

I believe that we can come together again to provide some relief through elimination of these and other onerous Obamacare taxes that drive up costs for consumers and hamper innovation.

Personally, I also believe members on both sides of the aisle should be open to rolling back or at least amending the individual and employer mandates, two of the most unpopular components of Obamacare.

These are just some examples of things that members of this committee have been working on to address our runaway health-care costs and to amend a beleaguered Obamacare. Even our newest members, like Senator Cassidy, are eager to tackle these complex issues. So let us put our differences aside and work together

on meaningful changes. We have done it before, and we can do it again.

I look forward to hearing from our witnesses today and from my friends on both sides of the dais. Hopefully, today's discussion will provide some clarity on how we can better work together on these matters going forward.

With that, let me now turn to Senator Wyden for his opening remarks.

[The prepared statement of Chairman Hatch appears in the appendix.]

**OPENING STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON**

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

And, Mr. Chairman, I want to associate myself with your remarks on these horrible disasters that we have seen across the country. What we have said on a bipartisan basis is, we are going to be there for communities that suffer.

And I also want to say that much of the west is facing disaster as well with our communities literally on fire in numerous States. I was in many counties in Oregon where we are seeing the human toll of people losing essentially everything.

And I can just tell you that the Chetco Bar fire near Brookings this last Sunday, when we were up at 6:00 in the morning at the base camp, we had Americans from all over the country pitching in to help Oregon fight that fire.

So I very much appreciate your comments, Mr. Chairman, with respect to disaster and working with our colleagues in a bipartisan way to be there for our communities when disaster strikes.

Now, with respect to this morning's hearing, I want to frame my discussion in two parts. First, I want to just respond really to some of the common arguments about the Affordable Care Act and then I would like to get to what the committee does best, which is to work in a bipartisan way on big ideas dealing with the health-care challenges.

Now, with respect to the cost issue and the Affordable Care Act, I want to put this in the context of the 320 million people who live in our country. Fifty million of those are older Americans, and they think Medicare has been a pretty darn good deal.

One hundred and sixty million Americans get their insurance coverage at work, so they are not touching the Affordable Care Act exchanges. If their premiums go up, it has not been, on average, by a whole lot. And nearly eight out of 10 people who did sign up for private coverage through the Affordable Care Act this year could find a plan for less than a hundred dollars a month after tax credits.

So this proposition that somehow every single person in America, the 320 million people, are unhappy with health care or think their costs have gone into the stratosphere as a result of the Affordable Care Act—the record, the actual factual record, does not show that.

Now, when you are talking about cost increases in the Affordable Care Act, you are really looking at a portion of the individual exchanges. These are the people who do not get their care through

Medicare or the military or a large employer. These are the people we are talking about.

And my own view is, one of the major reasons these folks have had some real challenges is that the President has for months and months poured gasoline on the fires of uncertainty in the private insurance marketplace. It strikes me as particularly odd because this administration is an administration that cites its background in private business.

And what we are talking about is private businesses in these individual exchanges suffering dramatically as a result of the uncertainty with respect to cost-sharing and the administration still being unwilling to give a straight answer as to whether it is going to cut off cost-sharing payments. And that already has caused insurers to raise rates.

And we also have had to deal with an awful lot of negative rhetoric and propaganda about the Affordable Care Act, manipulating government websites to play hide-the-ball with Americans who are pretty much just getting up and saying, how can I learn how to get coverage?

And certainly, if you are predicting doom and gloom when you are supposed to be trying to work with people in the private sector and people of all political parties, it certainly does not help the individual market.

It is a similar story in many of the States. The States have put serious effort into building competitive marketplaces and holding costs down, and many of them have been successful. But in some States, we have seen little effort to get people signed up into the insurance pool. There has not been a pushback against rate increases.

Two and a half million Americans are stuck in what is called the coverage gap. Lawmakers in their States have denied them the opportunity to sign up for Medicaid, and they do not earn enough to qualify for subsidies under the Affordable Care Act. Premiums on the individual market are 7-percent higher in States that did not expand Medicaid than they are in States that did. That is a bit of context about where the Affordable Care Act stands.

Now, I want to close up by talking about some of the big ideas that we can work on in the historic way that the Finance Committee has done—in a bipartisan fashion.

The first is flexibility. I have always held fast to the notion that if States believe they have a plan that raises the bar for health care in terms of cost and coverage, rather than lowering it, they ought to have a chance to try it out. A simple proposition: if the States can do better, we ought to be just all-in on giving them the chance to do it. If States are looking for a back door to do worse, that is something different.

And that is why this committee, in the Affordable Care Act, included section 1332. I was the lead author of it—many colleagues were involved—but it was our effort to make clear on the side of folks who are progressive, on the side of folks who are conservative, the Federal Government does not have all the answers.

There is a lot of creative thinking going on at the State level. We wanted to give progressives and conservatives the opportunity to do that. That is what 1332 is all about.

As the provision went into effect this year, States are showing more and more interest, and they are getting results under current law. Many States, especially those interested in promoting private-market solutions, are considering a section 1332 waiver for State-based reinsurance programs. These are programs that help pay for some of the costliest patients, and they hold costs down for everybody else.

For other States, section 1332 may be an opportunity to pursue one of the progressive approaches, a single-payer approach, a public-option approach. The point is, 1332 gives States the chance to do better, but not worse.

I am very grateful to colleagues on the Finance Committee who supported that proposition and our jurisdiction. That is why we put it in there, and I think it is paying off.

The next area going forward ought to be transparency. One of the most frequent concerns we all hear at home is the sky-high cost of prescription medicine. People who need treatment are paying through the nose, and they have no idea why. They cannot make heads or tails out of the prescriptions or drug receipts. The high cost of drugs is also driving up premiums.

So I have introduced legislation to pull back the curtain on the broken drug-pricing system that burdens the country. And I know there are colleagues with other ideas as well.

Improving transparency on drugs is about holding down costs. It is about affordability, it is about competition, and it can have a direct effect on premiums in addition to the out-of-pocket costs families pay at the pharmacy. It is long, long, long past time Congress took on the challenge of drug pricing.

Finally, I would like to address competition and consumer choice. Over the past several months, my colleagues on the other side have accused Democrats of supporting a one-size-fits-all approach to health care. That is not the case. Choice and competition are essential to bringing down costs, and we ought to prioritize moving the needle on increasing choice and competition in the marketplace.

Finally, the chairman has been clear that he wants our committee to work on a bipartisan basis to help shape the future of Americans' health care. Today we have a chance for all members to be part of kicking off the debate.

I look forward to a productive conversation about it. This committee has done an awful lot of bipartisan work in health care in the past. And the chairman has issued a call to arms to our doing it again, and I look forward to pursuing it with him and colleagues on both sides of the aisle.

Thank you.

The CHAIRMAN. Well, thank you, Senator.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. I would like to welcome each of our four witnesses to our hearing today. And before we begin, I would like to thank you all for your willingness to testify and answer questions today. This is a complicated system. And your expertise is greatly appreciated at this time.

First, we will hear from Mr. Avik Roy, the president of the Foundation for Research on Equal Opportunity. Mr. Roy also serves as

the opinion editor at *Forbes*, where he writes on politics and policy and manages The Apothecary, a *Forbes* blog on health-care policy and entitlement reform.

From 2011 to 2016, Mr. Roy served as a senior fellow at the Manhattan Institute for Policy Research, where he conducted research on the Affordable Care Act, entitlement reform, universal coverage, international health systems, and FDA policy.

Mr. Roy attended the Massachusetts Institute of Technology, where he studied molecular biology, and the Yale University School of Medicine.

Second, we will hear from Mr. Edmund F. Haislmaier, the Preston A. Wells, Jr. senior research fellow in domestic policy studies at The Heritage Foundation. Mr. Haislmaier has 30 years of experience analyzing health-care markets and public policies.

He has particular expertise in the structure and regulation of health insurance markets, the tax treatment of health benefits, and pharmaceutical policy issues. He has published extensively on those and other health-care policy topics.

During the last several years, his work has focused primarily on measuring the effects of the Affordable Care Act on health insurance enrollment, insurer competition, insurer profitability, and the law's risk-mitigation programs.

Mr. Haislmaier is a member of the board of directors of the National Center for Public Policy Research and holds a bachelor's degree in history from St. Mary's College in Maryland.

Third, we will hear from Mr. Andrew M. Slavitt, senior adviser to the Bipartisan Policy Center. This is not Mr. Slavitt's first rodeo testifying before this committee. From 2015 to 2017, he served as Acting Administrator of CMS, during which time he testified several times before this committee.

During his time as Acting Administrator, Mr. Slavitt oversaw Medicaid, Medicare, CHIP, and the health insurance marketplace programs. His tenure at CMS was marked by the implementation of a number of large programs, including the significant shift to pay-for-value payment models, implementation of the bipartisan MACRA legislation, and the Affordable Care Act.

Mr. Slavitt has worked in a wide variety of private-sector companies as well, including as the group executive vice president for Optum, CEO of OptumInsight, founder and CEO of Health Allies, consultant for McKinsey and Company, and investment banker with Goldman Sachs.

Mr. Slavitt is a graduate of the Wharton School and the College of Arts and Sciences at the University of Pennsylvania, and he received an MBA from Harvard Business School.

Last but not least, we will hear from Dr. Aviva Aron-Dine.

She is a senior fellow and senior counselor at the Center on Budget and Policy Priorities in Washington, DC. From 2015 to 2017, Dr. Aron-Dine was a senior counselor to the Secretary of HHS, where she had responsibility for the Affordable Care Act implementation and for Medicaid, Medicare, and delivery system reform policies.

Prior to her position at HHS, Dr. Aron-Dine served as Associate Director for Economic Policy and then as Acting Deputy Director and Executive Associate Director of the Office of Management and

Budget and as a Special Assistant to the President for Economic Policy at the National Economic Council.

She also had previously worked at the Center on Budget and Policy Priorities from 2005 to 2008, specializing in Federal tax policy.

Dr. Aron-Dine holds a degree in philosophy from Swarthmore College and a Ph.D. in economics from MIT.

So I want to thank you all again for coming today.

And, Mr. Roy, will you please get us started by providing us with your opening remarks?

**STATEMENT OF AVIK S.A. ROY, CO-FOUNDER AND PRESIDENT,
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY,
AUSTIN, TX**

Mr. ROY. Thank you, Mr. Chairman, Ranking Member Wyden, and members of the Senate Finance Committee. Thanks for inviting me to speak with you today.

My name is Avik Roy, the president of the Foundation for Research on Equal Opportunity, a nonpartisan, nonprofit think tank focused on expanding economic opportunity to those who least have it.

A year ago, I published our first white paper making the case for why members of both parties and all philosophies should embrace the cause of universal coverage.

Ashley Dionne is a 30-year-old who suffers from asthma, ulcers, and cerebral palsy. She graduated from the University of Michigan in 2009. In the aftermath of the Great Recession, she had a tough time finding work, even with her college degree. Employers worried that she was overqualified and would not stick around.

Eventually, she went back to school for a second degree and found night work at a gym working 32 hours a week for \$8 an hour.

Despite these challenges, Ashley managed to afford health insurance. In 2013, she paid \$75 a month in premiums, but in 2014, after the Affordable Care Act went into effect, her monthly premium jumped from \$75 a month to \$319 a month. "I am the working poor," Ashley said, "and I cannot afford to support myself."

As all of you know, the high cost of American health care is a great burden on every American, not merely those who are uninsured, but also those who are insured and weighed down by rising premiums.

In addition, growth in our Federal deficit and debt is driven primarily by growth in public spending on health care. The poor, the elderly, and the vulnerable have the most to lose if we cannot bring this growth back in line with that of the rest of the economy.

The Affordable Care Act subsidies have helped millions of U.S. residents afford health insurance, but its regulations have frozen millions of others like Ashley out of the health insurance market by driving premiums upward.

I am going to focus my remarks today on the individual health insurance market, or the non-group market as it is sometimes called. This market, as you all know, is traditionally for Americans who do not get their coverage from the government or their employer and shop for it on their own.

Some people say the individual health insurance market is small and, therefore, not as worthy of public attention. I would disagree, because the health of the individual market is essential to 45 million U.S. residents who are either enrolled in individual market coverage or currently uninsured, because, if you are uninsured, it is individual market insurance that you would buy if you were trying to obtain coverage.

Much of the talk these days of stabilizing the individual health insurance market has been notable for an absence of talk about how the market got destabilized in the first place.

According to the Assistant Secretary for Planning and Evaluation, the effect of ACA regulations and taxes has been to double the underlying cost of individually purchased insurance, with even greater increases for those who are younger and/or in relatively good health. In 2014 alone, the ACA increased individual market premiums by an average of 49 percent.

The two largest drivers of higher premiums under the ACA have been 3:1 age bands, which often double premiums for younger enrollees, and actuarial value mandates, which are intended to make coverage more financially generous but end up making premiums far less affordable.

Other ACA provisions, such as essential health benefit mandates, health insurance premium taxes, and taxes on pharmaceutical and medical devices, play a secondary role in rising premiums.

The sum total of all these provisions is to make health insurance unattractive and unaffordable for younger and healthier Americans. The ACA's weak individual mandate, riddled with loopholes, has done little to force these Americans back into the market.

There are some in Washington who argue that section 1332 of the ACA gives States the flexibility to seek waivers from these regulations. As much as I am an admirer of Senator Wyden, I am not convinced that this is the case, because those regulations in section 1332 allow States to waive things like individual mandates and employer mandates, but not the age bands and other high-cost drivers that they need to increase enrollment and lower costs.

No State will be able to meet the test that section 1332 requires to repeal those mandates while also keeping the rest of the regulations in place and maintaining coverage.

The insurance industry has been pushing Congress for formally appropriate cost-sharing subsidies, because today under the ACA, insurers are legally bound to pay out these subsidies regardless of whether Congress funds CSRs. So it is appropriate for Congress to consider ways to provide legal certainty to insurers.

But it would be unfair and inappropriate for Congress to address the priorities of insurers without also offering relief to Ashley Dionne and the millions like her who have endured dramatically rising premiums despite the payout of CSRs for these last 4 years.

Relief from rising premiums should include reforms, like repealing the 3:1 age band, re-legalizing affordable copper plans, and replacing the individual mandate with waiting periods and late enrollment fees, like those used successfully in Medicare.

I look forward to the opportunity to discuss these ideas and others with you today in more detail and also in my written testimony. Thank you.

The CHAIRMAN. Thank you, Mr. Roy.
[The prepared statement of Mr. Roy appears in the appendix.]
The CHAIRMAN. Mr. Haislmaier?

**STATEMENT OF EDMUND F. HAISLMAIER, PRESTON A. WELLS,
JR. SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION,
WASHINGTON, DC**

Mr. HAISLMAIER. Thank you, Mr. Chairman. My name is Ed Haislmaier. I am Preston Wells senior fellow in health policy at The Heritage Foundation. I appreciate the opportunity to testify to you today.

The committee has copies of my written testimony, so I will not go over that again.

What I would like to do in my opening remarks is simply expand upon it a bit and address the applicability of the analysis in my written testimony to the questions in front of this and other committees as to what, if anything, should be done to stabilize the individual health insurance market.

I would begin by pointing out that the Affordable Care Act has effectively produced an individual health insurance market with two distinct subsets of people: those who get subsidies for their coverage and those who do not. And it has had different effects on those two different groups.

Essentially, what the Affordable Care Act did was to effectively convert individual health insurance from what had really been a financial service product into a social welfare program. So the size and the composition of the subsidized portion of the market is a fairly predictable result of the design of the law. As long as those subsidies remain in place, that portion of the market will, in my analysis, continue to remain essentially of roughly the same size and composition.

In other words, the subsidized portion, about half of the current market, seems to be settling into its natural, stable state, that is, a pool of lower-income individuals with moderate to significant medical conditions, typically served by, in most places, a single insurer with a narrow network of providers.

In contrast, the unsubsidized portion of the market consists of middle-income individuals without access to employer-sponsored coverage, often because they are self-employed, and they are the ones who traditionally comprised the individual market before the Affordable Care Act. And they are principally seeking a financial service product that mainly protects them against unexpected, large medical expenses.

So they are willing to trade less-comprehensive coverage and higher cost-sharing for lower premiums and more choice of insurers and medical providers. Therefore, it should not be surprising that those are the people who most resent the Affordable Care Act forcing them to pay more for benefits that they do not believe they want or need and limiting their available choices of insurers and providers in the process.

Given that bifurcation of the market, the various recommendations offered for stabilizing the current market should be assessed according to their effects on these two different subsets.

So, proposals to address the payment of cost-sharing reduction subsidies and maybe reinstitute some sort of taxpayer-funded reinsurance program for high-cost enrollees would essentially stabilize the funding of what I have termed the social welfare segment, that is, the lower-income segment receiving subsidies in the market.

The proposals to amend or repeal the Affordable Care Act's Federal insurance regulations would reduce premiums and stabilize the non-subsidized financial service segment, as I have called it, of the market.

So to stabilize that unsubsidized portion of the market, because there is a lot of talk about how to stabilize the subsidized portion, let me address it briefly.

To stabilize the nonsubsidized portion of the market, Congress essentially needs to reestablish a set of fair and balanced rules that create incentives for individuals to maintain continuous coverage so as to ensure that the market has a diverse pool of risk.

Now, the fairest and most effective way to do that—and my colleague has mentioned some others—is by linking the prohibition on health plans apply preexisting condition exclusions directly to a requirement that individuals maintain continuous coverage.

That was the policy successfully applied to the employer group coverage market by the 1996 Health Insurance Portability and Accountability Act. Congress should have applied that same policy to the individual market rather than adopting the ACA's approach of fining those who do not buy coverage, which has proven to be ineffective.

In addition, Congress should repeal or allow States to waive other major ACA regulations that have most contributed to increasing premiums. Again, some of those have been mentioned: benefit mandates, minimum actuarial value requirements, and restrictions on age rating being the largest.

In sum, the various stabilization proposals can be distinguished by whether they would actually stabilize the market for insurance or simply stabilize the funding for subsidies.

Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

[The prepared statement of Mr. Haislmaier appears in the appendix.]

The CHAIRMAN. We will go to you, Mr. Slavitt.

STATEMENT OF ANDREW M. SLAVITT, FORMER ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, EDINA, MN

Mr. SLAVITT. Thank you, Chairman Hatch, Ranking Member Wyden, members of the committee. Thank you for the invitation to be back here to discuss an issue of vital importance: how to improve health-care costs and coverage for American families.

My name is Andy Slavitt. I had the honor to serve in an acting capacity as Administrator for the Centers for Medicare and Medicaid Services from 2015 to 2017 alongside the high-caliber men and women of the agency who on a daily basis help the American public get the care they need at all stages of life.

I currently serve as a senior adviser to the Bipartisan Policy Center.

Prior to serving in government, for the large majority of my career, I worked in the private sector, first as a health-care technology entrepreneur and later helping to create a large health-care services company that participated in virtually every element of health-care cost and coverage.

Now, my written testimony contains what I see as the many important milestones we achieved as a country with the Affordable Care Act and also some of the challenges.

But I am not here as a champion of a law that has already been passed. I prefer to focus my comments today on paths forward for improving costs and coverage in health care.

Democrats in health policy often focus as a first priority on improving health-care coverage. Republicans often focus on the importance of reforms which reduce costs and improve sustainability.

I believe we can all do a better job of understanding both of these very valid perspectives: that we cannot have affordable health coverage we need for Americans without making costs a priority, and at the same time, we cannot simply cut and expect to improve care for Americans.

In the individual market, there are several recent bipartisan efforts, including one from the Bipartisan Policy Center which I participated in, from a bipartisan group of Governors, and several others which, taken together, offer something of a consensus on immediate reform recommendations.

Even while we address larger reforms, the Congress ought to take advantage of the fact that there are several fast-acting, budget-friendly steps, each of which will reduce the cost of health care for American families: funding for cost-sharing reduction payments, restoring cuts to marketing and in-person assistance, helping States efficiently account for high-cost claimants, and speeding up the review of 1332 waivers while ensuring appropriate protections, which are an option thanks to the foresight of members of this committee.

It seems to me that, despite the very challenging politics of health care, if the Congress can take action to make people's lives better, this is exactly what Americans want to see from Washington. Not acting when we know we can succeed is not what the public expects.

So how do we know exchanges can succeed? Because we have seen it, from Massachusetts before the ACA, to California, Florida, Kentucky, and many more States since.

Because of my 2 decades in the private sector, I have seen markets like exchanges work, whether Medicare Part D, Medicare Advantage, or insurance exchanges. But all have to have commitment, nimbleness, and adjustments along the way or they will not be successful.

So if your goal is to increase choice and reduce costs, predictable rules are vital. In fact, they are fundamental. Companies will not participate if they cannot rely on the commitments they receive from the government. For that reason, I recommend that any steps that Congress chooses to take, it does so through at least 2019.

Now, if we want to have an impact on health-care costs, we must address the real root-cause issues—poorly coordinated care, the high costs of chronic illness, our under-investment in primary care and prevention—and undergo a shift to a system that focuses on keeping people healthy and treating them in comfortable and low-cost settings, like their own homes.

We must commit to moving to pay for quality outcomes and rewarding smart ways to bring down costs.

And we must address the rising costs of prescription drugs and not accept that we can only have either innovation or efficiency. In America, we expect our best industries to do both, and we should expect that with prescription medicines as well.

One thing that will not reduce costs is simply transferring costs to consumers or States by allowing the return of Swiss cheese insurance policies or cutting or capping access to vital programs like Medicaid for people near the poverty level, low-income seniors, children, and people with disabilities.

I know you will hear a diverse set of views today. And I understand the difficulty of reaching compromise. As challenging as it is, I hope this hearing helps find common ground, as all Americans have a stake in improving health-care costs and coverage. I offer my support to your efforts and look forward to answering your questions.

The CHAIRMAN. Well, thank you so much.

[The prepared statement of Mr. Slavitt appears in the appendix.]

The CHAIRMAN. Dr. Aron-Dine, we will turn to you.

**STATEMENT OF AVIVA ARON-DINE, Ph.D., SENIOR FELLOW
AND SENIOR COUNSELOR, CENTER ON BUDGET AND POLICY
PRIORITIES, WASHINGTON, DC**

Dr. ARON-DINE. Mr. Chairman, Ranking Member Wyden, and members of the committee, thank you for the opportunity to testify before you today on these crucial issues of health-care costs and coverage.

I want to start by taking stock of where we stand on both fronts now and then turn to some of the most immediate issues facing the individual market.

If we compare our health-care system to how it looked back in 2010, three trends stand out. First and best-known, more than 20 million people have gained coverage, and for the first time in our history more than nine in 10 Americans have health insurance.

Less understood is how widespread these gains have been. Compared to 2010, uninsured rates are down more than 35 percent for low- and moderate-income people, but also for those with incomes too high to qualify for subsidies, for children, for young adults, for middle-aged and older people, for both urban and rural Americans, and for both sicker people—including those with preexisting health conditions—and among people in good health.

Second, these coverage gains have translated into large gains in access to care and financial security, the dual objectives of health insurance. For example, research finds that the ACA's Medicaid expansion has increased the share of low-income adults getting checkups, getting regular care for chronic conditions, and reporting excellent health, and has decreased the share who rely on the

emergency room for care, who skip needed care due to cost, or who struggle to pay their medical bills.

Third, the last few years have seen a marked slowdown in health-care cost growth. Medicare, Medicaid, and private insurance have all seen much slower growth in per-enrollee spending than over the previous decade. The ACA contributed to that slowdown through Medicare reforms, incentives for hospitals to prevent avoidable readmissions and other patient harms, and by creating mechanisms, like the CMS Innovation Center, that are supporting ongoing payment experimentation and reform.

Of course, there is more work to do, both to reduce costs and to expand coverage. But as we seek to make additional progress, it is also critical not to go backwards.

Compared to if we were having this hearing 7 years ago, the uninsured rate has been cut almost in half. Total national health expenditures this year are several hundred billion dollars below what the CMS actuaries were projecting back then. And the combination of the ACA and the bipartisan MACRA legislation, passed with leadership from this committee, offer a much stronger foundation for continued delivery system reform than we had back then.

In my written testimony, I provide suggestions for building on that foundation. And I look forward to discussing those options in response to your questions.

Most immediately, though, there has been an appropriate focus on strengthening the individual market. Governors, regulators, and experts have offered a range of suggestions for undoing the damage done by Federal policy uncertainty while also addressing some of the underlying challenges they have seen in their markets.

Common bipartisan recommendations, with which I concur, include providing an explicit appropriation for cost-sharing reductions, maintaining or increasing outreach, enforcing the law, which includes the individual mandate, establishing a Federal reinsurance program, and streamlining the process for 1332 waivers if they improve stability while maintaining coverage and consumer protections.

But I want to close by addressing a concern that has been raised about this entire paradigm for strengthening the market.

The argument is that addressing policy uncertainty and other incremental reforms will not work and that the only option is to go back to some or all of the major features of the pre-ACA individual market, such as plans that excluded core services or exposed consumers to very high out-of-pocket costs.

Fortunately, it is increasingly clear that if Federal policy uncertainty is addressed, the individual market is on track for stability without reversing the ACA's core protections. Not only are ACA markets already succeeding in many States, but national data indicate that the risk pool has been stable or improving for several years.

Especially important, 2017 data show that individual market premiums and claims are now roughly in line with employer market premiums and claims, on average. That is exactly what we would expect now that individual market plans, like employer plans, offer robust coverage and cannot discriminate based on pre-

existing conditions. And it is a sign of a maturing, stabilizing market.

Meanwhile, individual market insurers appear to be returning to profitability, which should mean lower rates and growing choice for consumers going forward.

Consistent with that, major insurers across a number of States have said they would be requesting low or moderate rate increases this year if it were not for policy uncertainty.

Timely action to address those concerns can still mitigate the damage for 2018. And importantly, it would put the market on track for growing stability and success in 2019 and beyond.

Thank you again for the opportunity to testify, and I look forward to answering your questions.

The CHAIRMAN. We appreciate all four of you and the testimony that you have given here this morning.

[The prepared statement of Dr. Aron-Dine appears in the appendix.]

The CHAIRMAN. Let me just ask this question for everybody at the dais. What role can health savings accounts play in addressing health-care costs? And how can we expand accessibility to these accounts?

We will start with you, Mr. Roy.

Mr. ROY. Senator, they absolutely can play a role in addressing health-care costs. The way I sort of generalize the principle is that the fundamental problem with our health-care system cost-wise is that too many Americans are removed from the opportunity to control the health-care dollars that are spent on their behalf.

They do not shop for the coverage that is bought on their behalf by the government or their employer in many cases—in most cases—and they do not pay for health care directly where that is appropriate.

So the more we can move to a system where people are shopping for the insurance that they want and shopping for the care that they want, the more accountability will be built into the system by consumers, the way it is in every other sector of the economy.

The CHAIRMAN. Okay.

Mr. Haislmaier?

Mr. HAISLMAIER. Mr. Chairman, I think that the role is twofold. One, it provides the ability for individuals to have more control over the decisions and control the money.

Two, it is the only thing we have right now in this country that encourages people to save for and pre-fund future medical needs. And as we get older, we inevitably, at least in the aggregate, wind up costing more in health care, so that pre-funding is important.

As to what could be done, I think rather than the health savings accounts being linked to a specific product, a high-deductible plan, Congress should think about them being a sort of independent vehicle that can be used with any form of insurance, any type of insurance, for any payment arrangements.

I think what we need is more diversity and creativity on the provider side in payment arrangements, and so you want a system that is responsive to that.

The CHAIRMAN. Thank you.

Mr. Slavitt?

Mr. SLAVITT. Health savings accounts are useful for two types of individuals: people who have the wherewithal to save, so people generally in the middle class, and people who are healthy enough to be able to save. And so it is a useful tool for those populations.

Now, like everything else, there is a cost to it, and the cost to the Federal Treasury is not insignificant. So if the Congress decides that is where our highest priority ought to be, to those populations, that is when we would use a tool like that.

If we decide that in fact there are other, more pressing needs for our Treasury, then I think that is not the right tool.

The CHAIRMAN. Okay.

Dr. Aron-Dine?

Dr. ARON-DINE. I am also somewhat skeptical about broadening health savings accounts as a broad solution, because they are expensive and because they require people who may already be struggling to save in their 401(k)s to then also be able to save in HSAs.

That said, I think the objective of helping consumers choose, make better choices about their health care, is obviously an important one. And I think there is more promise to insurance designs that encourage preventive care and other high-value care as opposed to HSAs.

The CHAIRMAN. Thank you.

Senator Wyden?

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

Let me begin, if I could, with you, Dr. Aron-Dine. With respect to State flexibility—and the reason we felt so strongly about adding 1332 into the Affordable Care Act was to create more choices, choices for progressive States, choices for conservative States, so everybody would have the opportunity to get better.

Thus far, the number-one request from the States has been for reinsurance. That has been their single-biggest request thus far.

And Alaska used 1332 to get their reinsurance program. Minnesota is essentially moving forward—their Governor feels they are going to lower premiums 20 percent using the existing law.

So States may have ideas for speeding up the process to get reinsurance, that kind of thing. We are open to that. But I am very concerned about the possibility that some may be using the concept of flexibility to roll back consumer protection and to roll back protections on making sure people get covered and that coverage is affordable, and we do not want to go back to the days when there was all this junky insurance.

You are an authority on this subject. What does it mean if you roll back these basic consumer protections? I guess, technically, professionals call them guardrails, but, I mean, I think about them in terms of basic consumer protection.

What would it mean for Americans if you were to roll back those consumer protections I described?

Dr. ARON-DINE. Thank you, Senator. I think there is a lot of confusion about 1332 waivers, since, as you alluded to, they already allow a lot of flexibility. In fact, 1332 is an unusually broad waiver authority, and that is why it is coupled with, as you said, stringent standards or guardrails.

Those guardrails are really just the common-sense requirement that if States are going to make big changes, the coverage they

offer needs to be just as good, just as comprehensive, just as affordable, and cover as many people without adding to the Federal deficit.

If you were to poke holes in those guardrails, the consequences could be extreme, because the waiver authority is so broad. Effectively, States would be able to turn back the clock to the pre-ACA individual market where 75 percent of plans did not cover maternity care, where many people with insurance were exposed to medical bankruptcy because their plans did not have out-of-pocket limits.

Those are protections that could be waived, and that is why those strong standards to protect consumers are needed.

Senator WYDEN. Okay.

Mr. Slavitt, let us talk about prescription drug prices.

And, Mr. Roy, if you want to chime in too, I am happy to have you do it.

Here is my take on this. My take is that transparency in this marketplace would be enormously helpful. In other words, this is not a debate now about price controls and discouraging research and development. This is a debate, in my view, about ways to promote more information out there that can help hold down costs, ensure people get access to quality products.

I am told a number of States—the two Senators from New Hampshire told me recently that they are in the process of getting this information out to people of their States through their State government. And we are going to follow up on it, obviously.

But I have introduced a bill that would require companies simply to publicly disclose online, in various kinds of forums, the reason for price hikes. And we can debate the details of getting that kind of information out. But it just seems to me that sunlight would be an antiseptic here that would really make a difference.

One of the other reasons I believe this, and I think Mr. Roy is familiar with this, Senator Grassley and I did a year-and-a-half inquiry into the hepatitis C drugs, and we could not get anybody to really explain why they were raising the prices.

They constantly said, research and development. And Chairman Grassley and I would go through all these documents, but we could not find anything.

So I would like you, Mr. Slavitt—and, Mr. Roy, having read a lot of your scholarship on this, you are welcome to contribute as well—what would you think of the idea of simply, as a second big step for this committee, focusing on transparency with respect to pharmaceutical prices?

Mr. SLAVITT. So I think it is a very smart step. As you do, I greatly appreciate the work of our Nation's scientists. You know, with their help, we are going to make advances in Alzheimer's and cancer, heart disease. But if you talk to many of these scientists, they understand that the medicines that they are innovating are not getting to many of the very people who need them because they cannot afford them. They are as deeply troubled as I think the rest of us are.

Now, the fiscal conservative in me says these are Federal taxpayer dollars that we spend through the Medicare and Medicaid program, and we ought to have complete transparency into where

that money is going. And if someone is going to raise the price on, effectively, the Federal Government, because the Federal Government carries so much of that, we ought to know about it. And that, as you say, is a first step to helping people understand that there are a lot of costs and a lot of potential non-costs—actual profit margins—that are in different parts of the system that we all have a right to know about because we pay for them.

Senator WYDEN. My time is up, Mr. Chairman. But if Mr. Roy could answer, should he want to, that would be great.

Mr. ROY. Thank you, Senator Wyden. And I am grateful for the work that you and Senator Grassley have done to shine a light on this very important problem.

Transparency is an important first step. I think absolutely it can make a difference in highlighting reasons for price increases. But at the end of the day, we know why price increases happen. Price increases happen because the providers of these pharmaceutical products have the power to do so because taxpayers foot the bill.

Why do taxpayers foot the bill? For the same reason that hospitals can charge more and more money for services every year, because we subsidize health care and health insurance for almost everybody, but we do not, as a government or as a country, hold people accountable for costs.

There are only two ways to hold people accountable for costs at the end of the day: you can have a consumer-driven system where consumers are holding people accountable for costs, or you can have a government-driven system where government is regulating prices. So one of these two alternatives is really the only way, at the end of the day, to get prices down.

And one thing, as you know, that I have written a lot about is the importance of competition. We have seen through the Hatch-Waxman law and many other amendments to it how competition, generic competition, can do a lot to drive prices down for branded drugs.

One big problem we have right now is that FDA regulations and also the rules around biosimilars are not the same as they are for small-molecule drugs that are governed by Hatch-Waxman. So the more this committee and the Senate can do to make biotechnology drugs more reflective of the competitive principles embodied in Hatch-Waxman, I think that will make the biggest difference in drug prices.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman and Ranking Member.

And I first, Mr. Chairman, want to thank you for focusing on health care and moving forward with this hearing and our bipartisan efforts on the Children's Health Insurance Program. Both of these are very significant.

I would hope that the era of just moving forward on something partisan in a rush has stopped and that we will be moving forward with both this committee and the HELP Committee, because we have been having positive conversations about how to move forward and actually bring down costs and increase coverage.

And I do want to just stress something that Dr. Aron-Dine mentioned, which is right now 50-percent fewer people are uninsured than were a few years ago. In other words, 50-percent more people have insurance.

And in our State, that means taxpayers are saving money, because folks are not walking into the emergency room who cannot pay so taxpayers are picking up the cost, or health providers. So we are saving hundreds of millions of dollars in Michigan because people have health insurance.

But I wanted to follow up on what Senator Wyden was talking about on prescription drugs, because to go a little deeper—I know, Mr. Roy, Mr. Slavitt, you have an August report from the Bipartisan Policy Center, “Future of Health Care: Bipartisan Policies and Recommendations,” where you talk about long-term reductions in prescription drug costs, which I would argue are one of the main drivers of health-care costs at this point, at least from what I hear from doctors and hospitals and patients and so on. And certainly for patients, the number-one cost concern right now is skyrocketing prescription drug costs.

So I know you look at the long term, but we also need to be doing something sooner rather than later, when we have so many people who literally are choosing whether they are going to eat today or get their medicine. And so I wonder if each of you might talk in more depth about your recommendations to bring down the costs of prescription drugs and what the administration could be doing right now to make that happen.

Mr. Roy?

Mr. ROY. Thank you, Senator. Well, there are a number of specific details we could get into, and I have detailed them all in this document called “The Competition Prescription,” which we have published at our website, *freopp.org*.

A number of them, as I alluded to, involve making biosimilars, biologic drugs that right now are, first of all, more difficult to develop—and also the process for putting them onto the market is more difficult and more costly. That means that when biosimilars get onto the market to compete with biotech drugs, they charge higher prices and the competitive dynamic is not as robust as it is for the traditional Hatch-Waxman small molecules. So that is number one.

There are other things we can do. The Orphan Drug Act, while a well-intentioned effort to make sure that drug companies develop drugs for very rare diseases—we have kind of over-corrected for the previous system, and now we have a system where a lot of drug companies will generate studies for a small slice of a disease or a subset which grants them another 7 years of exclusivity for a drug that should have gone off patent. And a lot of companies are exploiting that to gain higher prices and market exclusivity.

The FDA has struggled with complex generics. So, for example, we know about the EpiPen controversy from a year or two ago. Asthma inhalers are another example. Where there is a generic drug, a very old drug—like adrenaline is a hundred-year-old drug—but a device that might have intellectual property, the FDA has struggled to figure out ways to allow generics to substitute for a generic drug but with a patented device.

And so Congress can play a role and the FDA can as well in streamlining the process for those kinds of products to get to market more quickly. Those are some examples.

Senator STABENOW. Thank you.

Mr. Slavitt? And by the way, thank you for your service at CMS. It was a pleasure working with you.

Mr. SLAVITT. Thank you, Senator. So I want to start by saying that I think Mr. Roy is exactly right. There are things we can do to increase competition, I think both with biosimilars, but also with branded products.

We did a study when I was at CMS which looked at the large amount of either branded or generic drugs that took price increases over 50 percent every year over the course of a number of years that were really invisible to people. And I think that the industry argued that those are retail prices and that they are not as important as the net price. But consumers pay, in the Medicare program, they pay their share based upon that retail price, so that is very important.

Secondly, I am concerned about States. State Medicaid plans, if you take the example of hepatitis C, all charged very different amounts for their populations. And so the best price that should be there for Medicaid certainly, was not there.

And then finally I will just say, while there is an array of things we can talk about, I look at the VA, and the VA has a very stringent—they are one of the largest purchasers in the country. And when I was running Medicare, I admired them: I wished that we had the power at CMS to be able to get medications as inexpensively for taxpayers as the VA does for veterans.

Senator STABENOW. Well, and I would just underscore my support for that as well. I think Medicare should be negotiating best price for seniors, people with disabilities, and I would also love to see us open up the border. Michigan is pretty close to Canada, right across a bridge or a tunnel. And we know that FDA-approved drugs are sold on both sides of that bridge. And on one side they are 40-percent less, on the Canadian side, than on the American side sometimes. So I personally would like to see that happen as well.

Thank you very much.

The CHAIRMAN. Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

And thank you all for being here. I appreciate the chance to take a look at health-care costs and coverage. It is an important topic, and I appreciate our panelists presenting their thoughts to us today.

Unfortunately, we still have a lot of Americans who are feeling the pain of the Affordable Care Act, which is why I have long believed we need to repeal the law, and one of the reasons for that is because we continue to see these monthly premiums escalate and go up.

If you look at the *HealthCare.gov* States, there has been a 105-percent increase between 2013 and 2017. And while the forecasts for completely bare counties next year has changed, higher costs, higher taxes, and fewer options continue to be the experience of millions of people across the country.

So, although it has been frustrating that efforts stalled this summer, I am glad that the talks continue on bipartisan options for market stabilization. And we certainly cannot lose sight of the fact that health-care spending continues to grow, both as a portion of our country's budget and of American families' budgets. And we have to look for better ways to reform our health-care system that will help both families and taxpayers in the long term.

So I would like to ask Mr. Roy, we have heard criticism from some of our colleagues of the recent decision by the Trump administration to reduce advertising funding for the upcoming enrollment period. However, the administration recently took steps to enable consumers to purchase ACA-approved plans online through a private health insurance exchange or through an agent or insurer.

What effect do you think these additional consumer shopping options will have on enrollment? And will it be more cost-effective for the private sector to be competing to enroll these individuals?

Mr. ROY. Thank you, Senator. Brokers, of course, have a historical role and a well-established role of helping consumers find insurance products that are suited to them. At the end of the day, you can do a certain amount of marketing to convince people to sign up for health insurance, but if the premiums are twice what people were paying before, or three times in some cases, and the coverage is really no better from their point of view, no amount of marketing is going to make them buy that product. And so that is ultimately the problem.

Marketing is not the reason why people are buying individual market insurance and neither is the mandate. The individual mandate, because of all the exemptions and loopholes and the weak enforcement of it—that is not really having an effect either.

At the end of the day, what is having an effect on enrollment is the price of insurance and also the subsidies that are being offered to offset the price of insurance. Those are the two big levers that Congress has to address enrollment and the exchanges.

And I would say the most effective thing we can do is make insurance less costly by reforming some of the regulations that do not have an impact on the quality of insurance or the value of insurance that people purchase, such as age bands.

Senator THUNE. As you know, in recent health reform efforts, I was interested in working to avoid the benefit cliffs that trap people in a situation where they cannot move up the economic ladder for fear of losing benefits. Have you done any analysis of the ACA's current tax credit structure and its impact on upward mobility?

You know, as we were looking at the tax credit and the discussions we had over the summer, that was one of the issues that we were trying to address. So maybe respond on ACA's current tax credit structure and its impact on mobility. But then secondly, what could be done better to both empower individuals and to address costs?

Mr. ROY. Senator, I followed closely and appreciate a lot of the work you did to address that problem.

I would say that, in general, the idea of a sliding scale of subsidies that gradually phases out as you go up the income scale is the right approach, because that minimizes a cliff that you might otherwise see if you have a benefit, like the old Medicaid program,

where you cross over the threshold of eligibility and, boom, you lose all that assistance and you are discouraged from lifting yourself out of poverty as a result.

So a gradual phase-out of subsidies is the right way to go. Switzerland has done that with great success.

In theory, the ACA will strive to do that as well. But the challenge is, because the premiums have gone up so much, there is this cliff at the 400 percent FPL, Federal poverty level, income threshold. So it is a very technically tricky problem to get the right balance because the prices, of course, are different in every State and every county.

But at the end of the day, having a sliding scale is the right approach. What we have to do is really address the underlying cost of premiums, because, as Mr. Haislmaier addressed earlier in his opening remarks, we have created this bifurcated system where if you are over 400 percent FPL, you are paying through the roof for these premiums. If you are under 400 percent FPL, you are somewhat insulated from the costs. And we need to bridge that gap a little better than we have.

Senator THUNE. Mr. Haislmaier, you wrote papers earlier this year regarding continuous coverage as a key to stable risk pools. Could you tell this committee about your ideas in this space and how it would affect health-care costs?

Mr. HAISLMAIER. Yes. Thank you, Senator. The issue with continuous coverage is that insurers spread risks and costs not just among a group of people, but over time. So somebody who is perfectly healthy—I have a college-age son who, you know, fractured his elbow flipping his skateboard, okay. Now, somebody like that is a good health insurance risk. But if you only get 6 months of premium for them, that does not cover the cost of that one incident, whereas if you get a year's worth of premium, it covers the cost of that incident and then some, and it is a profitable customer.

And what you are hearing from the insurers is people jumping in, getting coverage, and exiting when they do not need it.

Now the administration, the Trump administration, has tried to tamp that down with some regulatory changes. But in the end, it really comes down to the design of the law.

And so what I have recommended and what I said in my opening remarks—and as you mentioned, what I have written about—is, if we go back and look at the structure that was put in place for the employer group market, which is 90 percent of the private market, by the Health Insurance Portability and Accountability Act in 1996, we have a structure that works very well and it says, look, if you do the right thing and you buy and keep coverage, you take the coverage when it is offered, then when you change employers or your employer changes plans or whatnot, there is no pre-ex, you are guaranteed issue, you can get the coverage. You are not charged separately at a different rate—you know, pre-ex does not count. You have earned the right to be covered. And that gives you an incentive.

That created what analysts have called group-to-group portability. The problem was HIPAA did not go further. It did not do a very good job of group to individual, and it did not do anything about individual to individual portability.

So what I would do is, I would condition—this is the single-best way to do it—condition the prohibition on preexisting condition exclusions that applies if you have continuous coverage, and then there is a path to earn it.

And by the way, all the people who have gotten covered now would qualify, since they have already gotten coverage. That is the absolute best way to do it to make it most effective so that people are in the system and paying premiums when they are not actually needing medical care.

Otherwise, people have found it just too easy to drop out when they do not need medical care. I have had insurers say, we could not believe that people would get this subsidized coverage when they needed medical care and then would not pay the next month's premium, even though after the subsidies it was only \$10.

Senator THUNE. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Heller?

Senator HELLER. Mr. Chairman, thank you.

Thank you to the panel for being here today. I certainly appreciate your expertise and your taking the time.

And issues related to health care are so important for the State of Nevada and, of course, across the country. And there is no doubt in my mind that every member on this committee and probably on this panel is committed to discussing and finding solutions to our health-care needs here in this country.

So I would argue that health-care reform should do three things, and they are to lower costs, increase access, and improve the quality of health care in this country. I cannot imagine that anybody in this room would disagree with that.

And one of the critical ways to accomplish these goals is to provide States with the tools they need to meet the unique health-care needs of their patients, and that is why I have been working with my colleagues Senators Cassidy and Graham on a proposal that will take the decision-making process and money out of Washington and bring it back to the States.

So one of the goals of the Graham-Cassidy-Heller bill that I think is so important is providing States with an increased flexibility to innovate, come up with tailored approaches that are most appropriate for their citizens.

So, I guess, Mr. Roy, I will direct this question to you. Are you familiar with the proposal?

Mr. ROY. I am somewhat familiar with it. I mean, I have seen outlines of it and things like that that have been circulated. I obviously have not seen legislative text. I am eagerly awaiting, as many people are, your big rollout on Wednesday.

Senator HELLER. Does a 50-State solution make sense?

Mr. ROY. I think it does. I mean, I certainly am a big believer in the value of State flexibility. I am also a big believer in the value of individual flexibility. And I think one thing that is very important is to make sure, while States should have more flexibility to run their health-care systems in a way that reflects the unique populations in their States, I hope that we can also make sure that individuals have as much choice as possible and that the

Federal Government is not limiting the choices that individuals have to seek the coverage and care that they need.

Senator HELLER. One of the reasons why I am attracted to this piece of legislation is that recently in the State of Nevada we were going to have 14 bare counties as of January 1st next year. Fortunately, through the work of our office and the Governor's office, we have found a carrier that will cover those 14 counties, but which means no choices, this is your only choice. And so it has caused some great concern as to how long, of course, this particular carrier will stay with us.

You talked a little bit about flexibility. What will this flexibility mean for premiums and for enrollment?

Mr. ROY. Well, what flexibility could allow—and a lot of it will depend on the details of your legislation and other efforts to provide this flexibility—is that by reforming some of the regulations in the ACA that I described that are particularly responsible for higher premiums, you can bring premiums down, and you can expand the choices that people have to buy coverage that suits their need. That means more people will enroll in health insurance, and you will have more people with coverage. That means less uncompensated care.

And it also means that States can refine the criteria for eligibility in ways that make sure that the maximum number of people who need help are getting it.

Senator HELLER. Mr. Haislmaier, I mentioned, and Senator Thune also mentioned, the fact that on these bare counties, the situation with these bare counties—and 14 of 17 counties in the State of Nevada would have been bare except for the intervention of my office and the Governor's office. Again, we do not know how long we will be able to keep it together.

Do you anticipate that States will be faced with similar situations in the future, in other States besides just Nevada?

Mr. HAISLMAIER. They will, and I would say that my take on it is I do not think—and I said this in my written testimony—that those counties will remain bare.

I think what played out in your State of Nevada, Senator, is likely to play out elsewhere, and that is that there will be an insurer that steps in, because this subsidized market has really two-thirds below 250 percent of poverty. This is really very close to a Medicaid eligibility market. It looks like Medicaid, the enrollees.

And so what will happen—and I think it was interesting in your State, the carrier that stepped in is Centene. It is a company whose basic business is Medicaid managed care. And I see that as the norm. I see that as the steady state for the ACA, which is, the subsidized market will be served most places outside of major, major metropolitan areas by one carrier. The one carrier is probably going to be a carrier that has experience with basically Medicaid managed care, because it is going to look a lot like Medicaid, the population is going to be looking like it.

And this is very generous coverage, with the government paying the subsidies. And if you are the only carrier there, you can charge whatever, because the enrollee does not pay anything. If the price goes up, the government just simply gives you a bigger subsidy.

So I think exactly what happened in Nevada will happen elsewhere. You know, in Ohio the same thing happened. CareSource is a local Medicaid managed care company. It is in Ohio and Kentucky and West Virginia. And they stepped in and filled the gaps in Ohio. I would see that happening elsewhere.

Now you know, the good news is they will probably stick around, but that is what the market is going to look like. It is not going to grow; it does not get better from here. You are not going to get more healthy people in there; no amount of advertising is going to do that. You are going to have what you have today.

Senator HELLER. Yes.

Mr. Chairman, thank you.

And thank you to the witnesses.

The CHAIRMAN. Thank you.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman.

This is an interesting discussion, and I would like to keep it going on this topic.

First of all, I want to know from each of you “yes” or “no” if you think managed care helps drive down costs.

Mr. ROY. It depends on how much flexibility Congress gives managed care to drive down costs.

Mr. HAISLMAIER. It would partly do that. Managed care has different tools to drive down costs. What we have seen in the ACA is, it is mostly selective contracting with providers. That is, I think, part of what explains lower premium increases in California, because they were already doing that before the ACA and maybe in your State, Senator, as well.

That runs into trouble when you have this situation which is occurring in rural areas where, on the one hand, you have an insurer monopsony, they are the only insurer, but on the other hand they are up against a provider monopoly, they are the only provider. That makes it very difficult for any plan to play providers off to bring costs down.

Senator CANTWELL. Mr. Slavitt?

Mr. SLAVITT. Yes.

Senator CANTWELL. Thank you.

Dr. ARON-DINE. I would also say “yes,” I think both for the provider contracting reasons identified, but also because managed care can take advantage of care coordination tools and other things that actually reduce costs by improving health.

Senator CANTWELL. Okay. So I am going to generally take that as everybody is in agreement that managed care is a good idea. Okay.

And I am assuming—I am not even going to ask the question; you can nod if you want to—the delivery system reforms that keep driving down costs are also good and we should pursue them.

I mean, we are all having this big discussion here about the system and how we pay for insurance, but in reality we need delivery system reform to drive down the costs of health care. Several of you mentioned that in your testimony.

One thing I am interested in—and maybe, Mr. Slavitt, you are the best person to answer this—I am also interested in a different

concept in the purchasing market, which is: when you buy in bulk, you get a discount.

Now, I guess you could say that that applies to negotiated rates for either drugs or for health care. But we have seen, at least with the basic health plan for New York anyway, that they were able to drive down costs because they have bundled up a population and 13 different providers wanted to bid on that. Why should we not be pursuing that more?

Mr. SLAVITT. Well, I live in a State, Minnesota, that has taken advantage of that, and it has worked very well. And to your broader question, Senator, I think what we are seeing in the marketplace is what we should see. We have had a major disruption, a new set of rules for covering folks, and some insurers are doing quite well with it because they focus on affordability, they know how to buy in bulk, they know how to contract. Others say, that is not us, we prefer to serve the large-group employer market where it is about tailoring hand-picked services to people.

But affordability, if affordability and cost are the keys for our country, those are the people I hope are the winners in offering coverage.

Senator CANTWELL. Well, to Mr. Haislmaier's point about these people who are in that Medicaid market, I mean, what is wrong with that? I mean, in the concept of people who know that business and are getting very good at driving down the cost of that delivery system, what is wrong with that?

Mr. SLAVITT. Nothing is wrong with that. You know, I have been very close to this market, having overseen it for 4 years, and I would say the people who do well are the people who really know how to build relationships with patients. Medicaid plans have historically done better at that—because these are people with a lot of needs.

But it is also true that there are new tech-innovative insurance companies that know how to build digital relationships with people. There are many Blue Cross plans that have a brand and relationships in their community that do quite well.

So I suspect that it will be the commonalities will not necessarily be the type of plan, but their philosophy and how they build relationships with physicians, hospitals, and patients.

Senator CANTWELL. Mr. Haislmaier, what are you saying about that two-thirds of the population that lives below 250 percent of poverty? Are you saying that they should have access to these?

Mr. HAISLMAIER. Well, what I am saying is, there is sort of what is and then what should be. The what is is, effectively, the way the law works is it is sort of like a Medicaid expansion-plus, basically. And so in thinking about the individual market, the half of the market that is not getting subsidized, those are the middle-class people who want a financial service product. They were the people who were in the market before the ACA.

What this half of the market is is really something that looks like Medicaid and is sort of devolving down to that because that is the target population. It is very generous coverage like Medicaid. And so what I am saying is, these are two different groups of people who are looking for two different things. The people who are

not subsidized, they want more choice of insurer, they want more choice of provider, they are more consumer-directed.

The buying in bulk strategy, the downside to that, if you will—and this is the sort of what should be—is it presupposes that patients are just sort of like a herd of cattle and they are all the same and you just shift them around as opposed to them having a lot of say in the subject. You know, sort of “you get what we have.”

Senator CANTWELL. Yes, but Mr. Slavitt—I think the New York case had 13 different providers chasing that market. What was interesting for—

Mr. HAISLMAIER. Yes, but it is a bulk contract.

Senator CANTWELL. But, hello, like, that is the answer. Anybody who is going to serve up 650,000 people to you instead of having to search for them on the exchange, it was, like, they said, yes, I would like a piece of that, and here is how much I am willing to bid on it. So it put those individuals in the marketplace in a better position of having the clout that you would want somebody who was with a large employer to get.

But I mean, you think we should drive down costs, right, of the 250-and-below market? If we can drive down costs there, we should drive them down.

Mr. HAISLMAIER. Well, yes. I mean, the question is, as Mr. Roy was saying, how do you do that? Are you doing that by creating incentives in the marketplace for people who provide better value by providing lower cost and better results to get more business? These are providers, versus sort of the government at CMS saying, well, this is what you should be charging, et cetera.

Senator CANTWELL. Well, my time has expired, Mr. Chairman.

But yes, that is why I started with managed care, because I think that managed care does that. I think managed care drives down the cost.

I think when we look at this population and everything going forward, there is so much we need to discuss on health care in the delivery system that is going to drive down cost. But yes, getting a plan that manages that population for the most cost-effective way, and for us to help with the cost as well, that is going to be key.

So thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator.

Senator Cassidy?

Senator CASSIDY. Hey, gentlemen, I have enjoyed my conversations with you all.

Dr. Aron-Dine, I have never had the pleasure to speak with you, but I enjoyed your testimony, so thank you.

And I hope you do not mind me being familiar and using your first names, but I am kind of used to that, and I do not know how to pronounce Ed’s last name, so it works out well.

Andy, you and I have had a lot of conversations. The Graham-Cassidy-Heller amendment, I see you have written about that. But let me just ask conceptually, would it be acceptable if a State put in a combined 1332/1115 waiver if they wanted to combine their risk pools for the Medicaid expansion plus their individual market?

Mr. SLAVITT. Good to talk to you again, Senator Cassidy. And, you know, I think the good news is that, under the way that the

1332 legislation was crafted, you in fact can create combined 1332/1115 waivers. And for those who do not know, those are Medicaid and exchange-based subsidies. And I would be encouraging of States to take those steps.

Senator CASSIDY. So, just because I have limited time, if the Graham-Cassidy-Heller amendment basically allows a State the flexibility to use a combined 1332/1115, but instead of having two different review processes, you kind of combine it, just kind of in concept, is that okay, or is that something objectionable?

Mr. SLAVITT. No, but I have one significant concern, as you and I have talked about before, which is, the idea behind the waiver should not be to be able to take money out of the Medicaid program and move it into another program. That I would have concerns with.

Senator CASSIDY. Okay. But in concept, that is a fair statement. A waiver with guardrails, if you will—okay. Yes, I actually think you may end up being a cosponsor of Graham-Cassidy-Heller.

Ed, I really enjoyed your very succinct kind of breakdown of the individual market. I thought you put it very well. There is a fellow back home, Moon Griffon. He has a child with special needs, he is a small businessman. He is paying over \$40,000 a year in premiums on the individual market with a deductible. He has a special-needs child—he says this publicly; he has to buy insurance. He is paying the mortgage for a \$500,000 home—it is just incredible.

And so let me ask, though, in your testimony you suggest that the mandated benefits actually are a significant cost driver. But I have spoken to three or four different insurance companies, and they have all said that the mandated benefits are only about 4 percent of the total premium and I think 14 percent of the cost increase since the ACA passed.

And on the other hand, I think there is pretty good data that when mental health parity was put in in the Federal Employees Health Benefit Program, within the first year there was actually a cost savings. People with unmet needs were getting them addressed, and you actually had a cost savings within 1 year. Any thoughts about that? Because that is a little bit contrary to what you had said in your comments.

Mr. HAISLMAIER. Yes. There were a number of actuarial studies that were commissioned by States on this subject, and we sort of did a review of this and looked at it and published it. On average, it was about a 9-percent increase in premiums, but the literature shows that it is 3 to 17 percent. I think part of that is State variation, because—

Senator CASSIDY. Just because I have limited time—so the 9 percent does not actually seem unreasonable to me, but I have to pick my political battles. I have people who have never read my legislation condemning it. And so if I am going to pick a political battle, am I going to pick something which is only a 9-percent increase, or 4 percent of the total? I guess that is my question.

It sounds like, although it may increase the cost, relatively speaking, it is not the huge cost driver.

Mr. HAISLMAIER. It is—yes, there are several. The costs are a product of that and other things. And that is why in my testimony

this morning, I focused actually not so much on the benefits but on creating the incentives for continuous coverage.

Senator CASSIDY. Got it. So one more thing—

Mr. HAISLMAIER. And that is actually one of the bigger issues.

Senator CASSIDY. And one more thing. I think you omitted reinsurance, such as the Maine invisible high-risk pool, which is essentially a reinsurance program pre-ACA. And I think it was thought by the folks in Maine to have lowered premiums by 20 percent in their individual market.

Now, I think I got from your comments that you feel like that helps the subsidized population more. But again, I think of my friend Moon Griffon—it does seem like a hidden reinsurance pool, in which his daughter with significant needs would, you know, still have care management. To Senator Cantwell's point, I think the real issue is care management as much as managed care. So she still gets the care management, but there is that kind of hidden reinsurance.

But it seems as if you were nihilistic of whether reinsurance would help those in the non-subsidized portion of the individual market.

Mr. HAISLMAIER. It may have some benefit to those in the non-subsidized portion of the market, but most of the cost driver has been in the subsidized section of the market. But you are right, there are some cases there.

The issue with reinsurance as it is being discussed is basically, you are having the taxpayers step in and provide a back-door premium subsidy. That is really what you are doing. And so that raises the following question: what limits are there on that?

Senator CASSIDY. But you could argue, I think, if you go to Dr. Aron-Dine or Mr. Slavitt—both suggested that there is a certain premium for uncertainty. And so you get a little bit more bang for the buck, don't you, because you are creating certainty and, therefore, maybe deflating the driver of, we have to raise the premium because we do not know what is going to happen.

Mr. HAISLMAIER. No. As the reinsurance program was implemented under the ACA for 3 years by CMS, I mean, there was a fair amount of certainty there. It was basically underneath commercial reinsurance. Commercial reinsurance, they figured, would kick in about 250,000 a year of claims. So they said, right, we will subsidize between 45,000 and 200,000 claims. And so basically, it is just a subsidy going in there.

And so the issue has become, what parameters could you put on that in terms of both the timing and the amount? And then, what is to keep those parameters in place? And then finally, what is to keep or prevent happening, if those parameters get breached, the government stepping in and saying, well, to lower the cost to us as the reinsurer—

Senator CASSIDY. I am way over; I have to cut you off.

Mr. HAISLMAIER [continuing]. We are going to dictate your price for what—

Senator CASSIDY. I yield back. And thank you for your forbearance, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Now, I have to go to a meeting, so we are going to turn the time over to Senator Carper and then Cardin and then the Senator from Pennsylvania.

But I want to personally thank you all for being here. This has been a very, very interesting committee hearing, and I have been personally very interested in what you have had to say.

So with that, I am going to turn the time over to you, Senator Carper. If you will continue the hearing, I would appreciate it.

Senator CARPER [presiding]. Yes, thanks very much, Mr. Chairman.

In one of my first acts as chairman of this committee—
[Laughter.]

I had better not go there.

Had Chairman Hatch stayed, I would have said to him, we need more hearings like this, not fewer.

And we have people like Senator Cassidy and others who have an idea that is worth vetting, it is worth having a hearing on, and that is what we should do. We should be all about regular order. If folks have a good idea, let us have a hearing, let us bring in witnesses for and against, and let us have conversations outside of this room. That is what we need to do.

I think I have mentioned the importance of competition. I think Mr. Roy did so, I think, especially well.

And I want to turn to, if I could, Mr. Slavitt and Dr. Aron-Dine to help us think about developing consensus.

But before I do that, I want to say, Mr. Haislmaier, I just want to thank you and the folks at Heritage for giving us Obamacare. I sat here many times in this room. Where did the idea of the exchanges come from? Well, it was Heritage. Where did the idea of the individual mandate come from? Well, it was Heritage. Where did the idea of the employer mandate come from, the sliding scale tax credit, the prohibition against insurance companies denying coverage because of preexisting condition? Heritage is the gift that keeps on giving.

I was talking to Jim DeMint, former colleague Jim DeMint, the other day, and I said we owe you a lot for those gifts.

And no, no, no, you do not have a chance to respond, but we want to thank you for all those gifts. [Laughter.]

And I want to ask Mr. Slavitt and I want to ask Dr. Aron-Dine, thinking through the need for predictability and certainty and Mr. Roy's points on competition, if you look at the States where they have a lot of competition in the marketplaces—California, Minnesota come to mind, maybe New York—where we have a lot of competition, frankly you do not see the kind of huge increases in copays and deductibles and premiums.

And just think out loud for us, and especially looking at the things that our other two witnesses have said, things that we ought to do, should do, responding—anything that you have heard, either of you—saying, by golly, those are good ideas, whether they happen to be on this side of the panel or this side, really good ideas for fostering competition, because I think that is the key, a big part of the key.

Mr. Slavitt, please.

Mr. SLAVITT. Yes. And look, you know, I am a believer that in life it is 90 percent about implementation. And what we have seen is that States that really set out to create a competitive market, to create an affordable market, to cover more people, did so and have done so well. And of course, us, the Federal Government, and our country, we ought to be looking at things that got in the way, that did not allow that, that could allow States to do that better.

So if I were to focus on the challenges, the biggest challenges I think are in two places: one is, States that chose not to implement Medicaid expansion or their own exchanges and so forth, but also States that have large rural populations.

You know, considering Senator Heller's comments, he has vast regions of that State that have very, very low population density, very few hospitals.

So I have talked to probably more insurers about enrollment than probably anybody in the country, and many of them say, we do not have contracts with that hospital. So until we change the structure of how things work in rural America—and I think there are good ideas on the table, such as allowing people to buy into the Federal employee plan perhaps, allowing people to buy into a Medicaid managed-care plan, creating some other forms of competition—I think we are going to continue to see these sorts of needs in rural America in particular.

Senator CARPER. All right.

Dr. Aron-Dine, I am looking to draw on ideas you have heard from the other two witnesses, the first two witnesses, to help us think about, what are some of the things that they have said that would help us foster greater competition and bring down the copays, deductibles, premiums?

Please.

Dr. ARON-DINE. Thank you, Senator. If you look across the country this year, we have seen some insurers expanding into new markets, and then we have seen withdrawals, almost all of which have had insurers linking them to the Federal policy uncertainty. So I do think the first and most straightforward thing to do to address competition is to address those sources of uncertainty around CSRs, mandated enforcement, and outreach.

Another straightforward step, which Andy alluded to, even though it is outside the marketplace context, is to expand Medicaid by improving the risk pool. That can encourage insurer competition.

But to respond to your request for other ideas, I think reinsurance is one that has come from bipartisan sources and can help with competition if it addresses, as Mr. Haislmaier said, the tail risk, the truly uncertain cases of really expensive people whom insurers, especially smaller, regional insurers in smaller markets, have trouble pricing for.

And then I think the deeper issue, which a number of people alluded to, is places where there is limited insurer competition, often a long history of that, long before the ACA, and limited provider competition. And those are the places where I think you might want to think about some form of public option, which can be a way of getting at over-consolidation in both markets.

But just one observation. As we talk about what is going on in the marketplaces, you know, one way to figure out how coverage is working for people is to ask them. And a survey last week found that more than 80 percent of people in these markets are pleased with their coverage, so I do think the goal should be to build on that with greater affordability and competition, as you said, but not to think that we should somehow be reversing the basic construct of those markets, which is working for most people.

Senator CARPER. All right. As a new chairman, I am tempted just to grant myself another 15 minutes to ask questions, but I have to live with these guys, so maybe I will just stop it there and recognize Senator Cardin.

Senator CARDIN. Well, thank you, Chairman Carper. I appreciate that very much.

Let me thank the panel. I agree with Senator Carper in that we should have more hearings like this. This is important, and I think we are getting some great discussions.

The problems of Maryland, particularly in the individual marketplace, are typical of problems we have around the Nation. And when I talk to our insurance companies of interest, they tell me their main problem with the increase in premiums has to do with the risk selection, so reinsurance will help in the short term, no question about that.

Enforcing the mandate would help greatly—they mention that.

But then when you get to the second problem, which is affordability, because you mentioned the issue of the \$40,000 premium, the problem there basically is the overall cost of health care and the lack of enough competition. Competition certainly would help, and I support a public option. I think a public option would be helpful.

But let me just drill down on the cost issues. In Maryland, I tried to find out the per-capita cost of health care, and it is somewhere around \$8,600. So for a family of four, that is in excess of \$34,000. And if you do not have an employer making a contribution and you are not eligible for subsidies, then I do not care how you divide it, whether it is the premiums or the out-of-pocket expenses, it is going to be around \$34,000, and that is not affordable to a lot of families.

So we have to deal with the realities. So one of the suggestions that is being made is that we can solve this by giving more flexibility to the States. Okay, maybe that can work.

And then I hear about guardrails, which to me are absolutely essential, because I do not want to see us do flexibility to States where less people have insurance coverage or the quality of coverage is affected, because that does not help deal with the out-of-pocket costs for those who are going to need health care in the future.

So, Mr. Slavitt, how do you reconcile flexibility, the realities of which we are dealing with right now, and being able to politically maintain the guardrails necessary so we do not find millions of people losing health coverage or that all of a sudden certain areas of the health-care coverage are gone?

Mr. SLAVITT. Thank you, Senator Cardin. You know, I think the topic of 1332 waivers is getting its due, it is getting its 15 minutes in the spotlight, as it should.

And I think, as people are beginning to understand it, one of the things that is important, and Dr. Aron-Dine said as much, is there are tremendous flexibilities in the way that the law was written that allow States to do a number of things, from, as Maryland does, an all-payer solution, to delivery system reform, to reinsurance—you know, many, many other things.

All that the guardrails suggest is that States have to not use money that is going to people's coverage in ways that cause them to lose that coverage or make that coverage more expensive or somehow bring them back to a place where they do not know what they are getting. And of course, they have to do it in a fiscally responsible fashion.

I think those are fairly common-sense rules that have been big advancements in this country; they are massively popular.

But within that framework, I hope that we live in a world where over time many, many States take advantage of opportunities, whether they are more conservative or whether they are more liberal, it does not matter, but that they take these new approaches, and those new approaches, I think, will be good for people and will also help us learn.

Senator CARDIN. Well, one of the problems that we run into on this is that there are different definitions on value added by the local flexibility. And if the value of the package is comparable, but certain services are not covered—let us just take behavioral health for one moment—then clearly there is an element in our population that is being adversely impacted by the local flexibility. How do you protect against that with the guardrails?

Mr. SLAVITT. Well look, I think the standardization of benefit design is to say that when you buy an insurance product, you do not have to worry about whether or not, God forbid, your child, whom you do not think will need mental health services, next week needs mental health services and you do not have to go, oh, it was not in my policy. So a certain amount of standardization is good.

Actually, standardization leads to innovation. You know, we have very innovative automotive companies like Tesla, but they all have to meet a basic standard. It does not mean that they cannot innovate.

So I do not think we should be going back, personally, to a place where 75 percent of policies do not offer maternity coverage. I do not think we should go—

Senator CARDIN. I am in agreement with you, but there are some proposals that are out there that, in the name of flexibility, would allow a redesigned policy that could leave out maternity benefits or could leave out mental health or could leave out addiction or could put, again, arbitrary caps on that.

Mr. SLAVITT. And I think that is what the guardrails are for.

Dr. ARON-DINE. And if I could just add, I think the key issue here is that a la carte health insurance does not work. If you say that plans do not have to cover behavioral health, that is not actually a choice for people about whether to buy behavioral health insurance because, in practice, the only people buying plans with

those services are those who need them. And the costs become unaffordable, and it is no longer insurance; it is just requiring people to buy their own health care coverage.

So I do think that the confusion about how choice actually works in health insurance and the need for pooling is confusing some of the conversation about exactly those issues, Senator.

Senator CARDIN. Thank you all very much.

Senator CARPER. Senator Casey?

And then it looks like, unless someone else comes, Senator Brown.

Senator CASEY. Thank you, Senator Carper.

We had a long, several-month-long debate in the Senate, and the House as well, on health care. The principal reason that I remained unalterably opposed to the various Senate bills is that they centered on Medicaid. And I remain unalterably opposed to any attempt to do what they tried to do in those bills.

So we had a big fight about that, and I hope that does not arise again. It might in the context of this discussion about Graham-Cassidy-Heller.

At the same time, since July the 28th, there has been a lot of very positive bipartisan, not only discussions, but now actual hearings. We are in our second week of bipartisan hearings in the HELP Committee. It has not happened in years, so we are in a good place right now trying to solve near-term, real problems, not some problems that people point to, which are not significant, but real problems in the marketplace in terms of stabilization, cost-sharing reduction payments, and the like.

So the concern I have is, not only will that bipartisanship that will solve real problems in the near term be derailed—that is concern number one—but I have a larger and more overarching concern about what a bill like this could do to Medicaid.

Dr. Aron-Dine, I am going to direct my question to you first—not simply because you have a Swarthmore degree, but that helps enormously—and it is centered on this concern that I and many people have about Medicaid.

On page 11 of your written testimony, you set forth the standard or the principle of building on progress. And then you said that, including the recent bill, that that principle of building on progress would be violated. Quote, “Each,” meaning each bill, you say, “each would cause millions of people to lose coverage and make coverage worse or less affordable for millions more.” And then you go on to explain it. I want to read that into the record.

But if you could, highlight or expand upon your concerns about the so-called Graham-Cassidy-Heller bill.

Dr. ARON-DINE. Thank you, Senator. We have been talking a lot about State flexibility in this hearing, but I think what is clear is that for State flexibility to actually benefit people, three criteria need to be met. There need to be resources, there needs to be appropriate risk-sharing with the Federal Government, and there need to be standards that actually protect consumers.

And unfortunately, as far as I can tell in the not-yet-introduced Graham-Cassidy legislation, those standards are not met; and therefore, the consequences would be very similar to the previous repeal bill.

That is because the basic construct of the bill, as I understand it, is to eliminate the expansion of Medicaid under the ACA, completely eliminate the ACA subsidies—so it would go beyond the earlier Senate bill and actually leave working people with no guarantee of financial assistance in the individual market—and completely overhaul the underlying Medicaid program.

And in place of expansion and subsidies, what States would be left with is a block grant that provides fewer resources, does not address any unexpected costs—including not growing at all during a recession when millions of people lose their jobs and need exactly the coverage that expansion and the subsidies provide—and would also redistribute across States in ways that would leave some States facing even deeper cuts, sort of counterbalancing the statement by the Senators that the goal is to let States maintain the ACA coverage gains if they want to. They just would not be feasible. It also undercuts some of the ACA's protections for people with preexisting conditions.

And so, because the construct is the same as those earlier Senate bills, I think the consequences would be the same; namely, many millions of people losing coverage and big gaps in affordability, especially for vulnerable low-income people and vulnerable moderate-income people who have preexisting health conditions.

Senator CASEY. I appreciate that.

I am almost out of time, but, Andy Slavitt, is there anything you want to add to this?

Mr. SLAVITT. Well, I agree with Dr. Aron-Dine. And as much as I appreciate what I interpreted from Senator Cassidy as basically the sponsor of the legislation, you know, I have significant problems with it. And he knows that. And to his great credit, he seeks input from his critics, which I greatly admire and I think is reflective of the spirit of this conversation today.

But to me, it is fairly simple. Anything that cuts access to care for people who are low-income or modest-income or who are living with disability or are seniors is something that I am going to be opposed to, and I think the vast majority of the American public will as well.

This cuts Medicaid expansion instantly. And it also cuts care across the populations that Dr. Aron-Dine described.

And then further, what I think is even more challenging is, it takes States, big States that have significant health-care issues, like Florida, like North Carolina, like Ohio, and like Pennsylvania—by the way, I went to—

Senator CASEY. That is right, you did. I forgot to mention that, I should have.

Mr. SLAVITT. But as all of those States have severe cuts—over time everybody has a cut, that is part of the design—but there are significant cuts in some of these States that I do not think are, quite frankly, manageable, having talked with a number of Governors and insurance commissioners and Medicaid Directors. I just do not know how it is possible.

Senator CASEY. I am over time.

But, Dr. Aron-Dine, I will submit a question for you on 1332 and 1115, because in the HELP Committee, that is one of the issues we

are dealing with, and there are some concerns that have been raised about combining those.

But Senator Brown is waiting, and I never want to hold him up because he is a great questioner, and I think I do not want to hold him up any longer. And I am over by 1 minute and 12 seconds. Thank you.

Senator CARPER. All right. Before Senator Brown begins, let me just—I had not planned on getting into this, Senator Casey, but those witnesses who actually went to college in Pennsylvania were wait-listed at the University of Delaware. [Laughter.]

I just thought I would get that on the record.

All right. Senator Brown?

Senator BROWN. And Senator Carper, not to play too much university stuff, went to The Ohio State University. So how about that?

Mr. Slavitt, thanks; it is good to see you again. Thanks for your service and your speaking out about the importance of stabilizing the insurance market, of getting younger, healthier people in the market, your work to do that. And I know that you are particularly concerned about the repeal-and-replace debate and the constant threats from the Trump administration and about the injection of uncertainty into the insurance markets.

You could have predicted, as many did in this body, what would happen in State after State after State. In my State, as you know, Anthem made the decision to exit Ohio's exchange for the 2018 plan year. Twenty counties in Ohio were left without an insurer for 2018. That was several months ago.

The news today was of CareSource agreeing to offer coverage to the 88th county, and other insurers, including CareSource, stepping up after Anthem. In spite of the uncertainty injected by the Trump administration, in spite of the "woe is us, the sky is falling" view of right-wingers who are trying to repeal the Affordable Care Act, Anthem offered coverage in Paulding County, one of our smallest counties, at the Indiana border, so now we at least have that.

Now is the time for this Congress to come together. I appreciate Senator Casey's comments. I know that Senator Alexander and Senator Murray are working to do that.

I want to talk to you about lowering costs. My colleague Senator Cassidy and I recently wrote to the Secretary of HHS urging him to work with us to convene a panel of experts to discuss delivery reform, a better way to pay for care. I am hopeful you will be involved in that.

We also, in addition to delivery service reform—and there are good ideas about what to do there, Mr. Slavitt—we must address the outrageous prices of prescription drugs. I get calls and letters pretty much every day from Ohioans who are struggling to afford their medicines and their premiums.

Let me ask you a series of questions about that. What can Congress do to address the high cost of prescription drugs with a goal of lowering costs for everyone?

If we are successful in addressing the cost of prescription drugs, will we better be able to control the rising costs of premiums?

If you would just expand on sort of either the Slavitt plan, if you will—

Mr. SLAVITT. Thank you, Senator. Yes; we have this wonderful dichotomy in our country right now where we have the best scientists in the world who are working on cures to cancer, to Alzheimer's, to heart disease, and yet the Americans who most need them cannot afford them.

And the States, including many of the States that are represented here on the committee, are increasingly facing challenges where, as the cost of prescription drugs go up, it becomes challenging for their Medicaid programs. So I think there are a number of things we ought to be thinking about and looking at.

You know, I would start with where Senator Wyden has been focused, on transparency and making sure that the American taxpayer, who is actually paying the cost of these drugs, and the American consumer, knows what is happening, where the costs are, where they are increasing.

Secondly—and I think I credit Mr. Roy for many of these comments—there is a lot we can do to make these markets more competitive, both for generics, for biologics, but also just for name-brand drugs that have been on the market for quite some time.

And then, you know, when I ran—

Senator BROWN. For biogenerics especially, for biologics, yes.

Mr. SLAVITT. Yes, that would be one. And then I will say that when I was overseeing the Medicare program, I was envious that at the VA, at the Veterans' Administration, they were able to use the power of the VA to buy drugs for veterans in a really efficient, affordable fashion and to be able to direct people to the most effective and efficient drugs.

We could not do that at Medicare. That cost the Federal taxpayer lots of money, but it also cost Medicare beneficiaries a lot of money in their copays. So I think those are the issues that we should be going at for prescription drugs.

Senator BROWN. Good, thank you so much.

Thanks to all four of you.

Senator CARPER. Mr. Slavitt, you mentioned, I think, five steps that you suggested that we take in your testimony. I think one of them dealt with the CSRs. I think one may have dealt with restoring cuts to marketing. I think a third dealt with reinsurance. Another one was to speed up the 1332 reviews.

I am going to ask you to just briefly restate those, and then I am going to ask each of our witnesses to just react to them briefly, to your ideas. Okay? What was the first one?

Mr. SLAVITT. Yes. So the first one is funding cost-sharing reductions through 2019.

Senator CARPER. Okay. Let me just ask, just very briefly, if I could, each of our witnesses, please.

Mr. ROY. I support funding CSRs in concert with other reforms that reform underlying premiums. That is reflected in my testimony.

Senator CARPER. All right, thank you.

Mr. Haislmaier? Thank you for being a good sport, Mr. Haislmaier.

Mr. Haislmaier. Yes, I will correct the record on that later. [Laughter.]

Funding for CSRs for a couple of years will provide certainty. It would equally work if, just as CBO shows, it is paid and put into the premium, so it is just stabilizing the subsidies.

Senator CARPER. All right.

Same question, Dr. Aron-Dine.

Dr. ARON-DINE. I agree with the recommendation, and I would just underscore the importance of long-term certainty.

Senator CARPER. All right.

Restoring cuts to marketing, I think that was the second point. Yes? Just very briefly, how do you rate that, Mr. Roy?

Mr. ROY. As I mentioned in an earlier question, I do not believe it makes much of a difference either way.

Mr. HAISLMAIER. Yes, I think that is a waste of money. It is pretty clear that you are not going to get a more healthy market from this.

Mr. SLAVITT. Do you mind if I answer my own question before Dr. Aron-Dine?

Look, let me just say, what we found—

Senator CARPER. Just very briefly.

Mr. SLAVITT [continuing]. Overseeing the exchanges for 4 years is that most people do not know the options available to them yet, despite the fact that we think that all people think about is health care.

The fact that eight out of 10 people can buy a policy for under \$100 a month and most people do not know that—we have cut the open enrollment period in half, and many people think we have repealed the ACA to boot because of all the rhetoric.

So that is vital money, and it comes out of insurers; it does not come out of the Federal Treasury.

Senator CARPER. Good.

Dr. Aron-Dine?

Dr. ARON-DINE. I agree. The information gaps persist, and they are most intense among exactly the young, healthy people whom we need to bring in to strengthen the risk pool.

Senator CARPER. Okay.

What was your third point?

Mr. SLAVITT. The third point was to help States efficiently account for high-cost claimants through reinsurance.

Senator CARPER. All right.

Reaction to that please, Mr. Roy?

Mr. ROY. Yes, in general I support it, though I think Mr. Haislmaier's points about how it raises overall premiums are worth taking into account.

Senator CARPER. Okay.

I am not going to ask you to answer this question. But earlier in the conversation we had with the witnesses who are before the HELP Committee right now—we had an earlier roundtable with them before they convened their hearing, and one of the questions I asked of those folks was, if we do a Federal reinsurance program along the lines that Senator Kaine and I have suggested and others have supported, can we do that in conjunction with 1332 waiver expansions to allow States to do their own reinsurance plan, a la Alaska? I am not going to get into that, but I think that is a good thing to consider.

Mr. Haislmaier, did you want to comment briefly, or did you already do that?

Mr. HAISLMAIER. Yes, the reinsurance program in the ACA was basically to account for a shift of poor risks into the individual market coming from previous State high-risk pools and employer dumping. And so that has happened. It happened over the last 3 years. I do not see a huge amount of that going forward, and I am skeptical as to how useful it would be.

Senator CARPER. All right, thank you.

Dr. Aron-Dine?

Dr. ARON-DINE. As I said, I think reinsurance, particularly if it addresses the tail risk, as Mr. Haislmaier suggested earlier, can be helpful for both competition and affordability.

Senator CARPER. Good.

Senator McCaskill, the question that they are answering, and I will be done in just a minute, but the question they are answering was, Andy had given his five ideas and I am asking the other witnesses to respond to this.

What was your fourth idea? Was it speed up 1332s?

Mr. SLAVITT. Yes, speeding up 1332 waivers while ensuring the appropriate consumer protections we have talked about.

Senator CARPER. All right.

Mr. Roy?

Mr. ROY. As I explain in some detail in my written testimony, I believe that 1332 waivers are very inflexible and do not give States the ability to really reform the markets in a way that makes them more affordable.

Senator CARPER. All right, thank you.

Mr. Haislmaier?

Mr. HAISLMAIER. Yes, the question is, where does somebody go to get their pre-ACA kind of coverage restored? And again, 1332 waivers do it because that is what your average small-business, self-employed person is looking for.

Senator CARPER. All right, thanks.

And, Dr. Aron-Dine, please? Should 1332 waivers speed up?

Dr. ARON-DINE. Yes, I agree. And I would say, when Andy and I were working at HHS and we were working with States, we often found that when people came in with a good idea, they thought it ran up against the guardrails, but that was not actually the problem.

If it was a good idea that improved coverage and protected consumers, it was often feasible under the guardrails, and it was other aspects of the process that were causing the problem. And that is where I think there is room for streamlining.

Senator CARPER. Okay, thanks.

Andy, what was your last point?

Mr. SLAVITT. I think the last point is the enforcement of the individual mandate. It is the law of the land, and, look, what it suggests is that we are going to ask people to—well, let me just skip all of that, because that is known to you. The net effect of it is, it makes insurance cheaper for everybody by about 20 percent by many estimates.

Senator CARPER. All right.

Mr. Roy, just a quick reaction?

Mr. ROY. The individual mandate is having limited to no effect on participation in the individual market, and it should be replaced by continuous coverage, waiting periods, late enrollment penalties, and other models that have worked in Medicare.

Senator CARPER. All right, thanks.

Mr. Haislmaier?

Mr. Haislmaier. I would concur: little to no effect. And I would actually add to that that as premiums rise, more people will qualify for an affordability exemption from the individual mandate, so the effect not only is little to nothing now, but it will diminish further going forward.

Senator CARPER. I am not going to ask this question to anybody, just kind of an exit question. Where did the individual mandate come from in the first place?

Mr. Haislmaier. The Urban Institute.

Senator CARPER. Thank you. [Laughter.]

Mr. Haislmaier. We can prove that, Senator.

Senator CARPER. Last, Dr. Aron-Dine?

Dr. ARON-DINE. Yes. I watch the insurer pricing behavior, and what we saw this year was a number of major insurers across States saying they would raise rates an extra 15 percent just because of the risks that the mandate was not enforced. So clearly, they think it is important to the risk pool and is working to broaden the pool as recommended by conservative experts at Heritage and in Massachusetts and elsewhere.

Mr. Haislmaier. Actually, if I could add to that, Senator.

Senator CARPER. No, nope, we are out of time. I am sorry. [Laughter.]

We will talk over lunch, okay? Thank you, though.

All right. Senator McCaskill—saving the best for last.

Senator MCCASKILL. Thank you, Senator Carper.

I feel like a kid in a candy store. It is just me and the four of you. I could go for a long time, and no one is here to stop me.

Senator CARPER. I am going to pass the gavel to you. [Laughter.]

Senator MCCASKILL. Yes, that is just my point.

Let me start with Mr. Haislmaier. Let me give you the example I give in my town halls. There is a 27-year-old man, he is finally making enough money at a machine shop, where there is no employer insurance, that he can afford one of two things: a monthly health insurance premium or a monthly payment on a Harley-Davidson. And it probably will not surprise you to guess that he takes the Harley-Davidson.

He gets out on the highway, he gets cut off, and he puts the bike on the pavement. He has traumatic brain injuries, and he is life-flighted to Barnes-Jewish Hospital in St. Louis. Nobody stops him in the parking lot or as he comes into the emergency room and says, "I am sorry, you decided you would rather have a Harley than health insurance."

We take him into the hospital and we give him \$2 million minimum of traumatic brain care. He goes bankrupt in 10 minutes. What is the most efficient way to cover that bill?

Mr. Haislmaier. Senator, I think you have put your finger on a very important point that gets missed in a lot of this discussion, and that is that part of the problems with this law are that we are

working against the backdrop of something fairly unique in this country, and that is we actually have, through EMTALA, the Emergency Medical Treatment and Labor Act, a right for that person to get health care. They do not get turned away. We provide them, as you pointed out, with health care.

Senator MCCASKILL. Correct.

Mr. HAISLMAIER. The problem is, why should they buy insurance if they know that, if something happens, we will pick up the bill?

Senator MCCASKILL. That is not my question. I need you to answer this question. How do we cover the bill?

Mr. HAISLMAIER. That is what I am saying. The theory—

Senator MCCASKILL. So you do not have an answer?

Mr. HAISLMAIER. No, I am going to get to that. The theory is in the ACA that we would take the money that we are currently spending on the hospital to offset those losses, because we are spending a lot of money through Medicaid disproportionate share and other things.

Senator MCCASKILL. DSH payments.

Mr. HAISLMAIER. We would take that money and we would buy that person insurance. That was the theory. That was also the theory in Massachusetts.

We have two problems that we have discovered in the process by experience with that theory. One, that individual does not sign up for the insurance, or, if you sign them up, they do not keep the insurance. The insurers tell us, you know, assuming it was less traumatic than that and assuming they walked out of the hospital, the next month they will not pay the premium, even though it is heavily subsidized. Insurers are telling me they will not pay 10 bucks a month to keep it. Why? Because they know that if they need it again, the same thing will happen.

So the other problem is that the money never got out of the hands of the hospitals to pay for it. So I think, to get to the answer to your question, I am thinking that we need to get creative around making what we are spending on the hospitals for that more accountable and transparent and, in effect, rather than trying to take the money away from them, turning that more into a de facto insurance program.

Because right now we have a situation where neither that individual nor the hospital—

Senator MCCASKILL. I do not understand your answer. How do we pay that bill?

Mr. HAISLMAIER. So the way I would do it is, I would add a State-level pool, all of that money, and say to the hospitals, when you have—

Senator MCCASKILL. All of what money; money that comes from where?

Mr. HAISLMAIER. The uncompensated care funding that States and Federal Governments are paying into the hospitals. We would say to the hospitals, if you have these claims, rather than dole that money out based on a formula, we are going to have you come to us with who are the claimants and everybody gets an even distribution of the money.

Senator MCCASKILL. So the government should pay that bill?

Mr. HAISLMAIER. Well, we are paying it today is what I am saying.

Senator MCCASKILL. That is what I am trying to hear The Heritage Foundation tell me. You want the government to pay the health-care bill of the individual who does not take personal responsibility and gets insurance. You want the government to be responsible for his bill.

Mr. HAISLMAIER. No. What I am saying is, the government today is paying that, okay?

Senator MCCASKILL. That is not my question. I am saying going forward.

Mr. HAISLMAIER. Oh, I would certainly want to incentivize that person to buy and keep private health insurance, absolutely. But the problem we have today is, that person is not incentivized under the current system to do it.

Senator MCCASKILL. I think what I am trying to say here is that when left out of all the bumper stickers of “repeal and replace” and “sell across State lines” and medical malpractice, that anybody who really understands our medical delivery system in this country knows these are not even good Band-Aids, much less an answer to our problem. These simplified solutions avoid the reality that when someone does not buy health insurance and we take care of them anyway, those costs are paid one or two places. Either they are paid by the government, which means we are all paying for it, for the guy who decides he does not want to have health insurance, he wants to have a Harley, or they call their best customers—I think you would agree with this, I think that the other doctors on the panel would agree with me on this—they call their best customers to raise prices, the hospitals—and who are their best customers? Their best customers are the insurance companies.

So they call the insurance companies at the end of the year when they have all this uninsured care, and the DSH payments do not come close to denting it because nobody has any obligation to get health insurance in this country, like they do car insurance.

And they call the insurance companies and they say, we are going to raise your prices for labor and delivery; we are going to raise your prices for angioplasty. And then they call the small business down the road and say, your premiums are going up 20 percent.

That is the nub of the problem here, that we provide health care to everyone in this country, even if they do not take personal responsibility to get health insurance. So I do not understand how doing away with the requirement of personal responsibility is in any way going to solve this problem.

Mr. HAISLMAIER. I was simply pointing out that the design in the ACA is not working. I am not saying that people should not be—

Senator MCCASKILL. But you believe people should have to buy insurance.

Mr. HAISLMAIER. I think people should buy insurance. What I am saying is, the approach of “buy insurance or pay a fine” is not working, so you have to have a different approach to that. Okay?

Senator MCCASKILL. Maybe we should do it the same as we do for car insurance. What if we said, you cannot get your car license until you show proof of health insurance?

Mr. HAISLMAIER. Well, there are a number of ways. I mean, I have heard—

Senator MCCASKILL. That works with car insurance.

Mr. HAISLMAIER. Years ago, before the ACA and working with States on this issue, I had heard of some States—Senator Casey is not here, but I think his was one of them—where they said, gee, I know how to get their attention: tell them they cannot get a hunting license. But the reality is that we are paying for those people, as you pointed out, either through Federal and State subsidies or through cost shifting.

I think there is a lot that can be done, because it is very opaque at the hospital level. I mean, keep in mind that there are hospitals that are getting more in subsidies than they are incurring in uncompensated care, and that was one of the things that we discovered in Massachusetts in the reforms. So there is a lot of reform that could be done with the existing money in the system to make that more effective.

In the earlier testimony, I was pointing out that there were a set of balanced rules in the Health Insurance Portability and Accountability Act that were applied to the employer group market that I would apply to the individual market as well.

Senator MCCASKILL. We all have lots of ideas to make it better, but at the root of this is a country that has decided, I think for all the right reasons, that we are not going to make that man who bought the Harley die, we are going to take care of him. And how we more fairly and efficiently cover his health insurance costs is in fact what we are struggling with.

And it is just astounding to me that the party that has lectured me on personal responsibility for many, many years all of a sudden wants personal responsibility to fly out the window, that it should be nobody's personal responsibility to buy health insurance. And frankly, it is like the world is turned upside down. I do not get it.

I want to talk a little bit about prescription—

Senator CARPER. Senator McCaskill, I am going to ask you to ask this last question, and then we are going to wrap it up. Okay? Thanks.

Senator MCCASKILL. Okay. So he is not going to let me get away with going as long as I want to go. [Laughter.]

I am really fascinated by prescription drug advertising. I am fascinated that it has gone from \$150 million in 1993 to \$4 billion in 2010. The average American watching television spends 16 hours a year just watching pharmaceutical ads. So I do not understand why the rest of this supposed free market is not moving into this space. Why are the MRI manufacturers not saying, tell your doctor to come to our MRI machine down the road at this urgent care center; if you need an MRI, we can give it to you for less money? Or why are doctors not advertising, you know, come to see me, I can lower your costs?

And by the way, this advertising, telling people what they need to be prescribed to them by prescription only, is clearly working. It is driving our pharma costs through the roof. So why are the rest of the parts of this system—and I will let you take this, either Dr. Aron-Dine or Andy—why are the other parts of the system not trying to move into this advertising space? And if you have an opinion

on whether or not we should be subsidizing this kind of advertising through tax cuts—the government is helping pay for this advertising.

Dr. ARON-DINE. Thank you, Senator. I think what I hear in your question is more concern about what the pharmaceutical companies are doing with their advertising than an actual recommendation that we would benefit from seeing the same kind of advertising in the rest of the health-care sector.

Senator MCCASKILL. I do not know about that, though, honestly. It might be good. I would like it if a doctor told me I really needed an MRI; I would like to be able to comparison-shop. I can find the best grilled cheese sandwich within 5 miles from here, see pictures of it, know exactly how much I would pay. I have no idea what an MRI even does cost; nobody will tell me.

Dr. ARON-DINE. And if the goal is to get people better information on both the actual cost of care and the cost-effectiveness of the care and what they are buying, I think Andy and I both at HHS looked for ways to do that across the health-care system for drugs, but also getting more information out there about other services which were high-value and incentivizing high-value care.

I think, generally speaking, television advertising is not the best way people get that information, though there are exceptions and there are cases where it raises awareness of real health concerns.

Senator MCCASKILL. Well, it is perplexing to me, because people say, well, we cannot advertise that because the doctor should be the one recommending. Well, wait a minute, these are prescription drugs, and we are advertising. So why isn't that same bromide being applied to other parts of the health-care delivery system?

And if either of you who represent—

Mr. HAISLMAIER. Well, actually, I see a pretty fair amount of hospital advertising as well.

Senator MCCASKILL. Yes, for cancer.

Mr. HAISLMAIER. Well, not even, just in general hospital advertising. I mean, you know, certain specific—

Senator MCCASKILL. Labor and delivery.

Mr. HAISLMAIER. Yes, cancer, whatnot, but also just general branding and things like that.

Senator MCCASKILL. But not docs.

Mr. HAISLMAIER. Yes, well—

Senator MCCASKILL. But not knee or joint replacements. I would like to know where I could get a cheaper joint. I would like to know how much my joint costs and where I could get a cheaper one.

Mr. HAISLMAIER. And this is why people like myself and Mr. Roy here think that what you need to do is empower more patients to have the ability to choose where they go, as opposed to simply being in somebody's predetermined network. And then you create a market for that and people will respond to that, and they do.

We see that with the Federal Employee Health Benefits Program. When they created a market there, which they did in 1960, with FEHBP and people had a choice, suddenly, what does the Washington Consumers' Checkbook do? It publishes a guide every year to comparing the different plans.

Now, you can do this in health care. And I have had this discussion with insurers too. But right now, the game is all about, I need

to have a bulk purchase, a bigger club to beat up the providers. I mean, I tell the insurers, look, if you want to go into a new market, just tell the providers, we will take your rates, but we will score you based on your cost and quality and we will tell our patients how you rank and let them make the decision. That is not a hard business model to do.

Senator McCASKILL. I wish somebody would do it. Thank you.

Thank you, Mr. Chairman.

Senator CARPER. You are welcome. Thank you. You are worth waiting for.

Let me just say, for the record, I am going to ask each of our witnesses to do this for us. I am going to ask our majority witnesses, Mr. Roy, Mr. Haislmaier, I am going to ask you to pick one of the points made by either Andy or Dr. Aron-Dine, pick one of the points that you agree with and communicate to the chair and the ranking member one point that you agree with and that you think we ought to do.

And I am going to ask similarly for Mr. Slavitt, for Dr. Aron-Dine to do the same: pick something that our other two fellow witnesses have said they think we ought to do and tell us that.

And the great thing about a hearing like this is, really excellent witnesses, very smart witnesses, and if we can actually get this panel to agree on the steps that we need to take in order to fix the pieces of the ACA that should be fixed, drop those that should be dropped, preserve those that should be preserved, if we can get the four of you in a room to hammer that out, that would save us a lot of time and energy.

We are not going to get you into that room, but one of the things I hope we can do—and I will be talking with the chairman and the ranking member on it; I am sure others will too—we need more hearings like this. And we need more hearings with well-informed witnesses like you who can come in and talk about the existing issue there, but just really help us develop consensus, and I think sooner rather than later with respect to stabilizing the exchanges.

And then as we get past this month and that challenge, then we need to look more broadly at the issues of health care.

It is not often that people get a second chance in life. We do not get a lot of second chances, but we actually do have a second chance here to fix the ACA in ways that will actually get the three goals we all share: cover everybody, better health care, less money. That is where we are going. And we do that, I think, with more conversations like this rather than fewer and, frankly, more enlightened witnesses like you.

So we thank each of you for spending your time and preparing for this and for being with us and for responding to those questions.

The last thing I want to say is, for any of our colleagues who have written questions for the record, I ask that they submit them by close of business on September 19th; that is, about a week from today.

With that, this hearing is adjourned. Thank you all.

[Whereupon, at 12:25 p.m., the hearing was concluded.]

A P P E N D I X

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF AVIVA ARON-DINE, PH.D., SENIOR FELLOW AND SENIOR COUNSELOR, CENTER ON BUDGET AND POLICY PRIORITIES

Chairman Hatch, Ranking Member Wyden, and members of the Finance Committee, thank you for the opportunity to testify before you today. My name is Aviva Aron-Dine. I am a Senior Fellow and Senior Counselor at the Center on Budget and Policy Priorities, a non-profit, non-partisan policy institute located here in Washington. The Center conducts research and analysis on a range of Federal and State policy issues affecting low- and moderate-income families. Previously, I served in government in a number of roles, including as the chief economist at the White House Office of Management and Budget (OMB), as Acting Deputy Director of OMB, and as a Senior Counselor at the Department of Health and Human Services, where my portfolio included Affordable Care Act (ACA) implementation and Medicaid, Medicare, and delivery system reform policy.

This Congress, and especially this committee, have important opportunities to strengthen health-insurance markets in the near term and to continue expanding coverage and making health care better and more affordable over the longer term. But legislation could also easily take us backwards. In my testimony, I provide an overview of the progress made in expanding coverage and access to care under the ACA, the baseline against which future policy changes should be measured. I then discuss some of the challenges facing the individual market and how they could be addressed, and recommend some objectives for health-care policy after these immediate issues are resolved.

PROGRESS UNDER THE AFFORDABLE CARE ACT

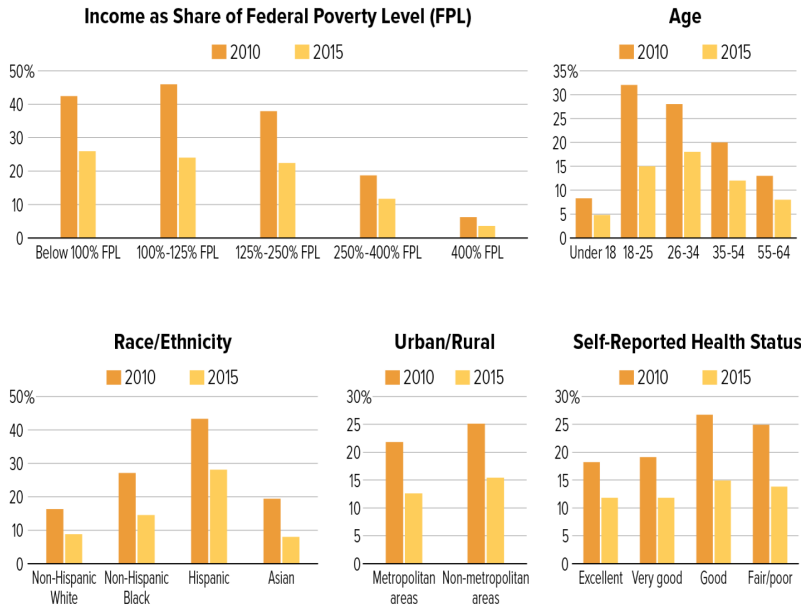
The most recent National Health Interview Survey (NHIS) data show that the uninsured rate in early 2017 remained at its lowest level in history: about 9 percent, compared to 16 percent when the ACA was enacted in 2010.¹ The data also show that these dramatic coverage gains have been broadly shared across non-elderly Americans (seniors already had near-universal coverage through Medicare). As shown in Figure 1, uninsured rates from 2010 to 2015 fell by 35 percent or more for low-, moderate-, and middle-income Americans; for all age groups and racial and ethnic groups; across both urban and rural areas; and for people in both good and poor health.² These gains reflect the combined effects of the ACA's coverage provisions, including the expansion of Medicaid to low-income adults, the creation of the health insurance marketplaces and subsidies for individual market coverage, allowing young adults to remain on their parents' plans until age 26, and individual market reforms such as prohibiting insurers from denying coverage or charging higher premiums based on health status.

The quality of health insurance has also improved, including for people already covered through their jobs. For example, as of 2009, 59 percent of people with employer coverage had plans with lifetime limits on benefits, while almost 20 percent had plans with no limit on out-of-pocket costs, exposing them to catastrophic costs in the event of serious illness.³ The ACA prohibits lifetime (and annual) limits on coverage and requires plans to cap consumers' annual out-of-pocket costs.

FIGURE 1

Coverage Gains Under the ACA Have Been Widely Shared

Non-elderly uninsured rates



Source: U.S. Department of Health and Human Services calculations based on National Health Interview Survey data

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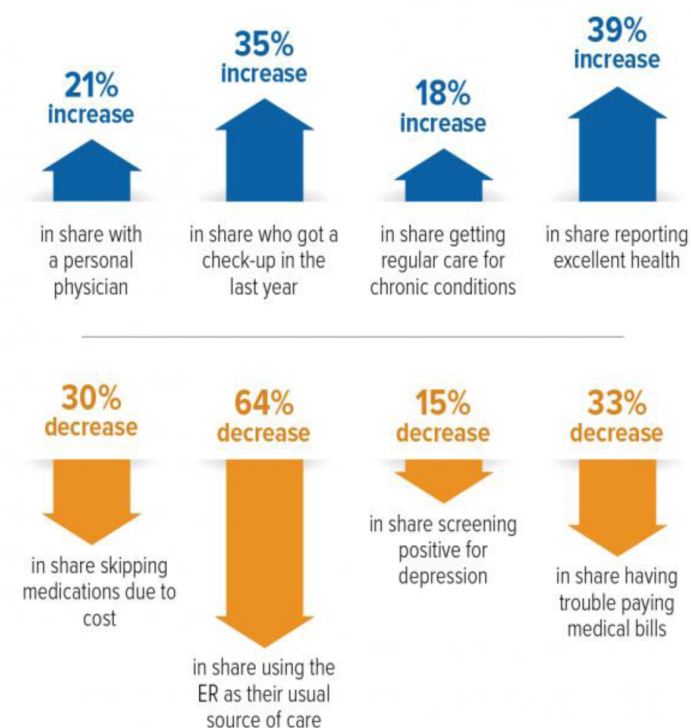
In the individual market, quality improvements have been even greater. As of 2013, before the ACA's major individual market reforms took effect, 75 percent of individual market health plans excluded maternity care, 45 percent excluded substance use treatment, 38 percent excluded mental health services, and up to 17 percent excluded various categories of prescription drugs.⁴ Today, all plans subject to ACA rules—the large majority of individual market policies, excluding so-called “grandfathered” and “transitional” plans—are required to cover these essential health benefits. The ACA also ended pre-existing conditions exclusions, which meant that even when people with pre-existing health conditions were able to obtain individual market coverage, that coverage often excluded treatment related to their pre-existing condition. And individual market insurance now offers greater financial protection. Among families with individual market coverage, average out-of-pocket costs (counting premiums, deductibles, copays, and coinsurance) fell by 25 percent in 2014, when the ACA's major individual market reforms and marketplace subsidies took effect.⁵

There is growing evidence that the expansion of and improvements in coverage under the ACA are translating into improved access to care and greater financial security. Some of the most in-depth research has focused on the impact of the ACA Medicaid expansion, with a group of Harvard researchers tracking changes in access to care, financial security, and health for low-income adults in Kentucky and Arkansas (which expanded Medicaid) versus Texas (which did not). As shown in Figure 2, this research has found sizable increases in the share of people with a personal physician, getting check-ups, getting regular care for chronic conditions, and reporting excellent health, and decreases in the share relying on the emergency room for care, skipping medications due to cost, struggling to pay medical bills, and screening positive for depression.⁶

FIGURE 2

Affordable Care Act's Medicaid Expansion Helping Low-Income People in Kentucky & Arkansas

Estimated effect



Note: Study estimates changes in outcomes in Kentucky and Arkansas relative to changes in Texas, which did not expand Medicaid.

Source: CBPP calculations from Sommers, et al., Journal of the American Medical Association, 2016

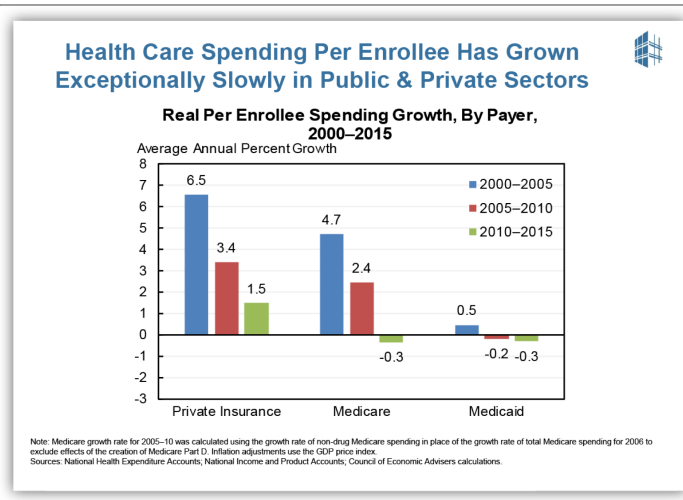
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Other research has found that Medicaid expansion increased access to preventive services, increased early diagnoses of chronic conditions, increased use of medication-assisted treatment for opioid addiction, and reduced third-party medical debt collection.⁷ Research also finds that marketplace enrollees are accessing care at rates similar to people with employer coverage, that more than 80 percent of enrollees are satisfied with their plans, and that many marketplace (and Medicaid expansion) enrollees say their coverage is letting them access care they would otherwise have to forgo.⁸ Meanwhile, national surveys show a roughly one-third decline in the share of the U.S. population who report forgoing medical care due to cost (since 2010), as well as increases in the share of people with a personal physician.⁹

These expansions in coverage and access to care have coincided with a marked *slowdown* in per-enrollee health-care cost growth—a slowdown to which the ACA has contributed, although it is certainly not the sole cause. As shown in Figure 3, per-enrollee spending growth since 2010 has been slower than over the previous decade in private insurance, Medicare, and Medicaid. This unexpected slowdown is yielding substantial savings for consumers and for the Federal Government. For example, family premiums for employer coverage averaged nearly \$3,600 less in 2016

than if premiums since 2010 had grown at the average rate over the preceding decade. Meanwhile, the Congressional Budget Office (CBO) now projects that total Federal spending on major health programs will be more than \$600 billion *less* from 2011 to 2020 than it forecast in January 2010, before the ACA was enacted, with lower-than-expected health care costs more than outweighing costs for expanded coverage.¹⁰

FIGURE 3



— From “The Affordable Care Act: Seven Years Later,” Jason Furman, Peterson Institute for International Economics, March 23, 2017, <https://piie.com/system/files/documents/furman20170323ppt.pdf>

While the ACA is sometimes criticized for having focused on coverage expansions to the exclusion of cost concerns, in fact it contributed in important ways to this slowdown in health-care cost growth. Most directly, the ACA instituted reforms to Medicare payment rates to more closely align them with costs; these reforms likely also had “spillover” impacts on health-care cost growth for private payers.¹¹ The ACA also established incentives for hospitals to avoid unnecessary readmissions and prevent hospital-acquired conditions (such as infections); these programs have contributed to large declines in these adverse outcomes, improving care and reducing costs.¹²

Harder to quantify, but more important over the long run, the ACA created mechanisms for ongoing payment reform and experimentation in Medicare. Between the Medicare Shared Savings Program (the statutory Accountable Care Organization program created as part of the ACA) and payment models developed through the ACA’s Center for Medicare and Medicaid Innovation, more than 30 percent of Medicare payments are now tied to “alternative payment models” that reward efficient delivery of high-quality care, rather than being made on a purely fee-for-service basis.¹³ Medicare’s leadership has also helped catalyze similar efforts by private insurers and employers and State Medicaid programs, a number of which are engaged in large-scale shifts toward population- or episode-based payment.

Of course, health-care costs remain a challenge for families, the Federal budget, and States, with additional reforms needed to deliver better care at lower cost. But the ACA put in place a foundation for payment reform. Congress, with leadership from this committee, has already built on that foundation through the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), and there are opportunities to do more—an issue I return to later in my prepared statement.

INDIVIDUAL MARKET TRENDS AND POLICY RECOMMENDATIONS

In the near term, however, policymakers are appropriately focused on strengthening the individual market for health insurance, the source of coverage for roughly 6 percent of Americans and the part of the health-care system that faces the most pressing challenges.

Since the ACA's reforms took effect, individual market enrollment has grown, contributing to the overall decline in the uninsured rate. People with pre-existing conditions have seen especially large gains in individual market enrollment, reflecting the ACA's provisions barring insurers from denying coverage or charging higher premiums based on health status.¹⁴ Meanwhile, as discussed above, individual market plans offer more comprehensive coverage than before the ACA, and families' total out-of-pocket costs are less (on average), thanks in large part to premium tax credits and cost-sharing reductions.

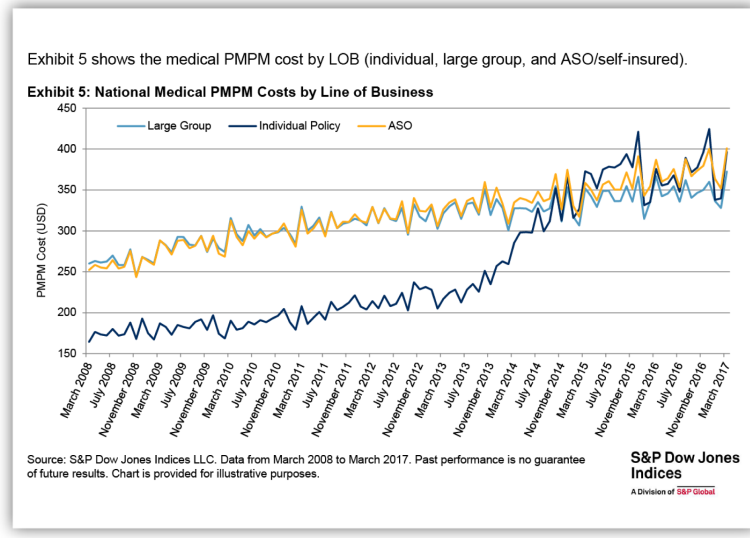
In the early years of the ACA marketplaces, coverage expansions were accompanied by moderate premium growth, with benchmark premiums increasing by an average of about 5 percent per year from 2014 to 2016. In 2017, however, premiums increased much more rapidly, with benchmark premiums rising by an average of 22 percent in States with available data.¹⁵ While most individual market consumers were protected from rate increases by the ACA subsidy structure (under which premium tax credits increase with premiums), rate increases were burdensome for a minority of enrollees with incomes too high to qualify for subsidies. They also raised questions about the health of the individual market. Did high rate increases indicate a deteriorating risk pool and health-care claims spiraling out of control, or were they a transitional pricing correction reflecting the end of the ACA's temporary reinsurance program and the fact that insurers in many States set initial premiums for the marketplaces that turned out to be well below costs?

With additional data available, it is now clear that these rate increases were primarily transitional, and the individual market at the start of 2017 was poised for greater price stability going forward. Three graphs tell the story.

Figure 4, from the Standard and Poor's (S&P) health-care claims dataset, shows the path of per-member per-month health-care claims costs in the individual market and in the large group and self-insured employer markets. As the figure shows, prior to the ACA's reforms, individual market costs were far below costs in the employer market. That's consistent with the fact that the pre-ACA individual market largely excluded people with serious health conditions, and (as discussed above) these plans covered far less than typical employer plans. Unsurprisingly, as the ACA's individual market reforms took effect, individual market per-enrollee costs more or less caught up with employer plans costs (overshooting a bit through 2015, perhaps reflecting pent-up demand for medical care among new enrollees, but then coming back down). Critically, over the last couple years, growth in individual market claims has almost exactly kept pace with growth in employer plan claims, with slow year-over-year growth in both markets. That pattern is consistent with a market that is largely stable, and inconsistent with a deteriorating risk pool and spiraling costs.¹⁶

Figure 5, based on analysis by researchers at the Urban Institute, shows that premium increases in 2017 brought premiums in most of the country roughly in line with employer plan premiums. The Urban study compares 2017 benchmark premiums with average premiums for people with employer coverage, taking into account differences in enrollee age mix and plan generosity. As of 2017, the median marketplace consumer now lives in a State where marketplace premiums are almost exactly in line with employer plan premiums. In contrast, before the 2017 rate increases, the Urban researcher found that individual market premiums were well below employer plan premiums, on average.¹⁷ It's not surprising that discrepancy proved unsustainable, since employer plans and individual market plans are operating in the same health-care system and face much the same costs.

FIGURE 4

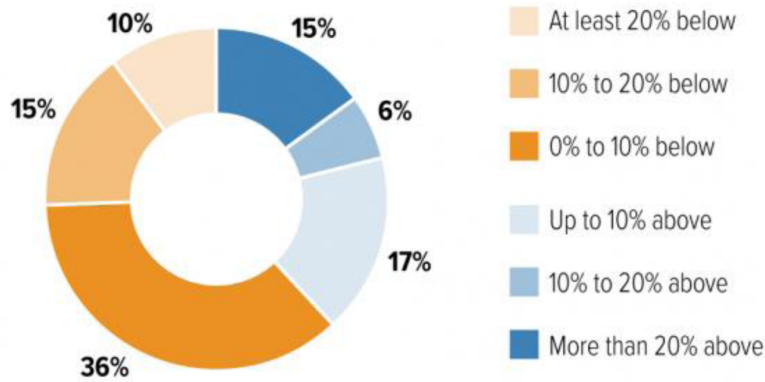


— From “S&P Healthcare Claims Indices Monthly Report,” S&P Dow Jones Indices, August 2017, <https://us.spindices.com/documents/commentary/sp-healthcare-claims-monthly-report-aug-2017.pdf>

FIGURE 5

Most Marketplace Consumers Face Premiums In Line with Or Lower Than Employer Premiums

Share of marketplace consumers by difference between marketplace and employer premiums in their state, 2017

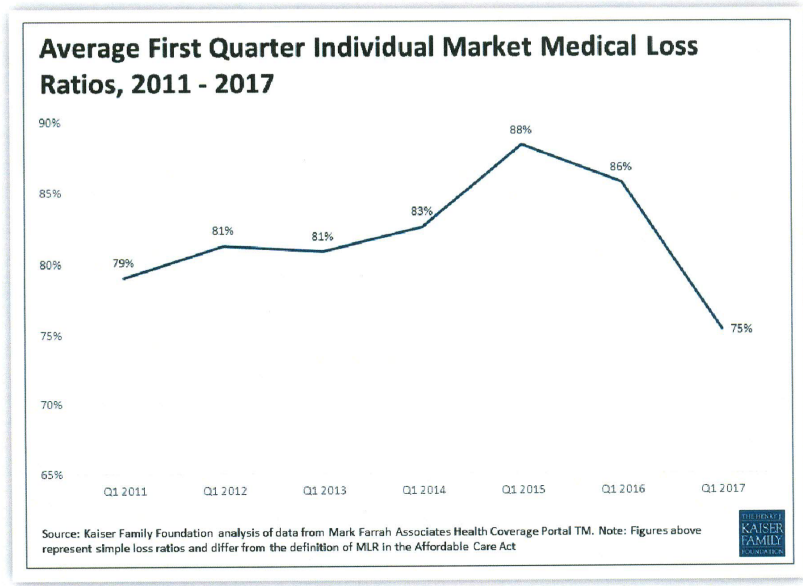


Note: Percentages may not add up to 100 due to rounding.

Source: Urban Institute premium comparisons; Centers for Medicare & Medicaid Services state-level marketplace enrollment

With premiums now roughly in line with employer premiums (on average), and with health-care costs remaining in line with employer plan costs, one would expect individual market insurers' finances to be stabilizing as well. And Figure 6, from the Kaiser Family Foundation, indicates this is indeed occurring.¹⁸ In the first quarter of 2017, medical loss (claims-to-premiums) ratios in the individual market fell to slightly below their pre-ACA levels. Other data also suggest that many insurers will break even or earn profits on their individual market business this year.¹⁹

FIGURE 6



— From “Individual Insurance Market Performance in Early 2017,” Cynthia Cox, The Henry J. Kaiser Family Foundation, July 10, 2017, <http://www.kff.org/health-reform/issue-brief/individual-insurance-market-performance-in-early-2017/>

Greater financial stability for individual market insurers should be good news for consumers: all else equal, it would mean lower rate increases and growing competition going forward. And in fact, there is evidence that consumers would be realizing these benefits in 2018—if it weren't for Federal policy uncertainty. In a number of States, individual market insurers have published their requested 2018 rate increases both with and without uncertainty around whether cost-sharing reduction (CSR) payments will be made, whether the individual mandate will be maintained and enforced, and other Federal policy choices. Many of these insurers—including major health plans in Arizona, North Carolina, Pennsylvania, and Tennessee—have said that their premium increases would be in line with or below their expectation for economy-wide trend growth in medical costs, absent uncertainty about the continuation of CSR payments, individual mandate enforcement, or both.²⁰ Likewise, independent actuaries at Oliver Wyman estimate that, absent policy changes and uncertainty, average marketplace premiums would grow roughly with medical trend (plus an adjustment for the end of the health insurer tax moratorium).²¹ Early this year, 96 percent of marketplace insurers surveyed by Oliver Wyman said they planned to continue offering plans in the marketplace in 2018, and 88 percent said that they planned to either maintain or expand their ACA marketplace footprint.²²

Unfortunately, all else has not been equal, and consumers will mostly miss out on the benefits of a stabilizing market this year. Oliver Wyman projected that insurers would request additional rate increases ranging from about 10 to 20 percent due to the administration's repeated threats to stop reimbursing them for CSRs and additional increases averaging about 10 percent due to concerns that the individual mandate might not be enforced. Insurers have likely also priced in the risk—now a reality—that the administration would sharply cut funding for marketplace outreach, which plays an especially important role in drawing healthier people into the

market, and have likely also priced in the confusion created by the congressional repeal debate. (Remarkably, a Commonwealth Fund survey found that among uninsured adults who chose not to shop for plans on the marketplace last year, one-third attributed their decision at least in part to concerns that the ACA would soon be repealed.²³) And almost without exception, insurers that are withdrawing from the ACA marketplaces for 2018 have cited Federal policy uncertainty—arising from both the administration’s actions and the congressional repeal debate—as a contributing factor, if not the main driver, of their decisions. Notably, Anthem linked its decisions to withdraw or reduce participation in several States directly to the risk that the administration will stop CSR payments.²⁴

Meanwhile, even setting aside the harm done by Federal policy uncertainty, there is wide variation in the state of the individual market across the country. In many places, clarity about the rules of the road would likely suffice for stability. But some markets are struggling with additional challenges, including: small risk pools, in which a few unusually high-cost patients can make coverage less affordable for all or threaten insurers’ bottom lines; limited insurer or provider competition (generally dating from well before the ACA); and loopholes in Federal or State law or State regulatory decisions that contribute to adverse selection in the individual market risk pool.

Over the past 6 weeks, Governors, regulators, House members, and experts of both parties have weighed in on how to strengthen the individual market, with recommendations aimed at both undoing the damage done by Federal policy uncertainty and addressing some of the market’s underlying challenges. It is striking how much overlap there is across these recommendations, as well as how straightforward many would be to implement: while some would require additional resources, most would not. Among the more common suggestions, with which I concur, are:

- **Providing an explicit appropriation for CSR payments.** As policymakers, regulators, and experts have explained, guaranteeing that CSR payments will continue is not a give-away to insurance companies; it is a critical protection for consumers, who will otherwise experience unnecessary rate increases and insurer withdrawals. Congress can and should resolve this issue for good, by providing an explicit, permanent appropriation for CSRs. Not only would such a measure not require a budgetary offset, it would actually protect the Federal budget from tens of billions in extra premium tax credit costs that would result if insurers set prices year after year without knowing whether CSR payments will be made (or if the administration discontinues these payments outright).²⁵ A temporary appropriation for CSRs would be far less beneficial, while an appropriation limited to 1 year would send a damaging message to insurers already planning for 2019, putting them on notice to prepare for the same Federal policy uncertainty they experienced this year.
- **Maintaining or increasing outreach and enrollment assistance.** Going into the 2016 open enrollment season, only about half of uninsured Americans were aware of the financial assistance available to help pay for individual market coverage, even though an estimated 84 percent of the marketplace-eligible uninsured have incomes qualifying them for financial help.²⁶ The administration’s recent decision to cut consumer outreach by 90 percent, and cut enrollment assistance through the Navigator Program by about 40 percent, will increase the number of people who go uninsured and forgo needed care or incur unaffordable medical bills. But it will also damage the marketplace risk pool, increasing average costs—and therefore premiums—since healthier consumers are the ones least likely to enroll without outreach. Notably, the cost of maintaining both outreach and enrollment assistance is low (the administration’s funding cuts total less than \$150 million), and both programs are financed largely out of marketplace user fees, not general appropriations.
- **Enforcing the law, including the individual mandate.** Outside experts from both parties have urged the administration to enforce and administer the ACA as long as it remains the law of the land. This includes enforcing the ACA’s individual mandate, which discourages healthier individuals from going uninsured and shifting the costs of their unexpected emergency care onto others. While some have questioned the effectiveness of the ACA’s mandate, surveys and experiments show that it has a significant impact in motivating younger, healthier people to enroll in coverage.²⁷ The CBO has estimated that repealing the mandate would shrink the individual market risk pool by about a quarter and increase individual market premiums by about 20 percent, and rate requests from major insurers are consistent with that (with insurers in

Maryland and Pennsylvania, for example, requesting additional rate increases of about 15 percent for 2018 to account for the *possibility* that the mandate might not be fully enforced).

- **Reestablishing a Federal reinsurance program.** Reestablishing a Federal reinsurance program (along the lines of the now-expired ACA reinsurance program) could benefit consumers in two ways. First, the subsidy provided by reinsurance flows through to unsubsidized marketplace consumers in the form of lower premiums. Second, by assuming some of the risk associated with high-cost claims, reinsurance diminishes insurers' incentive to avoid covering high-cost individuals (such as by exiting the geographic areas where they reside), while also reducing uncertainty and thereby making it more attractive for insurers (especially smaller insurers) to participate in the marketplaces. Significantly reducing premiums through a reinsurance program would require meaningful Federal resources (although the net cost of reinsurance is well below the gross cost, because a reinsurance program that lowers premiums also lowers Federal premium tax credit costs). But addressing the risk associated with unusually high-cost claims could be done at much lower cost. (For example, a funded reinsurance program subsidizing claims above \$1 million, along the lines of the budget neutral high-cost claims pool HHS established administratively as part of the risk adjustment program, would likely cost well under \$1 billion per year.²⁸)
- **Streamlining the process for 1332 waivers that improve market stability.** In the absence of a Federal reinsurance program, several States have already followed Alaska's example and are seeking or developing waivers under section 1332 of the ACA to obtain Federal matching funds for their own reinsurance programs. The section 1332 application process could be simplified to facilitate these and similar waivers that are consistent with the section 1332 guardrails: they maintain or increase the number of people with health coverage, maintain or improve coverage affordability and comprehensiveness, and do not increase the Federal deficit. In contrast, weakening these guardrails would harm individual market consumers by opening the door to changes that would increase the number of uninsured, place consumers on the hook for higher premiums or out-of-pocket costs, or allow plans to exclude key services that are especially crucial to people with pre-existing conditions.

Other suggestions from policymakers and experts also deserve consideration. For example, experts have suggested a number of approaches to expanding choice for people in low-competition areas by introducing some form of public option, whether by building on Medicare, Medicaid, the Federal Employer Health Benefit (FEHB) program, or another form of coverage. Congress should also consider tackling the problem of providers steering high-cost Medicare- or Medicaid-eligible enrollees to individual market plans. Such steering benefits the providers involved, who get paid at higher rates in commercial plans than in Medicare or Medicaid. But it often harms beneficiaries, who may lose access to important Medicare or Medicaid benefits and cost-sharing protections, and it may be doing meaningful damage to the individual market risk pool in some States.²⁹

Some have raised the question of whether it is already too late for Congress to influence individual market rates and insurer participation for 2018. Unfortunately, it almost certainly is too late to fully reverse the damage done by Federal policy uncertainty. Even if Congress acts quickly, insurers will not fully remove the uncertainty premium from their rates, and most insurers that have already decided to exit State marketplaces are unlikely to re-enter.

But this hearing is still timely, in that insurers in many or most states would still have the opportunity to lower their rates to reflect a Federal commitment to make CSR payments. Even more important, a number of insurers (for example, Anthem in Maine) have made clear that they could still withdraw from State marketplaces for 2018 if they anticipate that the administration will stop paying CSRs or cause other market disruption, while at least one insurer (Optima Health in Virginia) has stated that it might re-enter key markets if CSRs were guaranteed.³⁰ Quick action on a stabilization measure could lock in these insurers' participation, not only by providing certainty around CSRs but by sending a signal that policymakers of both parties, with diverging views on the ACA, are committed to ensuring a strong individual market for consumers. As noted above, insurers are also already looking ahead to 2019; they will begin formulating preliminary rate requests early next year, and may start making decisions about marketplace participation even

sooner than that. Without action within the next several months, consumers could miss out on the benefits of a stabilizing market for yet another year.

OBJECTIVES FOR HEALTH CARE POLICY BEYOND MARKET STABILIZATION

The ACA was never intended to be the final word on improving the health-care system—far from it. But, new legislation should build on the progress made over the last several years in expanding coverage and access to care, not reverse it. The various repeal and replace bills considered by the House and Senate this year, as well as the repeal and replace plan offered by Senators Cassidy and Graham, violate that principle. Each would cause millions of people to lose coverage and make coverage worse or less affordable for millions more. That’s because each would effectively eliminate the ACA’s expansion of Medicaid to low-income adults; cap and cut Federal Medicaid funding for seniors, people with disabilities, and families with children; sharply increase premiums and other out-of-pocket costs for people with individual market coverage; and weaken consumer protections that are especially critical to people with pre-existing health conditions.

As with individual market stabilization, recommendations issued over the past 6 weeks by Governors, State regulators, members of Congress, and experts of both parties can help chart a different path forward. Rather than shifting costs to States and vulnerable populations by cutting funding for Federal coverage programs, many of these proposals urge Congress to focus on reducing health-care costs and improving the quality of care system-wide by continuing Federal, and supporting State and private sector, delivery system reform efforts. For example, the health-care proposal put forward recently by eight Governors of both parties recommends “resetting the basic rules of health-care competition to pay providers based on the quality, not the quantity of care they give patients,” while avoiding changes that “shift costs to States or fail to provide the necessary resources to ensure that (vulnerable populations) can get the care they need.”³¹

Congress already has a track record of working on a bipartisan basis, with leadership from this committee, to advance health care delivery system reform. The bipartisan MACRA legislation enacted in 2015 offers financial incentives for Medicare providers to participate in alternative payment models, while also adjusting fee-for-service payments based on quality metrics. Building on the tools provided by MACRA and the ACA, both Congress and the administration could do more to promote development of alternative payment models; promote participation in these models by hospitals (not included in the MACRA incentive system); support States in shifting their Medicaid programs toward alternative payment models and instituting other reforms that promote better care coordination and increased use of preventive care; and support both State and private sector delivery system reform efforts through improved data systems, improved and more consistent quality measures, and other efforts.

In contrast, the proposals considered over the past year to cap and cut Federal funding for Medicaid would not only cause millions of people to lose coverage, they could undermine ongoing State efforts to improve care and reduce long-term costs. Many of these efforts rely on up-front investments in care coordination, provider payment incentives, or improved behavioral health or other services. Under a Medicaid per capita cap, these types of investments would no longer be matched with additional Federal dollars, and States facing large Federal funding cuts would likely have to cut back on their own funding for these initiatives as well.³²

Looking forward, there is also more to do to continue expanding coverage. During the debate over ACA repeal, critics of the law highlighted the fact that, even with the historic gains in coverage under the ACA, about 28 million Americans remain uninsured. The repeal proposals under consideration would have nearly doubled that number, but that does not diminish the imperative to reduce it. Fortunately, there are many opportunities to do so, including both Federal legislation and State action.

Most straightforward, an estimated 4 to 5 million people would gain coverage if the remaining 19 States took up the ACA Medicaid expansion, as the majority of States, under the leadership of Governors of both parties have already done.³³ As discussed above, Medicaid expansion has improved coverage, access to care, and financial security for low-income adults. And, as Governors of both parties explained during the repeal debate, expansion has also strengthened State budgets, helped drive progress on major public health challenges like the opioid crisis, and had particularly large benefits for rural hospitals and rural Americans. (Rural Americans

would also gain disproportionately if the remaining States expanded Medicaid, since the rural uninsured are disproportionately concentrated in non-expansion states.³⁴)

While many other options for expanding coverage are beyond the scope of this testimony and this hearing, others directly relate to the goals discussed above: strengthening the individual market and making individual market coverage more affordable. Of the remaining uninsured, about 8 million are eligible for but not enrolled in marketplace coverage.³⁵ Most in this group could qualify for subsidies, but, as noted above, many remain unaware of them, pointing to the importance of continued outreach. Others find marketplace coverage unaffordable even with the subsidies currently available, or unaffordable because they do not qualify for financial assistance. Targeted increases in tax credits and expansions in eligibility for subsidies could meaningfully reduce uninsured rates. They could also catalyze a virtuous cycle. As new research confirms, increases in subsidies for low- and moderate-income consumers not only have large effects on enrollment, they attract new enrollees who are significantly healthier, on average.³⁶ Thus, targeted increases in subsidies that make coverage more affordable for some could in turn help bring down premiums for others.

End Notes

¹The most recent NHIS data are for the first quarter of 2017, when the uninsured rate stood at 8.8 percent. Data through 2017 are available at <https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201708.pdf>. For long-term historical comparisons, see Council of Economic Advisers, “2017 Economic Report of the President,” December 15, 2016, <https://obama.whitehouse.archives.gov/administration/eop/cea/economic-report-of-the-President/2017>.

²Tabulations of NHIS data for subgroups are from Kelsey Avery, Kenneth Finegold, and Amelia Whitman, “Affordable Care Act Has Led to Historic, Widespread Increase in Health Insurance Coverage,” Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, September 29, 2016, https://aspe.hhs.gov/system/files/pdf/207946/ACA_HistoricIncreaseCoverage.pdf.

³Kaiser Family Foundation and Health Research and Educational Trust, “Employer Health Benefits: 2009 Annual Survey,” 2009, <https://kaiserfamilyfoundation.files.wordpress.com/2013/04/7936.pdf>.

⁴Gary Claxton et al., “Would States Eliminate Key Benefits if AHCA Waivers Are Enacted?,” Kaiser Family Foundation, June 14, 2017, <http://www.kff.org/health-reform/issue-brief/would-states-eliminate-key-benefits-if-ahca-waivers-are-enacted/>.

⁵State Health Access Data Assistance Center tabulations from Current Population Survey, available at [http://www.chcf.org/aca-411/explore-the-data#trend%2Caffordability%2Cfinancialburden%2Cfmoop%2CBars%20\(InsuranceType\)%2C2014%2Cindividual](http://www.chcf.org/aca-411/explore-the-data#trend%2Caffordability%2Cfinancialburden%2Cfmoop%2CBars%20(InsuranceType)%2C2014%2Cindividual).

⁶Benjamin D. Sommers et al., “Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance,” *Journal of the American Medical Association*, October 2016, <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420>.

⁷See, for example, Lisa Clemans-Cope, Marni Epstein, and Genevieve M. Kenney, “Rapid Growth in Medicaid Spending on Medications to Treat Opioids Use Disorder and Overdose,” Urban Institute, June 2017, <http://www.urban.org/sites/default/files/publication/91521/2001386-rapid-growth-in-medications-to-treat-opioid-use-disorder-and-overdose-3.pdf>; Luojia Hu et al., “The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing,” National Bureau of Economic Research Working Paper, April 2016, <http://www.nber.org/papers/w22170.pdf>; and Assistant Secretary for Planning and Evaluation, “Medicaid Expansion and Impacts on Insurance Coverage and Access to Care,” Department of Health and Human Services, updated January 18, 2017, <https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf>.

⁸John Holahan, Michael Karpman, and Stephen Zuckerman, “Health Care Access and Affordability Among Low- and Moderate-Income Insured and Uninsured Adults Under the Affordable Care Act,” Urban Institute Health Reform Monitoring Survey, April 21, 2016, <http://hrms.urban.org/briefs/health-care-access-affordability-low-moderate-income-insured-uninsured-adults-under-ACA.html>, and Commonwealth Fund Affordable Care Act Tracking Survey for March–June 2017 (<http://www.commonwealthfund.org/publications/issue-briefs/2017/sep/post-aca-repeal-and-replace-health-insurance-coverage>) and February–April 2016 (<http://aca.tracking.commonwealthfund.org/>).

⁹National Health Interview Survey, <https://www.cdc.gov/nchs/data/nhis/earlyrelease/Earlyrelease201705.pdf>.

¹⁰Jason Furman and Matt Fiedler, “New Data Show That Premium Growth in Employer Coverage Remained Low in 2016,” Council of Economic Advisers, September 14, 2016, <https://obamawhitehouse.archives.gov/blog/2016/09/14/new-data-show-premium-growth-employer-coverage-remained-low-2016>, and Paul N. Van de Water, “Projected Health Spending Falling—Even With ACA Coverage Expansions,” Center on Budget and Policy Priorities, February 13, 2017, <https://www.cbpp.org/blog/projected-health-spending-falling-even-with-acas-coverage-expansions>.

¹¹See Chapin White, “Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates,” *Health Affairs*, 2013, <http://con>

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¹⁴Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act," Department of Health and Human Services, January 5, 2017, <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf>.

¹⁵Data on marketplace rate changes for 2015, 2016, and 2017 can be found at <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2015-health-insurance-marketplace>, <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2016-health-insurance-marketplace>, and <https://aspe.hhs.gov/pdf-report/health-plan-choice-and-premiums-2017-health-insurance-marketplace> respectively.

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²⁴Aviva Aron-Dine, "Anthem's Ohio Withdrawal Makes Consequences of Marketplace Sabotage Even Starker," Center on Budget and Policy Priorities, June 6, 2017, <https://www.cbpp.org/blog/anthems-ohio-withdrawal-makes-consequences-of-marketplace-sabotage-even-starker>.

²⁵CBO projects that failure to pay CSRs would increase total Federal costs by \$6 billion in 2018, \$14 billion in 2019, and nearly \$200 billion over 10 years; the cost of continued uncertainty could be a substantial fraction of those amounts. 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>.

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³⁵ Rachel Garfield, Anthony Damico, Cynthia Cox, Gary Claxton, and Larry Levitt, "Estimates of Eligibility for ACA Coverage Among the Uninsured in 2016," Kaiser Family Foundation, October 18, 2016, <http://www.kff.org/health-reform/issue-brief/estimates-of-eligibility-for-aca-coverage-among-the-uninsured-in-2016/>.

³⁶ Amy Finkelstein, Nathaniel Hendren, and Mark Shepard, "Subsidizing Health Insurance for Low-Income Adults: Evidence from Massachusetts," April 2017, <https://scholar.harvard.edu/files/hendren/files/commcare.pdf>.

QUESTIONS SUBMITTED FOR THE RECORD TO AVIVA ARON-DINE, PH.D.

QUESTIONS SUBMITTED BY HON. RON WYDEN

PROPOSED CHANGES TO SECTION 1332

Question. Section 1332 of the Affordable Care Act (ACA) grants States the flexibility to waive certain provisions of the ACA in order to design and implement innovative strategies for their health insurance marketplaces. However, to receive these section 1332 waivers, the ACA requires States to meet certain substantive and procedural standards. States must offer plans that will be as comprehensive, affordable, and cover as many people as plans under the ACA. Additionally, State waivers may not add to the Federal deficit. Beyond these four substantive guardrails, States must undergo procedural requirements to submit their waivers for review to the Centers for Medicare and Medicaid Services (CMS), including enacting State legislation, providing a notice and comment period for public input, and submitting a comprehensive application. These guardrails help States design marketplace rules that suit their needs without compromising Americans' ability to access to comprehensive and affordable coverage options.

Proposals to loosen section 1332's guardrails to afford States greater flexibility have emerged in recent discussions about how Congress can stabilize the individual marketplace, including during the hearing before this committee. However, when

asked about these proposals, you expressed concern that pulling back these guardrails could undermine Americans' financial security or ability to access the services they need. Please describe which modifications to section 1332 would compromise Americans' access to comprehensive, affordable coverage, particularly for Americans with pre-existing condition.

Answer. Weakening the section 1332 comprehensiveness, affordability, or coverage guardrails would compromise access to qualify, affordable coverage, especially for people with pre-existing conditions.

For example, section 1332 allows States to modify the essential health benefits (EHB) that the ACA requires insurers in the individual and small group markets to cover. If the comprehensiveness guardrail were removed or weakened, then this provision would allow States to let insurers go back to excluding key benefits such as maternity coverage, mental health and substance use treatment, or prescription drugs. Such exclusions would be especially harmful to people with pre-existing conditions and others with serious health needs.

Likewise, section 1332 allows States to modify financial assistance and to waive the ACA's limits on out-of-pocket costs. If the affordability guardrail were removed or weakened, then this provision could allow States to make changes that would increase consumers' net premiums, deductibles and other cost sharing, or both. Again, such changes would likely be especially harmful to people with pre-existing conditions and other serious health needs.

Eliminating or weakening the section 1332 coverage guardrail could open the door to even more harmful changes, since it would allow States to reduce tax credits or cost sharing reductions for low- and moderate-income people and redirect the funding toward other purposes, without regard to the number of people who would lose coverage.

Question. What are changes Congress could make to section 1332 that would facilitate the use of section 1332 waivers by States without risking Americans' access to affordable, comprehensive coverage?

Answer. Policymakers may want to consider streamlining the process around section 1332 waivers while protecting consumers by maintaining the current guardrails. Process changes that might be worth considering include expediting review timelines for waivers in certain cases; increasing transparency around Federal decision-making; or allowing States to demonstrate budget neutrality over the life of the waiver, rather than for each year.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. I heard from multiple State stakeholders at last weeks' hearings who wish to combine the savings from section 1332 waivers and section 1115 waivers. I understand the motivation behind increasing State flexibility and the desire to share savings, but how would you ensure that combining the savings from both waivers wouldn't be used as a means of helping consumers in the insurance marketplace at the expense of Medicaid beneficiaries, or vice versa?

Answer. Allowing States to pool savings across section 1332 and section 1115 waivers would pose significant risks to the Medicaid program and its beneficiaries. In particular, it could allow States to cut Medicaid to pay for expanded tax credits for people at higher income levels or for reinsurance programs that primarily reduce costs for higher-income, unsubsidized consumers.

Fortunately, some of the goals behind combined waiver proposals can already be achieved under current law. In particular, States can already use a combination of section 1332 and Medicaid (section 1115) waivers to improve coordination across programs. For example, States can submit coordinated section 1332 and section 1115 waivers, could use a combination of waivers to make it easier for people to maintain continuous coverage as income and circumstances change, or could use a combination of waivers to improve coordination between the ACA marketplaces and the Children's Health Insurance Program (CHIP).

QUESTION SUBMITTED BY HON. ROBERT MENENDEZ

Question. At the hearing, you highlighted how the Affordable Care Act's 1332 waiver authority is actually quite broad. Many of the Republican proposals have fo-

cused on expanding State flexibility. Can you provide insight into what additional flexibility States would benefit from beyond what is available in 1332 waivers? What protections would consumers benefit from in any proposal to expand State flexibility beyond 1332 waivers?

Answer. Policymakers may want to consider streamlining the process around section 1332 waivers while protecting consumers by maintaining the current guardrails. Process changes that might be worth considering include expediting review timelines for waivers in certain cases; increasing transparency around Federal decision-making; or allowing States to demonstrate budget neutrality over the life of the waiver, rather than each year.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. I have long supported the creation of a reinsurance program to help health insurance companies cover the cost of larger-than-expected insurance claims and lower the cost of premiums for individuals who get health coverage through the ACA's marketplace. A reinsurance program can help stabilize the marketplace, and yet there are some who call it an insurance bailout.

Do you consider reinsurance a bailout to insurance companies?

Answer. No. A reinsurance program is not a bailout to insurance companies; rather, it improves market stability and makes coverage more affordable for consumers. Reinsurance benefits consumers in two ways. First, by assuming some of the risk associated with high-cost claims, reinsurance diminishes insurers' incentive to avoid covering high-cost individuals (such as by exiting the geographic areas where they reside), while also reducing uncertainty and thereby making it more attractive for insurers (especially smaller insurers) to participate in the marketplaces. Second, the subsidy provided by reinsurance flows through to unsubsidized marketplace consumers in the form of lower premiums.

Question. How important is reinsurance for lowering out-of-pocket costs for consumers?

Answer. As noted, a reinsurance program can serve two functions. First, by assuming some of the risk associated with high-cost claims, reinsurance diminishes insurers' incentive to avoid covering high-cost individuals (such as by exiting the geographic areas where they reside), while also reducing uncertainty and thereby making it more attractive for insurers (especially smaller insurers) to participate in the marketplaces. Second, the subsidy provided by reinsurance flows through to unsubsidized marketplace consumers in the form of lower premiums.

The first of these functions benefits all marketplace consumers by reducing the risk of "bare markets" and improving choice and competition. The second function also benefits consumers, but only those with incomes too high to qualify for tax credits. That's because, for consumers eligible for tax credits, the amount paid in premiums out of pocket is determined by the ACA's "applicable percentages" of income, not by sticker price premiums.

Reinsurance is therefore an effective mechanism for reducing out-of-pocket premium costs for unsubsidized consumers. But in order to improve affordability for the majority of individual market consumers who are eligible for subsidies, policymakers may want to couple reinsurance funding with improvements in financial assistance.

PREPARED STATEMENT OF EDMUND F. HAISLMAIER, PRESTON A. WELLS, JR.
SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION

Mr. Chairman and members of the committee, thank you for inviting me to testify. My name is Edmund F. Haislmaier, and I am the Preston A. Wells, Jr. senior research fellow in domestic policy studies at the Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

We now have three full years of data on the effects of the major provisions of Affordable Care Act (or Obamacare). For perspective, it should be noted at the outset that during that 3-year period the ACA was being implemented by a strongly supportive administration. Thus, the results and trends for the period reflect implemen-

tation policies that were, or at least were intended to be, favorable to achieving the law's objectives.

HEALTH INSURANCE ENROLLMENT

A principal objective of the ACA was to increase health insurance enrollment. The design for achieving that goal was based on three key policies: (1) offering income-related subsidies for individual market coverage purchase through the new exchanges; (2) expanding Medicaid eligibility; and (3) applying regulatory mandates, most notably tax penalties on individuals who fail to obtain qualifying coverage and on employers of 50 or more workers who fail to offer qualifying coverage.

The effects of the law on coverage can be seen from the enrollment data for the individual market, employer-sponsored coverage and Medicaid reported in Table 1.¹

Over the 3-year period, enrollment in individual-market plans increased by 5.3 million individuals, from 11.8 million individuals at the end of 2013 to almost 17.1 million at the end of 2016.

For the employer-group coverage market, enrollment in fully insured plans dropped by 8.6 million individuals, from 60.6 million individuals at the end of 2013 to 52 million as of the end of 2016. During the same 3 years, enrollment in self-insured employer plans increased by 5 million individuals, from 100.6 million in 2013 to 105.6 million in 2016.

The combined effect of the changes in individual-market and employer-group coverage was a net increase in private-sector coverage of just 1.7 million individuals during the 3-year period.

Meanwhile, net Medicaid and Children's Health Insurance Program (CHIP) enrollment grew over the 3 years by 14 million individuals, from 60.9 million at the end of 2013 to 74.9 million at the end of 2016. In those States that adopted the ACA Medicaid expansion enrollment increased by 11.7 million, while in the States that did not adopt the expansion enrollment increased by 2.3 million individuals.

Thus, for the 3-year period the combined enrollment growth for both private and public coverage was 15.7 million individuals—with 89 percent of that increase attributable to additional Medicaid and CHIP enrollment. Furthermore, higher Medicaid enrollment in States that adopted the ACA Medicaid expansion accounted for almost three-quarters (73.5 percent) of total (public and private) enrollment gains during the 3-year period.

Table 1. Changes in Health Insurance Enrollment Relative to Prior Period, by Market Segment

	Change in 2014	Change in 2015	Change in 2016	Change over 3 years
Individual Market	4,738,257	1,109,156	-582,841	5,264,572
<i>Fully Insured Employer Market</i>	-6,654,985	-932,066	-1,049,725	-8,636,776
<i>Self-insured Employer Market</i>	2,131,690	1,858,189	1,045,322	5,035,201
Subtotal Employer Market	-4,523,295	926,123	-4,403	-3,601,575
Total Private Market	214,962	2,035,279	-587,244	1,662,997
<i>States Expanding Medicaid</i>	8,389,474	2,178,566	1,141,172	11,709,212
<i>States Not Expanding Medicaid</i>	603,251	587,743	1,112,318	2,303,312
Total Medicaid and CHIP	8,992,725	2,766,309	2,253,490	14,012,524
Total Private and Public Coverage Change	9,207,687	4,801,588	1,666,246	15,675,521

Looking at enrollment over time, the data show that the largest changes occurred in the first year of implementation (2014) and tapered off by the third year (2016).

In the case of Medicaid—which accounted for the vast majority of the total increase in coverage—enrollment grew by almost 9 million individuals in 2014, for an

¹ Private market coverage figures are from data reported in State insurer regulatory filings accessed through the Mark Farrah Associates subscription data service (<http://www.markfarrah.com>). Medicaid/CHIP enrollment figures are from reports published by the Centers for Medicare and Medicaid Services (CMS), based on program reporting by States to the CMS. For more detail, see: Edmund F. Haislmaier and Drew Gonshorowski, "2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed," Heritage Foundation Issue Brief No. 4743, July 26, 2017, at <http://www.heritage.org/health-care-reform/report/2016-health-insurance-enrollment-private-coverage-declined-medicaid>.

increase in program enrollment of almost 15 percent in a single year. However, subsequent enrollment growth was 4 percent in 2015 and 3 percent in 2016, part of which was the result of additional States adopting the Medicaid expansion.²

The pattern is even clearer when looking at the subset of 25 States that have had the expansion in effect since the beginning (January 2014). Table 2 shows that for that group of States, Medicaid enrollment increased 23 percent in 2014 but then only grew by a further 3.5 percent in 2015 and by 1 percent in 2016.

Table 2. Medicaid Enrollment in States That Adopted the Medicaid Expansion at the Beginning of 2014

	2013	2014	2015	2016
Total	33,606,965	41,540,951	42,991,324	43,456,143
Change	–	7,933,986	1,450,373	464,819
Percentage Change	–	23.6%	3.5%	1.1%

With respect to the individual market, the addition of 4.7 million persons to that market in 2014 represented a 40 percent enrollment jump relative to the preceding 3 years during which total individual-market enrollment had fluctuated between 11.8 million and 12 million people. Individual-market enrollment grew by a further 7 percent in 2015, but then declined by 3 percent in 2016, as shown in Table 3.

Table 3. Individual-Market Enrollment by Subsidy Status

	2013	2014	2015	2016
Total	11,807,534	16,545,791	17,654,947	17,087,652
Percentage Change	–	40.1%	6.7%	–3.2%
Subsidized	0	5,430,106	7,375,489	7,648,001
Percentage Change	–	–	35.8%	3.7%
Unsubsidized	11,807,534	11,115,685	10,279,458	9,439,651
Percentage Change	–	–5.9%	–7.5%	–8.2%

Table 3 also shows a similar pattern for the subset of individual-market enrollees that obtained subsidized coverage through the new health insurance exchanges. The number of individuals with subsidized coverage through the exchanges was 5.4 million at the end of 2014, increasing to 7.4 million at the end of 2015, and 7.6 million at the end of 2016. Thus, after growing by 36 percent in 2015, the number of subsidized exchange enrollees grew by less than 4 percent in 2016.

It is notable that the flattening of enrollment trends for both subsidized and unsubsidized individual-market coverage, as well as for Medicaid, predates the current administration and Congress. That suggests that, even without any changes to the law, future Obamacare enrollment gains would likely be, at best, only marginal.

Indeed, just last week the Department of Health and Human Services noted that while its spending on advertising to promote the 2016 annual open enrollment period was about \$100 million—double the \$50 million it spent on advertising the 2015 open season—new enrollments dropped by 42 percent in 2016 and the number of people buying coverage through *HealthCare.gov* declined from 9.6 million in 2015 to 9.2 million in 2016.

In sum, after 3 years the ACA's coverage effects appear to have already reached a point of diminishing returns. That situation is unlikely to change. Escalating premiums will continue to discourage enrollment of more healthy individuals. It is unlikely that the individual mandate penalty for not obtaining coverage will be sufficient to overcome price resistance. Indeed, escalating premiums could increase the number of people qualifying for an affordability exemption from the individual mandate penalty because the cost of a bronze-level plan exceeds the affordability threshold of 8.16 percent of household income.³

²Alaska, Indiana, and Pennsylvania implemented the expansion in 2015, and Louisiana and Montana implemented it in 2016.

³See Seth Chandler, "New Research Shows Many in Middle-Aged, Middle Class Can't Afford ACA Policies in 2018," *Forbes*, August 17, 2017, at <https://www.forbes.com/sites/theapothecary>

Continued

It is also worrying that in 2016 the number of persons with unsubsidized individual-market coverage declined by 839,807 while the number with subsidized coverage increased by only 272,512. Furthermore, Table 3 shows that the unsubsidized individual-market has shrunk at successively larger rates in each of the past 3 years. After declining 5.9 percent in 2014, the number of unsubsidized individual-market enrollees fell a further 7.5 percent in 2015, and then dropped another 8.2 percent in 2016.

That trend, particularly when viewed in the context of flattening growth in subsidized individual-market enrollment and no net change in employer-plan enrollment (see Table 1), is a disturbing indicator that Obamacare may be shifting from insuring the uninsured to un-insuring the previously insured.

INSURER COMPETITION

Supporters of the ACA also expected that the law would generate increased insurer competition. On that score the performance was initially somewhat mixed, but then turned negative. That pattern can be seen in the number of insurers offering exchange coverage in the States each year.

In 2013, the last year before implementation of the exchanges and the ACA's new insurance market rules, 395 insurers sold coverage in the individual market across all States and the District of Columbia.⁴ In 2014 there were 253 insurers offering coverage on the exchanges. That figure increased to 307 in 2015, but then declined to 287 in 2016, and to 218 in 2017. While insurer contracts for 2018 have not yet been signed, based on announced withdrawals and entries it appears that there will be only 194 insurers offering exchange coverage in 2018.

In 2014, New Hampshire and West Virginia each had only one insurer offering exchange coverage. New Hampshire then gained four carriers in 2015, leaving West Virginia as the only State with one exchange insurer. While West Virginia gained a second exchange insurer in 2016, the States of Alaska and Wyoming dropped to one carrier apiece that year. In 2017, those two States were joined by Alabama, Oklahoma, and South Carolina, bringing to five the number of States with only one insurer offering exchange coverage. That list is set to expand in 2018 to include Delaware, Mississippi, and Nebraska, for a total of eight States with just a single exchange insurer.

For consumers, the more relevant measure of competition is at the county level. That is because health plans are offered (and priced) on a local basis, and many insurers do not offer coverage statewide. Therefore, State-level figures can overstate the extent of choice available to many consumers.

Seventeen percent of U.S. counties had only one exchange insurer in 2014. That figure decreased to only 6 percent in 2015 and 7 percent in 2016, but soared to 33 percent for 2017.⁵ The most recent projection from HHS is that 47 percent of counties will have only one exchange insurer for 2018.⁶

In sum, it appears that during the first several years, despite uncertainties about the composition of the risk pool, most insurers were at least willing to try offering coverage through the new ACA exchanges. That is no longer the case. By next year the major national carriers (Aetna, United, Humana and Cigna) will have exited the market either entirely or in all but a few States. For those insurers individual market coverage is only a small piece of their total business, and the marginal increase in enrollment from the Obamacare individual market has proven to not be worth

[/2017/08/17/new-research-shows-many-in-middle-aged-middle-class-cant-afford-aca-policies-in-2018/#1fd04b5b461f](#).

⁴ Insurers that offer coverage through more than one subsidiary in a State are properly counted as one carrier (the parent company), while insurers that offer coverage in more than one State are counted for each State (as market participation is a State-level decision). The pre-ACA figure does not include insurers with fewer than 1,000 covered lives in a State's individual market on the presumption that those insurers were not actively selling new policies in the State at that time.

⁵ See Edmund F. Haislmaier and Alyene Senger, "The 2017 Health Insurance Exchanges: Major Decrease in Competition and Choice," Heritage Foundation Issue Brief No. 4651, January 30, 2017, at <http://www.heritage.org/health-care-reform/report/the-2017-health-insurance-exchanges-major-decrease-competition-and-choice>.

⁶ Centers for Medicare and Medicaid Services, "2018 Projected Health Insurance Exchange Coverage Maps: Insurer Participation in Health Exchanges (08/30/2017)," at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/2018-Projected-Health-Insurance-Exchange-Coverage-Maps.html>.

the risk of incurring additional losses. Thus, it is unlikely that they will resume offering Obamacare coverage anytime in the foreseeable future.

IMPLICATIONS FOR THE FUTURE

The ACA's coverage requirements and subsidy design were deliberately intended to provide comprehensive benefits with limited cost sharing to low-income individuals needing medical care, with the cost of their coverage heavily subsidized by taxpayers.

Consequently, it should not be surprising that the exchanges have produced a risk pool consisting mainly of lower-income individuals needing medical care. One telling indicator is that in each of the years 2014, 2015, and 2016, of the enrollees receiving premium tax credit subsidies a consistent 67 percent also received reduced cost-sharing. In other words, over 3 years consistently two-thirds of subsidized enrollees had incomes below 250 percent of the Federal poverty level (FPL) and picked silver-level plans with reduced cost sharing.

Given the structure of the ACA, there is no reason to expect that risk profile to improve in the future. Indeed, the resulting, and substantial, increases in premiums have made Obamacare coverage even less attractive to healthier individuals, and particularly so for those with incomes above 250 percent of FPL. This reality has several implications.

First, while there will continue to be people moving in and out of the subsidized coverage pool as a result of changes in incomes and health status, there is unlikely to be much growth in coming years in the aggregate number of subsidized enrollees above the current level of about 8 million enrollees. The only obvious exception would be an economic downturn that resulted in more people in poor health facing a simultaneous loss of access to employer coverage and reduced incomes.

Second, the number of insurers offering exchange coverage is likely to continue declining for the next couple years, particularly at the county level. Not only have some insurers entirely exited the exchanges, but also a number of those that remain have reduced their geographic footprints in the States where they still participate on the exchanges.

Third, the eventual norm will likely be a situation in which major metropolitan areas still have two or three insurers offering exchange coverage but the less populous areas have only one carrier offering exchange coverage.

Fourth, the carriers most likely to continue offering exchange coverage will be those that have significant Medicaid managed care contracts, and thus substantial experience providing coverage to subsidized low-income populations. This summer, when it looked like a number of counties would have no exchange insurer for 2018, it was carriers whose principal business is Medicaid managed care that stepped in to fill the gaps (such as Centene in several States and CareSource in Ohio).

Despite concerns this summer, the possibility is still low that some parts of the country will have no insurer offering subsidized exchange coverage. That is because subsidized exchange coverage can still be a profitable market niche if an insurer has a monopoly—particularly for insurers with a business focus on serving Medicaid-like populations. While the covered population will be costly, thanks to the ACA-subsidy structure those higher costs will simply be passed on to Federal taxpayers. Thus, an insurer with an exchange monopoly will have sufficient pricing flexibility. Functionally, the result will be very similar to pricing a contract for serving a predetermined subset of the Medicaid population.

More concerning are the instances of insurers ceasing to offer ACA-compliant coverage outside of the exchanges to the unsubsidized population. In that subset of the market there is more danger of a so-called “death spiral” setting in as escalating premiums price more customers out of the market. To prevent that occurring, lawmakers need to reverse or significantly amend a number of the ACA's regulatory provisions that have made coverage more expensive. Failing that, the ACA could effectively shift in the coming years from insuring the uninsured to un-insuring the previously insured—particularly the self-employed and small business owners who comprised the pre-ACA individual market.

CONCLUSION

While there was a significant increase over the first 2 years in enrollment in individual-market policies, those gains have tapered off and may even be in the process of reversing as a result of the law significantly driving up premiums in that market.

Lower-income individuals who qualify for premium subsidies for coverage purchased through the exchanges are largely insulated from those costs. However, middle-income self-employed persons—the more typical pre-Obamacare individual market customers—do not qualify for subsidies and are finding coverage to be increasingly unaffordable or even unavailable. The danger now is that, if the ACA's most costly insurance regulations remain in place, the law will effectively force more of those middle-income individuals to drop their coverage. That would mean that the ACA was actually causing some of the insured to become uninsured.

Mr. Chairman, this concludes my prepared testimony. I thank you for inviting me to testify today. I will be happy to answer any questions that you or the other members of the committee may have.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing entitled “Health Care: Issues Impacting Cost and Coverage.”

Before we begin, I would like to pause for a moment and say a few words regarding the traumatic events that have recently impacted so many of our fellow citizens. The damage and destruction we have seen with relation to Hurricanes Harvey and Irma has been devastating. But, I will say that the acts of heroism we've seen the past few weeks have been awe-inspiring. I think I speak for everyone here when I say that our thoughts and prayers go out to all of the individuals, friends, and family who have been affected by these disasters and that we urge all those who are able to provide assistance to do what they can to help the relief efforts currently underway.

With that, I want to thank everyone present for attending today's hearing on health-care costs and coverage.

Health care is always an important topic as it impacts literally everyone. Health care has also, since the passing of the so-called Affordable Care Act, become a rather contentious topic as well.

The divisiveness that surrounds the health-care debate is unfortunate in my mind, because it has far too often allowed politics and partisanship to cloud our judgment. This is true for those on both sides of the aisle.

We have discussed these issues at length many times before today—this is at least the 37th health-care hearing we've had in the Finance Committee since final pieces of Obamacare were signed into law. However, recent events have spurred us to reevaluate the current situation.

While I welcome the opportunity to reset parts of the health-care debate, the problems plaguing our health-care system remain pretty much the same as they were prior to the passage of Obamacare, and in some regards, I would argue they have become worse.

Costs are continuing to skyrocket. According to a recent report from CMS, because increasing health-care costs are still outpacing the growth of our economy, they are projected to consume 20 percent of our total GDP in just 8 years. That's one-fifth of the economy.

No one should say that we don't spend enough on health care in this country. Currently, health-care expenditures in the U.S. amount to nearly \$10,000 per person. That is more per capita spending than any other industrialized country and, according to OECD data, 20 percent higher than the next highest spending country and nearly double the overall average among OECD member countries.

From 2011 to 2016, the average health premium for employer-sponsored family coverage increased by 20 percent in comparison to a wage increase of only 11 percent during that same period.

A recent study from the PwC Health Research Institute found that medical costs are projected to grow between 6 and 7 percent between 2016 and 2018.

Unsurprisingly, this trend in health-care costs has forced families to divert their spending on other items and necessities—things like food and housing—to pay for growing health-care costs.

Of course, these general growth trends pale in comparison to those in the Obamacare exchanges, where the average premium has more than doubled in just the last 4 years.

One of the chief assumptions underlying the Affordable Care Act was that, if the government forced people to purchase health insurance, more young, healthy people would enter the insurance market, which was supposed to offset the increased costs imposed by all of the law's mandates and ensuing regulations.

Instead, the law imposes a legal requirement for people to purchase insurance while also making insurance unaffordable for millions of Americans. This, as I've noted in the past, is the ultimate irony of Obamacare.

Supporters of the law like to tout coverage numbers in order to claim that the system has actually succeeded. But, those numbers warrant a closer look.

True enough, from 2014 to 2016 insurance coverage in the U.S. increased by about 15.7 million people. However, the vast majority of those newly insured people—around 14 million—were added through either Medicaid or CHIP. As we will hear from some of our witnesses today, enrollment in the individual market may be reaching a tipping point where those who previously had insurance are being priced out of the market and actually becoming uninsured since the enactment of Obamacare.

None of this is surprising. Most of this was predicted at the time Obamacare was being debated.

And now, with virtually every nightmare scenario for the fate of Obamacare coming true, we are hearing calls for bipartisan fixes to shore up the failing system.

Let me be clear: I want to find a bipartisan path forward through this mess. At this point, it's pretty clear that the parties will need to work together if any of this is going to improve.

That said, I am concerned that many of the proposals for a bipartisan solution would amount to little more than a bailout of the current system. This, in my view, would be a mistake.

If we simply throw money into the system to maintain cost-sharing subsidies or make payments to insurers, without fixing any of the underlying problems, we would just be setting up yet another cliff, and likely another partisan showdown, in the future. Even worse, we wouldn't be helping to reduce premiums or increase insurance options for the vast majority of middle class families, whether they get their plans through the exchanges or elsewhere.

Of course, I'm neither naive nor oblivious. I don't want to simply watch health-care costs increase and choices diminish even further while purists in Congress demand the unattainable. We will likely have to act at some point, maybe even this year, to protect American families from the failures of the current system. Once again, I want to find a bipartisan path forward to address these problems.

But let me be clear. In my view, an Obamacare bailout that is not accompanied by real reforms would be inadvisable. We can't simply invest more resources into a broken system and hope that it fixes itself over time.

The status quo under Obamacare is not improving. I don't believe we should spend more energy to prop up a system that is already hurting millions of Americans.

While I may sound like a naysayer here this morning, that is far from the truth. I am an optimist, and always have been.

We had a hearing last week on the CHIP program, which demonstrated that we are more than capable of working together to address health-care needs. Hopefully, we can do the same when we talk about the broader effort to bring down costs and maintain coverage throughout the health-care system.

For instance, both Senators Cornyn and Wyden each have a bill to repeal the Independent Payment Advisory Board included in Obamacare.

Just last Congress, many of us worked together in bipartisan fashion to delay the HIT for 1 year and the Cadillac tax for 2 years. We also imposed a 2-year moratorium on the device tax.

I believe we can come together again to provide some relief through elimination of these and other onerous Obamacare taxes that drive up costs for consumers and hamper innovation.

Personally, I also believe members on both sides of the aisle should be open to rolling back, or at least amending the individual and employer mandates, two of the most unpopular components in Obamacare.

These are just some examples of things that members of this committee have been working on to address our runaway health-care costs and to amend a beleaguered Obamacare. Even our newest members, like Senator Cassidy, are eager to tackle these complex issues.

So let's put our differences aside and work together on meaningful changes. We've done it before and we can do it again.

I look forward to hearing from our witnesses today and from my friends on both sides of the dais. Hopefully today's discussion will provide some clarity on how we can better work together on these matters going forward.

PREPARED STATEMENT OF AVIK S.A. ROY, CO-FOUNDER AND PRESIDENT,
FOUNDATION FOR RESEARCH ON EQUAL OPPORTUNITY

INTRODUCTION

The two most important problems with American health care stem from its high cost. The high cost of U.S. health care is the reason that tens of millions go without health insurance. In addition, the unsustainable trajectory of the Federal deficit and debt are driven by growth in public spending on health care, a problem primarily driven by growth in the price of health-care services. If unsustainable public debt forces the United States to engage in aggressive fiscal austerity at some point in the future, it will be those most dependent on public health expenditures—the poor, the elderly, and the vulnerable—who will have the most to lose.

Hence, reducing the growth of national health expenditures is the most important domestic policy problem facing the United States.

Today, those most adversely affected by the high cost of U.S. health care are the working poor and lower-middle earners: individuals and households without employer-sponsored coverage who are not poor enough to benefit from Medicaid and ACA exchange subsidies, nor old enough to qualify for Medicare.

While the Affordable Care Act's subsidies have helped millions of these individuals afford coverage, its regulations have frozen millions of others out of the health insurance market. Furthermore, the ACA's structure has exacerbated long-standing problems with the U.S. health-care system, and substantially weakened the long-term sustainability of public health-care assistance. These problems require the urgent attention of the U.S. Senate.

DESTABILIZATION OF THE INDIVIDUAL HEALTH INSURANCE MARKET

The Affordable Care Act has had the greatest impact on the individual insurance market: the market for people who buy health coverage on their own, instead of having it purchased on their behalf by the government or their employer.

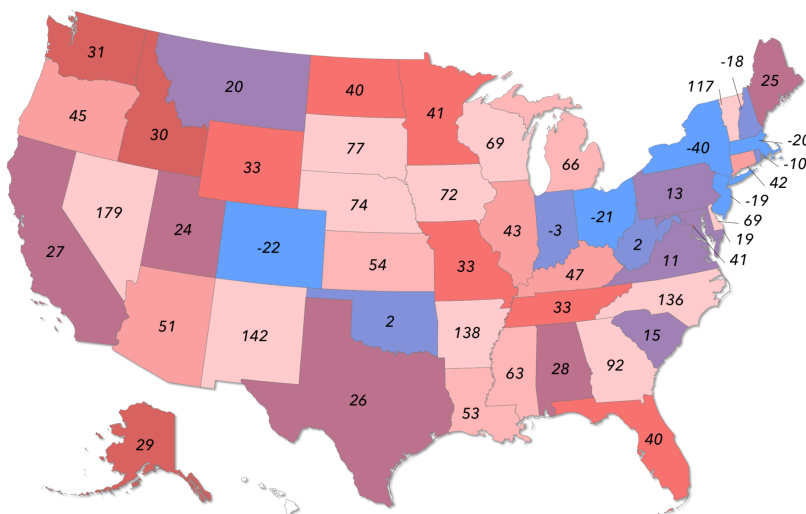
This market was—and is—worthy of substantial attention by policymakers. The individual market—sometimes called the “nongroup market”—is often described as small, because a relatively small proportion of U.S. residents own individually purchased health insurance policies. However, those who are uninsured today represent an important part of the individual market: those who choose to remain uninsured, rather than buying coverage, because of its high costs. According to the Congressional Budget Office, 18 million U.S. residents purchased nongroup coverage, while an additional 27 million went uninsured. That amounts to a total individual market of 45 million, comparable in size to Medicare.

The ACA created an entirely new layer of Federal regulation to restrict how nongroup health insurance policies could be designed, and devised new taxes on health insurance premiums and health-care products.

The effect of these regulations and taxes has been to double, on average, the underlying price of individual market insurance premiums, with even greater in-

creases for those who are younger and/or in relatively good health.¹ In 2014 alone, the ACA increased individual-market premiums by an average of 49 percent.²

Figure 1. Change in Individual Market Premiums Under ACA, 2013-14 (Percent)



Rate shock in the non-group health insurance market. Prior to 2010, the market for health insurance purchased by individuals on their own was almost entirely regulated by states. The ACA added a new—and costly—layer of federal regulation upon this market. Many healthy individuals experienced rate increases of 100 to 200 percent. Even when taking into account those with pre-existing conditions, the ACA increased underlying rates in the average county by 49 percent. (Source: *Manhattan Institute*)

The ACA attempts to use two tools to compensate for these premium increases: means-tested tax credits to subsidize premiums, and an individual mandate designed to force those with higher premiums back into the market.

While the subsidies have worked to blunt the impact of higher premiums for those with incomes below 200 percent of the Federal Poverty Level (which amounts to \$24,120 for a childless adult), millions of working families of limited means have not benefitted from the ACA's policy mix. Indeed, data from insurer filings indicates that, even after ACA subsidies are taken into account, most individuals above 200 percent of FPL are paying higher premiums than they did prior to the ACA.²

Furthermore, most independent research finds that the individual mandate is not doing much to drive the uninsured to enroll in the ACA's exchanges. In a 2016 article for the *New England Journal of Medicine*, MIT economist Jonathan Gruber and two co-authors wrote, "when we assessed the mandate's detailed provisions, which include income-based penalties for lacking coverage and various specific exemptions

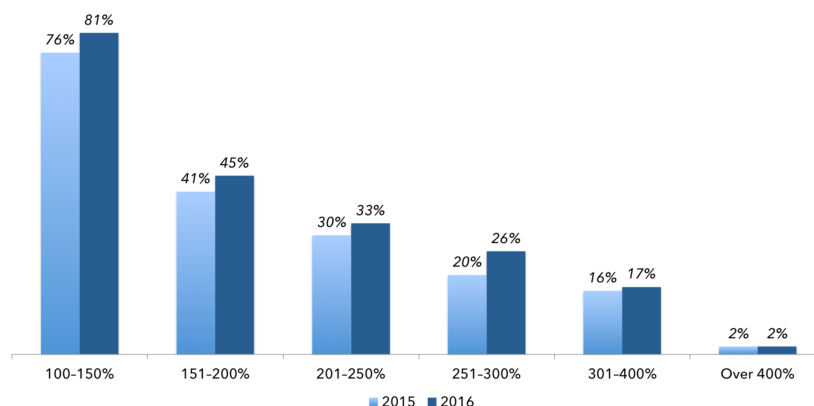
¹"Individual Market Premium Changes: 2013–2017." Office of the Assistant Secretary for Planning and Evaluation. May 23, 2017; <https://aspe.hhs.gov/system/files/pdf/256751/IndividualMarketPremiumChanges.pdf>.

²Roy, A., "3137-County Analysis: Obamacare Increased 2014 Individual-Market Premiums by Average of 49%." *Forbes*. June 18, 2014; <https://www.forbes.com/sites/theapothecary/2014/06/18/3137-county-analysis-obamacare-increased-2014-individual-market-premiums-by-average-of-49/#7239193a527b>.

from those penalties, *we did not find that overall coverage rates responded to these aspects of the law*” (emphasis added).³

That is because, while a heavily coercive and strictly enforced individual mandate could drive Americans to participate in the ACA’s high-cost market, the actual individual mandate stipulated in the ACA contains numerous loopholes and exemptions, with weak penalties for noncompliance.⁴

Figure 2. Percentage of Eligible Individuals in Exchange Plans, by Income (% FPL)



ACA premium subsidies are not sufficient to compensate for higher ACA gross premiums. The ACA’s premium increases, driven by the law’s extensive regulations of the individual market, exceed the subsidies that most Americans are eligible for. As a result, as one ascends the income scale, net premiums are costlier today than they were prior to the debut of the exchanges in 2014. (Source: Avalere Health, HHS Assistant Secretary for Planning and Evaluation)

The end result has been a partial actuarial death spiral, in which those below 200 percent of FPL enroll in large proportions in ACA exchanges, while those above 200 percent do not. A study by Avalere Health, using HHS data, found that in 2016, only 33 percent of those with incomes between 200 and 250 percent of FPL had enrolled in exchange-based coverage, and 26 percent for those between 250 and 300 of FPL.⁵

In summary, recent discussions about “stabilizing” the individual health insurance market have been notable for the degree to which they have failed to address the actual causes of market destabilization.⁶

THE PRINCIPAL DRIVERS OF HIGH ACA PREMIUMS

As noted above, there are two categories of ACA provisions that have increased individual market insurance premiums: regulations and taxes. Within each category, a few provisions stand out for their disproportionately negative impact.

³Frean, M., et al., “Disentangling the ACA’s Coverage Effects—Lessons for Policymakers.” *New England Journal of Medicine*. October 27, 2016; 375:1605–1608.

⁴Roy, A., “Obamacare’s Dark Secret: The Individual Mandate Is Too Weak.” *Forbes*. July 9, 2012; <https://www.forbes.com/sites/theapothecary/2012/07/09/obamacares-dark-secret-the-individual-mandate-is-too-weak/#34a209f26abf>.

⁵Ip, G., “The Unstable Economics in Obama’s Health Law.” *The Wall Street Journal*. August 17, 2016.

⁶“Future of Health Care: Bipartisan Policies and Recommendations.” Bipartisan Policy Center. August 30, 2017; <https://cdn.bipartisanpolicy.org/wp-content/uploads/2017/08/BPC-Health-Future-of-Health-Care-Recommendations.pdf>.

3:1 age bands. The ACA requires that insurers charge their youngest customers no less than one-third what they charge their oldest customers. Because 18-year-olds typically consume one-sixth of the health care that 64-year-olds consume, this provision has the effect of doubling premiums on the young, without any benefit for older enrollees, because as the young drop out of the market, premiums rise for everyone who remains.

Actuarial value mandates. “Actuarial value,” for a given insurance policy, represents the proportion of insurance claims that are paid by the insurer, relative to those paid by the enrollee, in the form of co-pays and deductibles. Prior to the ACA, the most popular plans in the individual market had an actuarial value of 40–45 percent. The ACA mandates that plans have a minimum actuarial value of 60 percent, and benchmarks “silver” plans to a 70-percent actuarial value. Because these mandates force insurers to pay more, these costs are directly passed through to consumers in the form of higher premiums.

Essential health benefits. Because of the plethora of State-based health insurance benefit mandates, the actual economic impact of the ACA’s Federal benefit mandates is smaller than the impact of 3:1 age bands and actuarial value mandates. But some of the ACA’s mandates, such as the one for normal labor and delivery, create considerable adverse selection in the individual market.

Health insurance premium taxes. The ACA’s sales tax on private health insurance premiums is passed onto consumers in the form of higher premiums, and has the paradoxical effect of increasing Federal spending on premium assistance.

Taxes on pharmaceuticals and medical devices. Similar to the direct premium taxes, these taxes are passed down to the consumer in the form of higher premiums.

Adverse selection. Because all of the above mandates drive premiums upward, they encourage high consumers of health care (*i.e.*, the sick) to enroll in coverage, and discourage low consumers of health care (*i.e.*, the healthy) from doing so. This degradation of the individual market risk pool drives premiums upward, separately from the inherent effects of the above mandates and taxes, because premiums are directly correlated to the average amount of health care consumed by enrollees in the individual market.

ACA’S SECTION 1332 DOES NOT PROVIDE MEANINGFUL STATE FLEXIBILITY

Some policymakers believe that the ACA’s section 1332 waiver process is a sufficient vehicle for State-based insurance market reform, and that further statutory reforms are not needed. This is entirely false.

Section 1332 of the ACA allows States to apply for waivers in which they would be granted exemptions from the ACA’s individual and employer mandates, so long as they kept the remainder of the ACA’s premium-increasing regulations in place. In addition, the Centers for Medicare and Medicaid Services are only allowed to grant State waivers if they conclude that the number of people with coverage in a given State would be equal to or greater than under the standard ACA model.

While it is possible for alternatives to the ACA model to result in comparable coverage numbers, such alternatives must include the flexibility to waive the ACA regulations that increase premiums and worsen adverse selection.

It is not sufficient for Congress to simply accelerate the decision-making timeline for section 1332 waivers, as some have proposed. States must have genuine flexibility in how health insurance can be designed and purchased in their jurisdictions, so that premiums can come down, and enrollment can go up.

PAIRING REAL RELIEF FROM ACA PREMIUMS WITH COST-SHARING SUBSIDIES

At the urging of the health insurance industry, much of the recent policy discussions around individual market stabilization have revolved around congressional appropriations for cost-sharing reduction subsidies, or CSR subsidies. These subsidies, available to ACA exchange enrollees with incomes below 250 percent of FPL, substantially defray eligible enrollees’ exposure to deductibles, co-pays, and other out-of-pocket expenses.⁷

⁷ Roy, A., “A Short-Term Bailout of Obamacare? Only if Accompanied by Long-Term Reforms.” *Forbes*. August 4, 2017; <https://www.forbes.com/sites/theapothecary/2017/08/04/a-short-term-bailout-of-obamacare-only-if-accompanied-by-real-long-term-reforms/#20d7106e39f0>.

While the ACA requires insurers to offer plans to these enrollees with extremely low deductibles—with actuarial values as high as 94 percent—the law does not appropriate funds to subsidize these extra costs that insurers incur. In *House of Representatives v. Price*, a Federal judge ruled that the Obama administration had been illegally offering cost-sharing subsidies to insurers that Congress did not appropriate. As a result, the legal status of cost-sharing subsidies is in doubt.

Insurers have said that if they are forced to offer plans to those below 250 percent of FPL with low deductibles, without being allowed to recoup those costs through Federal subsidies, they will increase individual market premiums by as much as 20 percent.

While the threat of increased premiums due to the cessation of cost-sharing subsidies is a serious problem, it is of no greater seriousness than the fact that nongroup premiums have doubled since the ACA's insurance regulations went into effect. It would be irresponsible of Congress to address the issue of cost-sharing subsidies without offering Americans with incomes above 250 percent of FPL relief from rising ACA premiums.

In theory, Congress could rectify the ACA's statutory sloppiness through either (1) relieving insurers of the requirement to offer high actuarial value plans to enrollees below 250 percent of FPL; or (2) explicitly appropriating funds for cost-sharing subsidies. Insurers have consistently advocated for the latter option, as it would lead to higher exchange enrollment and higher Federal spending on premium tax credits.

The optimal short-term policy for Congress to consider would be to pair an explicit appropriation of cost-sharing subsidies for the plan years 2018 and 2019 with relief from high ACA premiums. This relief should include the following policies:

- Repealing the ACA's age bands, or widening them to 6:1;
- Repealing actuarial value mandates, or re-legalizing "copper plans" with a 50-percent actuarial value;
- Repealing the ACA's individual mandate beginning in 2021 or later, and replacing it with a 6-month waiting period and State flexibility to institute late enrollment penalties; and
- Modifying section 1332 of the ACA such that it includes the flexibility to waive a broad range of ACA insurance regulations.

Relief from the health insurance premium tax, pharmaceutical tax, and medical device tax could be added to a package that included the above reforms, but they are not sufficient in and of themselves as relief from high ACA premiums.

Appropriating funds for CSRs without addressing these underlying causes of individual market destabilization would do nothing to help those who are being priced out of the health insurance market today. Indeed, it would make that more important set of reforms more difficult for Congress to enact. Hence, it is of great importance that Congress pair these reforms in a single piece of legislation.

ADDRESSING THE BROADER DRIVERS OF HIGH HEALTH-CARE COSTS

It is, of course, important to note that the high cost of U.S. health care far predated the passage of the Affordable Care Act. The exclusion from taxation of employer-sponsored health insurance, rooted in World War II-era wage controls, is the primary driver of high American health-care prices, because it heavily subsidized the expansion of insurance policies into health-care services that would, in a normal market, not be considered as appropriate for insurance. Medicare, which was modeled after the employer-based health-care system, substantially compounded this problem.

Hospitals, pharmaceutical companies, and other health-care industries charge extremely high prices because most patients do not directly purchase their insurance coverage, and are therefore in far less of a position to hold health-care providers accountable for high prices. Two monographs published in the last 12 months—*Transcending Obamacare* and *The Competition Prescription*—explore a wide range of policy options for tackling these problems.^{8,9}

⁸Roy, A., "Transcending Obamacare: A Patient-Centered Plan for Near-Universal Coverage and Permanent Fiscal Solvency." The Foundation for Research on Equal Opportunity. September 2016: <https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view>.

⁹Roy, A., "The Competition Prescription: A Market-Based Plan for Making Innovative Medicines Affordable." The Foundation for Research on Equal Opportunity. May 2017: <https://drive.google.com/file/d/0B4VpAFwBu2fUOUJqNjRRS3VYclk/view>.

At the end of the day, the best way to reduce the cost of health care is to build a consumer-driven, patient-centered system in which private insurers compete to provide affordable coverage to everyone. This is why it is so important to make the individual market work for every American. If and when Congress succeeds in enacting meaningful reform of individually purchased health insurance, it will have laid the groundwork for us to finally bend the cost curve and put America back on a fiscally sustainable path.

QUESTIONS SUBMITTED FOR THE RECORD TO AVIK S.A. ROY

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. Mr. Roy, one of the things you repeated in the course of your testimony was the importance of individuals maintaining their continuous coverage. One of the things the ACA sought to do was reduce churn in the Medicaid population by expanding the program and integrating it with the ACA Exchanges. How have the States who did not expand Medicaid fared relative to those that did in maintaining coverage for lower income individuals and reducing churn?

Answer. It depends on the population. For example, in States that did not expand Medicaid, churn was eliminated for those with incomes between 100% and 138% of the Federal Poverty Level, who became eligible for exchange-based coverage instead of Medicaid. Those with incomes below 100% FPL in those states, however, often do face churn, as do those crossing the 138% FPL threshold in expansion States.

As I discuss in *Transcending Obamacare*, the ideal way to eliminate churn is to expand eligibility for subsidized coverage to 0% FPL. The authors of the ACA, as you know, considered this approach but did not choose it, because CBO told the Senate Finance Committee that it would be too costly. It would be useful for CBO (and perhaps CMS) to revisit this question now that we have several years of experience with both the Medicaid expansion and the exchanges.

For your reference, here is the PDF of *Transcending Obamacare*: <https://drive.google.com/file/d/0B4VpAFwBu2fUQjNtaU82djRwM2s/view>.

Question. In your monograph, *The Competition Prescription*, you state that, “[T]he market for prescription drugs is not ‘free.’” How have the government rebate programs, the industry’s own programs to help individuals afford their medications, and the sporadic price negotiation that does exist clouded the market? More specifically, does anyone in the United States pay the list price for prescription drugs?

Answer. Few people pay the list price for prescription drugs; those who do tend to be uninsured. Some observers believe that the Medicaid “best price” rebate program incentivizes manufacturers to raise prices elsewhere, or decline to negotiate prices elsewhere, lest they be forced to offer the same discounts to the Medicaid program. I do not believe that this is correct. Pharmaceutical manufacturers do not offer lower prices to PBMs or other buyers out of the kindness of their hearts; they do so because PBMs et al. have market leverage to force pharmaceutical manufacturers to accept lower prices.

Industry efforts to fund co-pays for low-income patients actually increase overall costs, because they allow manufacturers to maintain high prices, and garner more revenue, under the guise of assisting the poor. Politically, manufacturers gain a win-win: they are helping low-income patients and also reducing the amount of attention paid to their prices. In reality, by eliminating co-pays for a category of patients using high-priced drugs, manufacturers make more net revenue from these patients than they would without such programs, and consumer’s premiums (and taxpayer spending on health care) is higher as a result.

PREPARED STATEMENT OF ANDREW M. SLAVITT, FORMER ACTING ADMINISTRATOR, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the invitation to be back in front of this committee to discuss an issue of vital importance to millions of American families: improving access to high-quality, affordable health care. My name is Andy Slavitt. I currently serve as a Senior Advisor to the Bipartisan Policy Center after having served in an acting capacity as Administrator of the Centers for Medicare and Medicaid Services from 2015 to 2017,

which followed a 20-year career in the private sector. While at CMS, I had the honor of working alongside the high-caliber men and women of the agency who set out on a daily basis to help the American public get the care they need at all stages of life. CMS serves over 100 million Americans, often at the most vulnerable times in their lives, as they age, have children, change employment, and struggle with complex medical conditions and a complex health-care system that, left on our own, few of us could afford.

I am grateful to the Senate Finance Committee for the role you have played through the years in advancing health care for our country and for holding this hearing. I hope that this is part of a new opportunity to discuss and debate bipartisan ideas to support the health-care needs of the people in the country. While I had the honor of participating in the implementation, I am not here as an unabashed defender of the Affordable Care Act, but as someone who believes we need to move forward with the best ideas to provide affordable, quality health care. I believe this is best done with an honest accounting of what is working and our challenges and a focus on practical solutions.

I have had the opportunity to see first-hand how the Affordable Care Act has advanced the lives of millions of Americans over its first few years.

- After decades of stagnation, the ACA has provided financial protection and improved access to a regular source of care for millions of Americans, reducing the number of Americans without insurance from 2013 to 2017 from 14% to 8.3% according to the CMS Office of the Actuary,¹ its lowest recorded level.
- The ACA also provided valuable consumer protections to all Americans like prohibiting discrimination against an estimated 130 million people with pre-existing conditions,² most of whom currently receive employer-based coverage. The law outlawed annual and lifetime policy limits, and the old insurance practice of often arbitrarily excluding coverage of certain benefits like pharmacy, hospital care, or mental health. Before the Affordable Care Act, if Americans could even qualify for individual coverage, they often did not know what they were getting in a plan. They could be charged more for existing illnesses, or could have limitations in their policies that excluded those illnesses altogether.
- The ACA made health care more affordable for millions more Americans. By providing income-based tax credits to people in the individual market, individual buyers were put roughly on par in terms of tax treatment, for the first time, with people who receive employer sponsored coverage. Along with positively impacting job mobility, this significantly expanded health care affordability. In the last open enrollment, nearly 8 in 10 people who bought coverage on the exchange were able to buy a policy for under \$100/month.³ Furthermore, according to the Kaiser Family Foundation, the cost of the most popular benchmark plan on the exchange has been virtually unchanged since 2014 when subsidies are accounted for.⁴ In fact, in 2018, net premiums will actually be slightly lower than 2017, because the IRS has reduced the percentage of income that people have to pay for the benchmark plan.⁵

These impacts are real. Over and over, when I was at CMS, I met and heard from people who, prior to the ACA, couldn't get insured for a chronic condition, couldn't

¹“National Health Expenditure Projections 2016–2017,” Office of the Actuary, Centers for Medicare and Medicaid Services, March 21, 2017. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>. The actual data referenced is in the “NHE Projections 2016–2025—Tables [ZIP, 298KB]” file, under “Table 17—Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years 2009–2025.”

²“Health Insurance Coverage for Americans With Pre-existing Conditions: The Impact of the Affordable Care Act,” Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, January 5, 2017. Available at: <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf>.

³“Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace,” Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, October 24, 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.

⁴Kamal, Raba, et al. “An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges.” Henry J. Kaiser Family Foundation, August 10, 2017. Available at: <http://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>.

⁵Norris, Louise. “Is the IRS changing how much I'll have to pay for my health insurance next year?” *HealthInsurance.org*, August 15, 2017. Available at: <https://www.healthinsurance.org/faqs/is-the-irs-saying-ill-have-to-pay-more-for-my-health-insurance-next-year/>.

afford insurance, or couldn't leave their job without fear of being without insurance. Life is immeasurably better for many people as a result of the ACA.

But as with any major legislation, there are areas ripe to address, some of which I will come to as I discuss policy recommendations. Others like the "family glitch," income cliffs, and certain Tribal issues I encourage addressing, but are beyond the time and scope of this hearing.

Nor am I here only with the perspective of a former government official. I understand the potential of the private sector because I have worked for one of the largest participants in the health-care private sector. Prior to joining CMS, I had a two-decade private sector health-care career. Most of my career has been focused directly on the expansion of coverage, including exchange markets, as well as major initiatives to improve health-care affordability for Americans. I have been a health-care technology entrepreneur and built a company focusing on online consumer access to health-care purchasing for the un- and under-insured as far back as the 1990s. I led an insurance company exclusively serving hard-to-reach rural and farming communities. And I helped build a large and successful private sector health-care company which contained among other things, a large actuarial consulting business, a private insurance exchange, and consumer transparency tools.

I have an understanding of how exchanges work and what they need to do in order to be successful from several perspectives—as a regulator, as a market participant, and now as a consumer. If anyone tells you the ACA is failing, doomed, or irreparably broken, I would respectfully disagree and suggest that with the proper management and support, most challenges are addressable. This doesn't mean the ACA doesn't need active management to be as successful as possible. It requires an administration committed to the goal of getting more people access to coverage, particular as these are still the early years for the program. And, to be successful, we must continually improve and capitalize on lessons learned from the early years of the exchange.

IMMEDIATE RECOMMENDATIONS

As a starting point, I believe we should be open to any improvements to current law, no matter the origin of the idea. As Americans, we all have a rooting interest in improving health care for our families, and in the communities we live in. Any improvements, however, should meet important criteria. We should support policies which are judged by an impartial body like the Congressional Budget Office to: (1) increase the number of Americans with coverage, (2) improve affordability, (3) maintain or improve the quality of coverage, and (4) do so in a fiscally responsible manner.

Following my recommendations, I will provide a link to a more exhaustive bipartisan set of recommendations from the Bipartisan Policy Center. The best immediate opportunity for Congress is to take steps to improve the affordability of premiums and the size of deductibles without hurting access to coverage.

- As a chorus of bipartisan insurance commissioners, Governors, and advocates on all sides have indicated, by simply committing to paying **Cost Sharing Reduction** payments, Congress can take immediate steps to reduce premiums by 20%.⁶ This commitment should be made at least through 2019 and has already been accounted for in the Federal budget. My experience over many years echoes the sentiment from these bipartisan and non-partisan experts. Uncertainty is not our friend when operating free market exchanges. Predictability and consistency will lead to more competition, lower premiums, and reduced deductibles. Insurance companies begin the 2019 rate filing process as early as the Spring of 2018, and having States and insurance companies and consumers uncertain about the rules for 2019 will limit their participation and increase the cost to consumers.
- Another bipartisan idea that is proven to bring down premiums for consumers is **reinsurance**. Particularly in smaller States, the cost of insurance for everyone covered can be impacted by even a small number of expensive patients with complex medical conditions. Innovative efforts, as we have seen in Alaska, have demonstrated that this approach works. In both Alaska and Minnesota, the estimated impact of a well-structured reinsurance program has been estimated at

⁶"The Effects of Terminating Payments for Cost-Sharing Reductions," Congressional Budget Office, August 15, 2017. Available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

20% of premium.⁷ Reinsurance is also budget friendly as approximately half of the outlay is recovered by the reduction in premiums and government subsidies.

- **Marketing, outreach, and in person enrollment support** are vital to not only bring down the uninsured rate, but to improve the risk pool. This directly reduces premiums for American families and benefits the U.S. taxpayer. No additional funds need to be allocated. Rather HHS should be directed to commit at least the funds that have been recently cut from marketing, outreach and in-person assistance, as well as to provide appropriate levels of call center staffing. Because these funds generally come from user fees paid by insurers, there would be no budget impact to doing so. Outreach is particularly important with a shortened enrollment period and polls showing much of the public is confused about the status of the ACA and the availability of insurance.
- Due to the foresight of this committee, we have provisions in the law to allow States to go further and provide local State-based innovations through the **section 1332 waiver process**. This is a significant opportunity, and one the committee should consider making easier. Only two waivers have been approved, and I know there are States that are quite concerned about the time it takes to approve a waiver, particularly one that looks a lot like a previous waiver. I would support steps to shorten the timeline for section 1332 approvals and other common-sense steps to simplify the waiver process, subject to maintaining the critical guardrails that protect consumers. These guardrails are the same ones I mentioned above—(1) increasing the number of Americans with coverage, (2) improving affordability, (3) maintaining or improving the quality of coverage, and (4) doing so in a fiscally responsible manner—that should be criteria for any health-care reform proposals considered.

All-in, while close to 85% of exchange participants don't pay the headline premiums,⁸ and as a result have not been subject to the widely reported rate increases, taken together, these recommendations represent an important opportunity for Congress to help reduce premiums for Americans who do not qualify for tax credits. These solutions are not beyond our scope—they are surgical, affordable, and appropriate for where we are at this stage of the exchanges. If the administration commits to enforcing the existing law and implements these straightforward and budget-friendly proposals, we can be confident of a stable, lower cost, competitive individual market heading into 2019.

COST AND COVERAGE: MEDIUM- AND LONGER-TERM REFORMS

We cannot simply focus on how insurance markets work if we want to make health care more affordable, and more accessible, to all Americans. We must address the underlying costs of care, where 85% of a consumer's premium is spent.

We must focus on root cause issues that drive health-care costs. Many are well-documented—poor care coordination, the costs of unmanaged chronic disease, the high administrative burden and complexity of our system, our underinvestment in primary care and the social determinants of health, and the costs of high need patients like those dually eligible for Medicare and Medicaid. Our health-care system, in particular, is not well situated to treat people with multiple chronic physical and mental conditions. Ultimately, we need to undergo a major conversion from institutional-based care to keeping people healthy and treating them in comfortable and low-cost settings, where the most successful and satisfying health care is delivered.

To be effective at this, we must also alter how we pay for care if we want to see better, more affordable results. We must commit to moving to a system where we pay for quality outcomes and reward the smart use of resources. This means paying for care in bundles so physicians and other clinicians work as a team to achieve a better outcome. This means paying for prevention like pre-diabetes care and cardiac prevention. And it means we must address the rising costs of prescription drugs, whose costs put a significant and growing burden on American families and taxpayers. The Medicare Access and CHIP Reauthorization Act Congress passed in

⁷“Alaska: State Innovation Waiver Under Section 1332 of the PPACA,” Centers for Medicare and Medicaid Services, Department of Health and Human Services, July 22, 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf>.

⁸“Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace,” Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, October 24, 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.

2015 on a bipartisan basis was an important step in the direction of a smarter payment system. Now, in implementing this law, we must listen to patients, caregivers and physicians and other clinicians so the law enables better results for patients—rather than additional complexity.

We also need to pay special attention to the needs of rural America when it comes to health care. This was one of my priorities when I was at CMS and we began an initiative to focus on the unique competition, access, innovation, and structural health-care issues in rural America. I held numerous sessions in rural parts of Oregon, Kansas, and other States to understand these issues first-hand. The issue of competition in rural counties on the exchanges is one that stems from the limited number of hospitals and contracting options. This dynamic results in higher costs and fewer insurers able to meet the needs of constituents. Special attention should be paid to these uniquely rural issues and to the consideration of creative solutions for consumers who lack access to sufficient choices, including consideration of access to the insurance options like the Federal Employees Health Benefits Plan or a modified version of the State's managed Medicaid plan.

One thing that will not reduce costs is simply reducing what insurance covers or cutting or capping access to vital programs like Medicaid for low-income seniors, children, and people with disabilities. We know from experience that when fewer people are covered or have “gotcha” policies, they accrue bills that go unpaid and worse, defer or avoid care until their illnesses are too advanced. This makes health care more expensive for everyone.⁹ Vital programs like Medicaid must always be examined and continually reformed. There are bipartisan approaches that move us beyond the current debate on Medicaid. Dr. Gail Wilensky, a former Bush administration official, and I published a set of bipartisan approaches to reform Medicaid this summer in the *Journal of American Medical Association*.¹⁰

Ultimately, as the title of your hearing indicates, covering more Americans and reducing health-care costs are linked. We cannot provide access to the care Americans need without a sustainable system. Likewise, covering fewer people with shoddier insurance only serves to drive costs up.

CONCLUSION

The above recommendations are my own. In addition to these recommendations, as a senior advisor at the Bipartisan Policy Center, I would also suggest that you look at recent recommendations published by BPC's Future of Health Initiative, in which I took part. Over the last 6 months, along with other Bipartisan Policy Center leaders, Republicans and Democrats, we have put together a set of recommendations.¹¹ During this process, I have had the opportunity along with other members of BPC's Future of Health initiative, to meet with hospital and insurer CEOs, Republican and Democratic State health officials, and experts from across the political spectrum to explore the question of what immediate and long-term priorities they have to improve the cost, quality and access to care. I have also personally had the opportunity to visit many parts of the country to hear directly from hundreds of ordinary Americans struggling with day-to-day health-care concerns. There are, of course, wide ranging views but also common themes.

Two things stand out from all of these conversations. First, everyone asks for additional certainty out of Washington. Uncertain Federal policy is not our friend and the only rational response to this uncertainty for many insurers and providers is to increase prices or decide not to participate in our programs entirely.

The second consistent theme from the world outside of Washington is a hope for bipartisanship—a desire that we can all come together to focus on pragmatic solutions when challenges arise. I understand the difficulty of reaching compromise, and I am realistic enough to understand that the politics of health care have grown complex. I know there will be a diverse and substantive set of views presented today. As challenging as it is, in the end it matters because we all have a stake in the same outcome.

⁹Subramanian, Suhja, “Impact of Medicaid Copayments on Patients With Cancer,” *Medical Care*, Vol. 49, No. 9, 842–847, September 2011. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21577164>.

¹⁰Slavitt, Andy, and Gail Wilensky, Ph.D., “Reforming Medicaid,” *JAMA Forum*, July 11, 2017. Available at: <https://newsatjama.jama.com/2017/07/11/jama-forum-reforming-medicaid/>.

¹¹“Future of Health Care: Bipartisan Policies and Recommendations,” Bipartisan Policy Center, August 2017. Available at: <https://bipartisanpolicy.org/library/future-of-health-care-bipartisan-policies-and-recommendations/>.

With Congress's leadership, I know that I join with many in my commitment to supporting a collaborative path to improving both cost and coverage in America.

QUESTIONS SUBMITTED FOR THE RECORD TO ANDREW M. SLAVITT

QUESTION SUBMITTED BY HON. RON WYDEN

MARKETING AND ENROLLMENT IN THE MARKETPLACE

Question. The Trump administration has taken multiple steps to undercut the Affordable Care Act by impeding outreach and enrollment efforts. These include stopping planned ACA sign-up advertisements during the final week of open enrollment this year, putting out negative materials about the ACA, cutting the enrollment period in half, and slashing funding for outreach and enrollment by 72 percent for the coming open enrollment period. This included a 90-percent cut to advertisements for ACA sign-ups and a 40-percent cut to the navigator program.

These changes to outreach and marketing funding could impact the individual market by causing fewer Americans to enroll and driving up the cost of premiums. A study conducted on behalf of the California State health exchange found that enrollment would likely drop by 1 million and premiums would increase more than 2.5 percent due to the decrease in marketing support.

Mr. Slavitt, as the former Acting Administrator at CMS, could you describe how these cuts to outreach could impact the cost of coverage offered in the individual marketplace?

Answer. Investment in outreach and enrollment can generate a significant return on investment in the form of lower premiums that result from a healthier and more balanced risk pool of enrollees. Analysis by California's Health Insurance Marketplace program, Covered California, indicates that investment in outreach and enrollment activities strengthened Covered California's risk pool and is directly responsible for a 6-to-8% reduction in premiums.¹

CMS closely studied the impact of outreach and marketing on enrollment during my time at CMS and confirmed the critical role it plays in the operation of the Federal marketplace. Outreach and marketing not only increase enrollment, but also increase the number of young and healthy people who sign up. When affordable options are available, people who are acutely ill or have a chronic health condition are highly motivated to get covered. Healthier individuals are less motivated to get covered. Outreach and marketing disproportionately drive the enrollment of healthier people. These healthier people improve the risk pool, which lowers costs for marketplace consumers.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

Question. I heard from multiple State stakeholders at last weeks' hearings who wish to combine the savings from section 1332 waivers and section 1115 waivers. I understand the motivation behind increasing State flexibility and the desire to share savings, but how would you ensure that combining the savings from both waivers wouldn't be used as a means of helping consumers in the insurance marketplace at the expense of Medicaid beneficiaries, or vice versa?

Answer. Fortunately, some of the goals behind combined waiver proposals can already be achieved under current law, such as coordinated section 1332 and section 1115 waivers. However, combining funding streams for Medicaid and marketplaces through combining section 1332 waiver authority with Medicaid section 1115 waiver authority presents significant concerns around the possibility of States shifting resources away from lower-income Medicaid enrollees and frail, disabled, or elderly Medicaid patients and toward coverage for higher-income marketplace enrollees. Such approaches would weaken health and long-term care coverage for the people who need it most.

¹Peter V. Lee, Vishal Pegany, James Scullary, and Colleen Stevens, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," 6-7, Covered California Research Report, September 2017. Available online at: http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

QUESTIONS SUBMITTED BY HON. ROBERT MENENDEZ

Question. During the hearing, Senator Cassidy asked for feedback on his proposal to combine Medicaid's section 1115 waiver with the Affordable Care Act's section 1332 waiver. What are the potential harms of eliminating the current protections in each waiver authority for beneficiaries? In particular, can you highlight what the potential impact on seniors and older Americans will be under Senator Cassidy's proposal if States are allowed to shift money from Medicaid to other programs?

Answer. The patient protections in section 1115 and section 1332 are paramount; and the impact of reducing or removing the protections would harm many Americans. For instance, those with preexisting conditions and others with serious medical issues could be harmed if insurers would once again be able to excluded key benefits such as maternity coverage, mental health and substance use treatment, or prescription drugs due to a relaxing of EHB. If the affordability protections were changed, States could make changes that would increase consumers' net premiums, deductibles and other cost sharing, or both, again impacting individuals with pre-existing conditions or other health needs.

Combining funding streams for Medicaid and marketplace coverage and merging the waiver authority for each program creates significant risk in reducing coverage for the lowest-income Americans. These risks would be even higher in instances where the combined pool of funding is then reduced below what it would otherwise be, as is the case with the "Graham-Cassidy" legislation. By combining both waiver programs, with less comprehensive and clear guardrails under Graham-Cassidy, the legislation could pose significant risk to the highest cost, highest acuity, and highest frailty patients—as States may need to extract significant budget savings in order to work within the new, lower combined budgets for Medicaid and marketplace coverage.

Question. The Cassidy proposal would end Medicaid expansion and eventually cap funding to States for Medicaid. What impact will that have on State budgets and will that put a strain on other programs?

Answer. Many independent analyses have concluded that capping Medicaid funding and ending Medicaid expansion would shift significant fiscal risk to States, likely leading States to make difficult decisions between increasing revenues, reducing health coverage for vulnerable low income children, parents, seniors and people with disabilities, and reducing funding for other important State programs. For example, according to a non-partisan analysis from Avalere Health, the Graham-Cassidy legislation would reduce Federal funding for Medicaid and marketplace coverage by \$205 billion between 2020 and 2026, and by more than \$4.1 trillion between 2020 and 2036. Although some States that opted not to expand Medicaid under the Affordable Care Act could see small increases in Federal funding for Medicaid and marketplace coverage during the 2020 through 2026 window, all States would lose Federal funding over the 2020 through 2037 window—ranging from \$4 billion reduction (*i.e.*, a 20% cut) in South Dakota to a \$797 billion reduction (*i.e.*, a 47% cut) in California. Federal funding for Medicaid and marketplace coverage in New Jersey would be cut by \$109 billion over the 2020 through 2037 window—equivalent to a 40% reduction in funding. The fiscal impact of these Federal spending cuts on State budgets is one reason why, on a bipartisan basis, the leadership of the National Association of Medicaid Directors indicated that the legislation would "fail to deliver on our collective goal of an improved health-care system."

Question. Beyond providing certainty on cost-sharing subsidies and bolstering the reinsurance program, what other immediate actions can Congress take to increase competition in the ACA marketplaces and help reduce the rate of premium growth?

Answer. Investment in outreach and enrollment can generate a significant return on investment in the form of lower premiums that result from a healthier and more balanced risk pool of enrollees. Analysis by California's Health Insurance Marketplace program, Covered California, indicates that investment in outreach and enrollment activities strengthened Covered California's risk pool and is directly responsible for a 6-to-8% reduction in premiums.²

²Peter V. Lee, Vishaal Pegany, James Scullary, and Colleen Stevens, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," 6-7, Covered California Research Report, September 2017. Available online at: http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

QUESTIONS SUBMITTED BY HON. BILL NELSON

Question. The Trump administration has proposed to cut funding for outreach and education for enrollment in the Affordable Care Act's individual exchange by 90 percent. The administration has also announced plans to reduce funding for the ACA Navigator program. One Florida Navigator announced it is shutting down its operations because it has not received notice from the administration about whether there will be a continued contract.

What role did outreach efforts and navigators play in getting people to sign up for a health insurance through the ACA's individual exchange?

Answer. We know that enrolling in health insurance is confusing for most people; having a trusted resource to walk through each complicated enrollment decision is very important. During the Open Enrollment Period for plan year 2017, CMS studied the impact of outreach and advertising on enrollment. CMS found that through the December 15th deadline 37 percent of enrollment was directly attributable to CMS's outreach efforts. Navigators and assisters play a critical role in reaching vulnerable populations and providing that in-person assistance that many may need because of language barriers, lack of Internet access or disabilities.

Question. What will be the impact of the administration's cuts to outreach and to the Navigator program on ACA enrollment?

Answer. Investment in outreach and enrollment can generate a significant return on investment in the form of lower premiums that result from a healthier and more balanced risk pool of enrollees.

Analysis by California's Health Insurance Marketplace program, Covered California, indicates that investment in outreach and enrollment activities strengthened Covered California's risk pool and is directly responsible for a 6- to 8-percent reduction in premiums.³

Question. Florida did not expand Medicaid under the Affordable Care Act, denying over 800,000 Floridians access to primary care.

How would expanding Medicaid have helped the State of Florida's bottom line? How much of an impact would expansion have on insurance coverage in Florida?

Answer. According to recent estimates from the Kaiser Family Foundation, approximately 384,000 uninsured Floridians currently fall into the "Medicaid coverage gap" due to the fact that their income is too high to qualify for Florida's current Medicaid eligibility thresholds and too low to qualify for premium tax credit-financed coverage through Florida's health insurance marketplace. If Florida agreed to expand Medicaid coverage, as authorized and federally-financed under the Affordable Care Act, many if not most of these 384,000 uninsured Floridians would be eligible for Medicaid coverage.⁴ In addition, Florida would get an estimated \$26 billion in Federal funding for Medicaid expansion over the next decade, according to a 2017 Avalere analysis prepared for *The New York Times*.⁵

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

I want to take my remarks this morning in two parts. First I'd like to respond to some of the common arguments about the ACA. And then I'd like to get to what this committee does best and look at big ideas to take on health-care challenges.

First let's look at a few issues dealing with the ACA, starting with the idea that it's sending everybody's health costs into the stratosphere. And let's examine this in the context of the more than 320 million people who live in this country. Fifty

³Peter V. Lee, Vishaal Pegany, James Scullary, and Colleen Stevens, "Marketing Matters: Lessons From California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," 6-7, Covered California Research Report, September 2017. Available online at: http://hbex.coveredca.com/data-research/library/CoveredCA_Marketing_Matters_9-17.pdf.

⁴Garfield, Rachel, and Damico, Anthony, "The Coverage Gap: Uninsured Poor Adults in States That Do Not Expand Medicaid," Kaiser Family Foundation Research Brief, November 1, 2017. Available online at: <https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/>.

⁵Margot Sanger-Katz and Kevin Quealy, "What Red States Are Passing Up as Blue States Get Billions." *New York Times*, November 13, 2017, www.nytimes.com/2017/11/13/upshot/what-red-states-are-passing-up-as-blue-states-get-billions.html.

million of those people are older Americans, and they're overwhelmingly happy with their Medicare. One hundred sixty million Americans get their insurance at work. They don't touch the ACA exchanges, and if their premiums go up, it isn't by much, on average. And nearly 8 out of 10 people who did sign up for private coverage through the ACA this year could find a plan for less than \$100 a month after tax credits.

So when you talk about cost increases and the Affordable Care Act, you're really looking at a portion of the individual exchanges. That leads us to fact that the President is pouring gasoline on the fires of uncertainty in the private market.

The administration can't give a straight answer as to whether it'll cut off cost sharing payments, and it's already forcing insurers to raise rates. It spreads negative propaganda about the Affordable Care Act, manipulating government websites to play hide-the-ball with Americans who are trying to learn how to get coverage, and touring the country predicting doom and destruction in the individual market.

It's a similar story in a lot of the States. The States that have put serious effort into building competitive marketplaces and holding down costs have largely been successful. But too many Governors and Statehouses have neglected to do the work. They haven't worked on getting people signed up and into the insurance pool. They haven't pushed back adequately against rate increases. Two and a half million Americans are stuck in what's called the "coverage gap"—the lawmakers in their States have denied them the opportunity to sign up for Medicaid, and they don't earn enough to qualify for subsidies under the Affordable Care Act. Premiums on the individual market are 7-percent higher in States that didn't expand Medicaid than they are in States that did.

That's a bit of context about where the Affordable Care Act stands. Now let's turn to some of the big ideas and opportunities that lie ahead of this committee, which has the authority to improve health care in sweeping ways that few others can.

First is flexibility. I've always held fast to the notion that if States believe they've got a plan that raises the bar for health care in terms of costs and coverage—rather than lowering it—they ought to be able to try it out. After all, as is often said, States are the laboratories of democracy. That's why I authored section 1332 of the Affordable Care Act.

As this provision went into effect this year, States have been showing more and more interest, and they're getting results. Many States—especially those interested in promoting private-market solutions—are considering section 1332 for State-based reinsurance programs, which help pay for some of the costliest patients to hold down costs for everybody else. For other States, section 1332 presents an opportunity to build a single payer system. The bottom line is that section 1332 is all about giving States the chance to do better, but not worse.

Next is transparency. One of the most frequent concerns I hear back home is the sky-high cost of prescription medicine. People who need treatment are paying through the nose, and they have no idea why—they can't make heads or tails of their prescriptions or drug receipts. The high cost of drugs is also driving up premiums. I've introduced bills to pull back the curtain on the broken drug pricing system that's burdening this country, and I know my colleagues have a number of other ideas as well. Improving transparency on drugs is about affordability—it has a direct effect on premiums in addition to the out-of-pocket costs families pay at the pharmacy. It's past time Congress took on the challenge of drug pricing.

Finally, I'd like to address competition and consumer choice. Over the past several months, my colleagues on the other side have accused Democrats of supporting a one-size-fits-all approach to health care for consumers. That's just not the case, colleagues. Choice and competition are essential to bringing down health costs. With that in mind, this committee should prioritize moving the needle on increasing choice and competition in the marketplace.

In the coming weeks and months, the Finance Committee will have a chance to take a leading role shaping the future of Americans' health care. Today's hearing is where members can kick off that debate, and it's my hope that the discussion is productive and conducted with an eye towards bipartisan consensus on bringing down health-care costs and ensuring every American has access to the health care they want and deserve.

COMMUNICATIONS

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Chairman Hatch and Ranking Member Wyden, AARP appreciates the opportunity to share with the Committee our priorities for protecting and strengthening our health-care system and the coverage that millions of Americans depend on. Older Americans care deeply about their health care, and they need and deserve affordable premiums, lower out of pocket costs, and coverage they can count on as they age. We recognize that current law is not perfect, and believe Congress should focus on commonsense, bipartisan solutions that will increase coverage, lower costs, stabilize markets, and improve care. On behalf of our 38 million members and all older Americans, we stand ready to work with you on solutions to protect and strengthen the affordable coverage that millions of Americans need and depend on.

Overall Goals

AARP will continue to support health-care principles that are vital to people 50 and older and their families.

- We support strengthening access to affordable health care and oppose increasing costs for older Americans through an age tax.
- We support strengthening Medicaid and increasing access to benefits that allow older Americans to live independently in their homes and communities.
- We support protecting and strengthening coverage for Americans with pre-existing conditions and will continue to defend against any weakening of the protections provided under current law.
- We support keeping Medicare strong and will strongly oppose cuts to Medicare funding that could open the door to benefit cuts and vouchers that would shift more costs and risks to seniors.

Access and Affordability

Over 6 million Americans 50–64 years old with median incomes of less than \$25,000 a year get their coverage through the Affordable Care Act (ACA) marketplaces. Furthermore, 25 million (40 percent) 50–64 year olds have a pre-existing condition.¹ As Congress looks for ways to lower health-care costs, we believe that any efforts to improve ACA marketplace risk pools must not come at the expense of older Americans. We strongly oppose any changes to the maximum age-rating limit of 3:1, reducing the tax credits that make health care affordable, and any weakening of protections for those with pre-existing conditions. Accordingly, we would strongly oppose any changes to the law that would permit a state to waive these critical protections and result in health care becoming more expensive and less accessible for millions of older Americans.

We believe that solutions to strengthen the marketplace should increase enrollment, create greater stability and competition in the marketplace, and lower costs for consumers. Congress should initially remove uncertainty from the market by moving market stabilization legislation. Common-sense market stabilization solutions include committing to paying for cost-sharing reductions (CSRs), which provide critical

¹ <http://www.aarp.org/ppi/info-2017/affordable-care-act-protects-millions-of-older-adults-with-pre-existing-conditions.html>.

assistance to those with modest incomes purchasing coverage, as well as improving the law's risk mitigation programs, such as through reinsurance, to help strengthen the ACA markets and reduce premiums. We have seen insurance companies file 2018 plan rates with double digit premium increases to account for the current uncertainty. In addition, greater certainty would help foster more robust competition among insurance companies in a given marketplace and help provide more financial stability to expand enrollment.

Congress could further help seniors and other Americans with long-term care costs by returning the medical expense itemized deduction threshold from 10 percent to 7.5 percent of adjusted gross income. The tax increase caused by the change to the higher threshold has fallen disproportionately on the sick—even those at more moderate income levels—especially since the deduction provides help to those with large medical costs that often include expensive long-term care costs.

Medicaid

Medicaid is a vital safety net and intergenerational lifeline for millions of individuals, including over 17.4 million low-income seniors and children and adults with disabilities who rely on the program for critical health care and long-term services and supports (LTSS, *i.e.*, assistance with daily activities such as eating, bathing, dressing, managing medications, and transportation). Older adults and people with disabilities now account for about 60 percent of Medicaid spending. As we have previously stated, we have serious concerns that cuts to the program, including recently proposed per capita cap or block grant proposals, would result in a loss of coverage and benefits and services for this vulnerable population.

Similarly, individuals with disabilities of all ages and older adults rely on critical Medicaid services, including home and community-based services (HCBS), for assistance with daily activities such as eating, bathing, dressing, and home modifications; nursing home care; and other benefits such as hearing aids and eyeglasses.² Individuals may have low incomes, face high medical costs, or have already spent through their resources paying out-of-pocket for LTSS, and need these critical services. For these individuals, Medicaid is a program of last resort.

AARP encourages Congress to finally address Medicaid's longstanding institutional bias. When Medicaid was created in 1965, nursing homes were the only option for a person who needed LTSS. States receive the funding they need to provide nursing home care for those who are eligible, but they can only provide HCBS to a more limited extent in practice. It is time to update the law to reflect where and how people want to receive services today. We recommend that states be given the ability to use Medicaid dollars for HCBS—without having to request permission from the federal government. HCBS are more cost effective—states can serve 3 people in HCBS for every one person in a nursing home on average per person in Medicaid—and help people live in their homes and communities where they want to be. The change thus makes both fiscal sense and common sense.

Medicare

Our members and other older Americans believe that Medicare must be protected and strengthened for today's seniors and future generations. This requires investment in Medicare, not cuts and cost shifts. The ACA put in place a strong framework for developing and testing new ways to deliver care with the goals of reducing cost and improving outcomes. We support the work that the Center for Medicare and Medicaid Innovation is doing, and urge Congress to enhance its ability to improve care coordination across Medicare. This includes investing in quality measurement and reporting infrastructure. Providers, patients, and policy makers deserve to know more about how health-care dollars are spent relative to the care being received.

Congress should also continue to invest in waste, fraud, and abuse prevention. Increased funding coupled with more rigorous oversight and enforcement by the Centers for Medicare and Medicaid Services and the Internal Revenue Service would reduce bad actors and help Medicare's finances. Considering that the return on investment for program integrity efforts is approximately \$5 for every \$1 spent,³ maintaining adequate resources is crucial.

²Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation, "Medicaid at 50," May 2015, 13. Available at: <http://files.kff.org/attachment/report-medicare-at-50>. Not all 17.4 million people receive LTSS.

³The Department of Health and Human Services and The Department of Justice Health Care Fraud and Abuse Control Program, "Annual Report for Fiscal Year 2016," page 8, <https://oig.hhs.gov/publications/docs/hcfac/FY2016-hcfac.pdf>.

Lastly, Congress should explore ways to strengthen the Medicare program. Medicare efficiently and effectively delivers high-quality care at affordable prices for consumers. Yet, traditional Medicare does not cover many aspects of health care, such as hearing, vision, and dental, which Americans rely more and more upon as they age.

Prescription Drugs

We believe that any health-care discussion must include solutions to combat the ever-growing problem of rising prescription drug costs. Older Americans use prescription drugs more than any other segment of the U.S. population, typically on a chronic basis. We strongly supported the closing of the Medicare Part D coverage gap (“donut hole”) under the ACA and would support an acceleration of that closure. Since the enactment of the law, more than 11.8 million Medicare beneficiaries have saved over \$26.8 billion on prescription drug costs.

AARP urges that any changes to the health law also tackle the issue of high prescription drug costs, including steps such as giving the Secretary of Health and Human Services the ability to negotiate drug prices on behalf of Medicare beneficiaries; reducing barriers to better pricing competition worldwide by allowing for the safe importation of lower priced drugs; reducing the amount of market exclusivity for brand name biologic drugs; prohibiting agreements between brand and generic manufacturers that delay timely access to affordable drugs; and greater transparency in prescription drug pricing. AARP stands ready to work with Congress and the Administration on commonsense solutions to combat rising prescription drug costs.

Conclusion

Thank you for the opportunity to provide input on the health-care priorities of AARP on behalf of our 38 million members. We look forward to working with you to ensure that we maintain a strong health-care system that includes robust insurance market protections, controls costs, improves quality, and provides affordable coverage to all Americans.

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The American College of Physicians (ACP) is grateful for the opportunity to share our views regarding the hearing in the Senate Finance Committee on “Health Care: Issues Impacting Cost and Coverage.” We applaud the Chairman of the Committee, Senator Orrin Hatch, and Ranking Member Ron Wyden for convening this hearing and hope that it will provide a platform to act on bipartisan solutions impacting the cost and coverage of health care. Although the health-care debate has turned more partisan in recent years, we believe that common ground can be reached on a pathway forward on policies that share bipartisan support. To that end, in May of this year, ACP released a forward-looking document that provides a prescription for Congress to implement a broad array of bipartisan solutions to improve the quality of health care. The intent of this statement is to provide a guide for Congress to work together on solutions that will lower cost and improve coverage of health care for our citizens.

EXPAND ACCESS TO COVERAGE

We urge Congress to act to sustain gains in coverage from the Affordable Care Act (ACA) rather than working to repeal and replace the current law. ACP has submitted letters of opposition to legislation to repeal and replace the ACA such as, the Better Care Reconciliation Act (BCRA), or the most recent legislation unveiled in September by Senators Lindsey Graham and Bill Cassidy that would take our country a step backward by vastly increasing the number of uninsured citizens and rolling back consumer protections on existing health insurance plans. We know that the Graham-Cassidy proposal is gaining some traction in the Senate, and we urge you to set aside this legislation and instead allow the Senate to follow the pathway forward on health reform through a more deliberative process of regular order, in

which hearings are held to solicit the advice of health-care experts and stakeholders, with any such improvements considered in a bipartisan manner in which both parties may offer amendments. This process will allow the Senate to ensure that any changes to current law, first, do no harm, to patients and build upon the gains in coverage provided by current law.

As outlined in detail below, ACP believes that there are steps that Congress can take now to build upon current-law coverage, including: stabilizing the insurance market, continuing cost sharing reduction payments, encouraging reinsurance programs, promoting ACA enrollment, preserving and strengthening the Medicaid program, and allowing individuals to buy into Medicare coverage. It is also vitally important that Congress extend funding for critical programs that will soon expire, such as the Children's Health Insurance Program (CHIP), the Title VII Health Professions Program, the National Health Service Corps (NHSC), and Teaching Health Centers Graduate Medical Education (THCGME). Finally, to further aid in driving down costs while also improving the quality of care, Congress must address ways to improve care for those with chronic illnesses, reduce the cost of prescription drugs, and promote value-based care.

Enact Reforms to Stabilize the Market

We are also encouraged that a bipartisan process for considering improvements to the ACA has also been started by the Senate, Health, Education, Labor, and Pensions (HELP) Committee as it recently hosted hearings on ways to stabilize premiums and help individuals in the individual insurance market for 2018. ACP offered the following statement to the HELP committee on reforms that could be enacted to lower premiums and stabilize the individual insurance market. We urge the Senate Finance Committee to work with the Senate HELP Committee to enact the following reforms to stabilize the insurance market, improve coverage, and lower costs.

Ensure 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 2018.¹ 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 2017.² 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-market place plans. However, eliminating CSR payments would in fact cost the federal government \$194 billion *more* over 10 years according to the CBO.³ 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's 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

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

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

³ 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>.

substantial amount of high-cost enrollees, and, in concert with the risk adjustment program, reduced the risk of adverse selection.⁴ Alaska's reinsurance program has successfully reduced premium costs,⁵ 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.⁶

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.⁷ 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 subsidies⁸ 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.⁹ 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

⁴Centers 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.

⁵Alaska 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>.

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

⁷Cliff, 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>.

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

⁹Karaca-Mandic, P., Wilcock, A., Baum, L., Barry, C.L., Fowler, E.F., Niederdeppe, J., and Gollust, S.E. "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.

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.

Preserve and Strengthen Medicaid

Medicaid is another program that provides a foundation for low-income children and adults to obtain quality affordable coverage. We remain opposed to attempts in this Congress to enact substantial cuts to Medicaid by converting the current federal financing formula for this program to a per capita cap or block grant model. Legislation to repeal and replace the Affordable Care Act, such as the Graham-Cassidy legislation, would significantly decrease federal funding for the Medicaid program by converting the current federal financing formula to a per capita cap model. The proposed per capita cap on federal funding would be devastating to coverage and access to care for many of the 72 million people currently enrolled. Because most states are required by law to balance their budgets, a reduction in and/or a cap on federal matching funds will necessarily require them to greatly reduce benefits and eligibility and/or impose higher cost-sharing for Medicaid enrollees, most of whom cannot afford to pay more out of pocket—or alternatively and concurrently, reduce payments to physicians and hospitals (including rural hospitals that may be forced to close), enact harmful cuts to other state programs or raise taxes.

The Graham-Cassidy proposal would also allow states the option to participate in a Medicaid Flexibility block grant program beginning in Fiscal Year 2020. Under the Medicaid Flexibility Program, states would receive block grant funding instead of per capita cap funding for non-elderly, non-disabled, adults who are not eligible for the Medicaid expansion. We remain opposed to this block grant funding structure as we believe it would be devastating to coverage and access to care especially under this legislation as overall federal funding for Medicaid would be reduced from current law. Under block grants, because states do not get any additional payment per enrollee, strong incentives would be created for states to cut back on eligibility, resulting in millions of vulnerable patients potentially losing coverage. Block grants will not allow for increases in the federal contribution should states encounter new costs, such as devastating hurricanes, flooding, or tornadoes that may injure their residents or destroy health-care facilities. Under either block grants or per capita spending limits, states would be forced to cut off enrollment, slash benefits, or curb provider reimbursement rates.

We are also concerned that the substantial cuts to Medicaid included in the Graham-Cassidy legislation will threaten coverage and treatment of individuals with substance-abuse disorders. ACP supported the bipartisan-enacted provisions to address the opioid crisis through the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act. However, those laws are simply not a replacement for the comprehensive, continuous coverage furnished through the Medicaid program, which not only covers substance-use disorder-treatment but also a host of services to prevent and manage other chronic illness, including those that disproportionately affect opioid users, like HIV and hepatitis C. Medicaid also plays a crucial role in financing treatment for people in recovery, funding counseling services and vital medications like buprenorphine and naltrexone. Medicaid has also greatly expanded access to life-saving naloxone, which all states cover in their Medicaid programs. Unfortunately, the Graham-Cassidy legislation will cap and cut Medicaid as well as phase out the Medicaid expansion, endangering comprehensive insurance coverage for patients and their families as well as the Medicaid beneficiaries with mental illness and substance-use disorder conditions who were covered as a result of the Medicaid expansion.

We urge the Committee not to restructure the Medicaid program to impose punitive work requirements as a condition for the receipt of Medicaid medical assistance. The Graham-Cassidy legislation would also permit states, effective October 1, 2017, to require non-disabled, non-elderly, non-pregnant individuals to satisfy a work requirement as a condition for the receipt of Medicaid medical assistance. We oppose this work requirement because Medicaid is not cash assistance or a job training program; it is a health insurance program and eligibility should not be contingent on whether or not an individual is employed or looking for work. While an estimated 80 percent of Medicaid enrollees are working, or are in working families, there are some who are unable to be employed, because they have behavioral and mental health conditions, suffer from substance use disorders, are caregivers for family members, do not have the skills required to fill available positions, or there simply are no suitable jobs available to them. Skills—or interview-training initiatives, if implemented for the Medicaid population—should be voluntary, not mandatory. Our Ethics, Professionalism, and Human Rights Committee has stated that it is contrary

to the medical profession's commitment to patient advocacy to accept punitive measures, such as work requirements, that would deny access to coverage for people who need it.

There is a substantial body of research that shows that the Medicaid program has improved access and outcomes to patients who depend on it for their care. Medicaid is an essential part of the health care safety net. Studies show that reductions in Medicaid eligibility and benefits will result in many patients having to forgo needed care, or seek care in costly emergency settings and potentially have more serious and advanced illnesses resulting in poorer outcomes and even preventable deaths. As an organization representing physicians, we cannot support any proposals that would put the health of the patients our members treat at risk. We believe though that improvements can and should be made in Medicaid, including more options for state innovation, without putting the health of millions of patients at risk.

Support Medicare Buy-In Option

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 care for individuals changing over to Medicare while at the same time helping to reduce premiums for individuals in the marketplace exchanges.¹⁰

Extend Funding for the Children's Health Insurance Program (CHIP)

One of the first steps that Congress could take to ensure that individuals continue to maintain affordable quality health-care insurance would be to reauthorize the CHIP program. We commend the Finance Committee Chairman Orrin Hatch and Ranking Member Ron Wyden for recently introducing legislation, S. 1827, the Keep Kids Insurance Dependable and Secure Act of 2017, that will extend funding for the CHIP program for the next 5 years. This legislation would ensure that the nearly 9 million children who are currently insured through the CHIP program will not lose coverage. ACP was pleased to offer a statement of support for the legislation and we urge Congress to act quickly on the consideration and passage of this legislation before the CHIP program expires at the end of the month.

The Title VII Program

It is also imperative that Congress continues to provide adequate funding for a primary care workforce to ensure that individuals who have insurance coverage have access to a physician to meet their health-care needs. ACP strongly supports increasing funding for Title VII, a critical resource as it is the only federal program dedicated to funding and improving training of primary care physicians. We urge Congress to provide \$71 million in funding for Fiscal Year 2018.

The National Health Service Corps (NHSC)

We urge Congress to continue funding for the NHSC that provides scholarships and loan forgiveness to encourage primary care physicians to work and care for patients

¹⁰ <http://election2016.actuary.org/sites/default/files/Medicare-Buy-In-Option.pdf>.

who live in underserved communities. This College requests the Congress to provide \$380 million for the NHSC for fiscal year 2018.

Teaching Health Centers Graduate Medical Education (THCGME)

The THCGME program was established by the ACA to provide funding for primary care residents in community settings. This program enriches the training of primary care residents by allowing them to see a wide variety of patients in an office based setting rather than solely in the hospital. The College recently signed on in support of reauthorization of the THCGME program to ensure stable funding. ACP supports the Training the Next Generation of Primary Care Doctors Act, H.R. 3394 and S. 1754 that would fund THCGME at \$116.5 million each year for three fiscal years until 2020.

STEPS CONGRESS CAN TAKE TO LOWER THE COST OF HEALTH CARE

As Congress considers proposals to expand health insurance coverage, it must also move forward with the consideration and passage of legislation that will lower the cost of health care for all Americans. ACP has been supportive of bending the cost curve of medicine and urges Congress and the administration to enact the following measures to reduce health-care costs to preserve access to affordable health care.

The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017

ACP commends the Senate Finance Committee for a commitment to advancing legislation to improve the quality and lower the cost of treating patients with multiple chronic illnesses. In April of this year, we submitted a letter of support to the sponsors of the legislation Senators Orrin Hatch, Ron Wyden, Johnny Isakson, and Mark Warner, that also included our recommendations to improve the bill. This legislation reforms Medicare to give physicians additional incentives to treat patients with chronic diseases in their homes, through advancements in telemedicine, and provides additional flexibility for Medicare beneficiaries to receive care through Accountable Care Organizations (ACOs).

This bill has been approved by the Senate Finance Committee and is now pending consideration by the Senate. We urge the Senate to move forward with debate on this legislation and ask Senators to offer the following amendments to strengthen the bill:

ACP Recommendation

We urge the Senate to add an amendment to the CHRONIC Care Act, that would require CMS to establish two new codes (perhaps initially as G codes) that would recognize the value of care for clinicians who treat patients with chronic conditions between 20–40 minutes and 40–60 minutes.

ACP Recommendation

We urge the Senate to add an amendment to this legislation that would move chronic care management services to the preventive services category under Medicare Fee-For-Services (FFS) to eliminate any beneficiary cost sharing associated with these services. Alternatively, a provision could be added that would allow CMS to give physicians the option of routinely waiving the copay for chronic care management codes for patients with chronic conditions.

Lower the Cost of Prescription Drugs

ACP recognizes that ensuring and improving patient access to prescription drugs and biologics is a growing need. Over the past several years, we have seen a dramatic rise in the cost of prescription drugs in this country. These increases apply not only to specialty drugs that treat life-threatening illnesses like cancer, but also common drugs like antibiotics that treat bacterial infections. Our internists see first-hand how the impact of rising prescription drug costs threatens the health of their patients. Approximately, 18 percent of retail prescription drugs were paid for out of pocket in 2012, and patients used various techniques to reduce costs, including not taking a medication as prescribed (7.8 percent), asking the doctor for a lower-cost medication (15.1 percent), purchasing drugs from another country (1.6 percent), or using alternative therapies.

There are several bills that we support and that Congress should approve to lower the cost and increase access to prescription medication. We urge Congress to enact the following measures to reduce the cost of these life saving medications:

The Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2017

ACP supports S. 974, the CREATES Act of 2017, that aims to prevent anti-competitive practices by brand name drugs to prevent or delay other companies from developing alternative lower-cost products. This bill would allow lower cost manufacturers to bring a cause of action in federal court for injunctive relief if a brand name company deliberately uses FDA protocols to deny samples of their product in a manner that prevents the development of lower-cost alternatives, thereby decreasing patient access to lower-cost medications.

The Medicare Prescription Drug Price Negotiation Act

We urge Congress to approve S. 41, the Medicare Prescription Drug Price Negotiation Act that will empower the Secretary of Health and Human Services to negotiate with pharmaceutical manufacturers the prices that may be charged for prescription drugs covered under Medicare Part D. The ACP has a long-standing policy in support of this legislation as a way to lower the cost of prescription drugs purchased by the federal government.

Promote Value-Based Care

One of the most effective ways to reduce cost and improve the quality of care provided to patients is to accelerate the transition from FFS payment systems toward a more value-based payment system. We urge the Senate Finance Committee to use its oversight authority to encourage and work with the Centers for Medicare and Medicaid Innovation (CMMI) to develop, test, and expand Alternative Payment Models that promote value based care authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform.

Support Funding for CMMI

The College strongly supports CMMI and its essential role in developing, financing, implementing, evaluating, and expanding innovative physician-led Advanced APMs as authorized by MACRA, as well as in the broader context of value-based payment and delivery system reform. ACP encourages CMS to fully use its authority under CMMI and the Physician-Focused Payment Model Technical Advisory Committee (PTAC) process to expand the availability of Advanced APMs and other models. The creation of additional APMs, including those that are specialist/subspecialist-focused, would provide additional pathways for practices to transition from traditional FFS to more valued-oriented payment approaches. It is also imperative that CMMI continues to have adequate funding to support its critical role in MACRA/QPP and the movement toward value-based payment.

Encourage and Promote the Testing of Accountable Care Organizations, the Patient Centered Medical Home, Bundled and Capitated Payments

The College strongly supports the movement from traditional FFS toward a more value based payment system. This should be achieved by testing a variety of payment models, such as accountable care organizations (ACOs), PCMH and patient-centered specialty practice models, bundled payments, capitated payments, and others. These models should include risk adjustments including adjustments for socioeconomic status, to the extent possible. In recognition that all clinicians are not willing or able to move directly into models with significant payment at risk, there should be pathways to help clinicians transition to models with increasing levels of risk at stake. In order to accelerate the movement toward value-based payments, ACP encourages CMS to develop an expedited process for CMMI to develop, test, and expand APMs. This should include a pathway for testing models recommended by PTAC, as well as models from other payers including Medicaid and private payers. Accelerated implementation of models should prioritize APMs for clinicians who currently lack opportunities, such as specialists/subspecialists and clinicians who are unable to participate in current models such as those in regions where models are not being tested and those who are unable to participate due to limitations in the model design. Additional options for PCMH models and patient-centered specialty practice models should also be prioritized, including models that do not require physicians to bear more than nominal financial risk.

Conclusion

We appreciate the opportunity to provide our thoughts on the pathway forward on enhancing coverage and reducing the cost of health care. We remain concerned that rushing through any legislation to repeal and replace the Affordable Care Act, without following regular order, securing complete cost estimates, and inviting stakeholder input, would only destabilize the insurance marketplace and increase the number of uninsured in our country. Instead, we urge you to work with your colleagues, in a bipartisan fashion, to improve coverage and reduce cost through a

more deliberative process. ACP stands ready to assist in that effort and to provide feedback on any policies that impact the medical profession and patients.

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America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public private partnerships that improve affordability, value, access, and well-being for consumers.

We appreciate the committee's interest in examining both health-care costs and the availability of high quality, affordable coverage options. These issues are particularly important in the individual health insurance market, where consumers are facing significant challenges due, at least in part, to uncertainty about government policies for the Affordable Care Act's (ACA) Health Insurance Exchanges.

Our members are strongly committed to advancing solutions that address these immediate, short term challenges while also supporting long-term reforms that are needed to help ensure a stable, competitive market that delivers real choice, high quality, and affordable care. To contribute to the discussion at today's hearing, our statement focuses on four priorities: (1) making coverage more affordable by bringing down the cost of care; (2) legislative solutions that could be enacted right now to provide relief to consumers, reduce uncertainty, and address the immediate challenges in the individual market; (3) regulatory steps to promote a stable market in the short term; and (4) principles for longer-term improvements in our nation's health care system.

Make Coverage More Affordable by Bringing Down the Cost of Care

Rising health-care costs have been a financial burden for too many families for too long. The affordability crisis poses a serious challenge to the U.S. health-care system—not only for consumers, but also for employers and government programs. Bold steps are needed to meet this challenge. From out-of-control drug prices to bureaucratic regulations to outdated payment models, we need effective solutions that bring down the cost of health care to U.S. health systems, thus reducing the overall cost of care for families.

More market competition, better coordination, using evidence-based medicine, and prioritizing value can deliver the affordable coverage and quality care that every American deserves. Below we highlight numerous areas where we see opportunities for decelerating the growth in overall health-care costs:

- *Competition, Transparency, and Consumer Engagement:* Encouraging competitive market forces and more market-oriented regulatory systems and promoting greater transparency—with respect to information on price, quality, and value—to support greater consumer engagement in health-care decisions;
- *Wellness, Prevention, and Care Coordination:* Moving beyond the sick-care paradigm to focus more strongly on wellness and prevention and increasing the integration and coordination of programs (e.g., Medicare, Medicaid) to address the burden of chronic disease;
- *Greater Options for Care Management:* Creating a broader range of options for wellness, acute care, chronic condition management, and end-of-life care—with greater discretion for individuals and families in selecting health-care providers and sites of care;
- *Paying for Value:* Accelerating the move away from volume and toward value by adopting value-based payment approaches that demonstrate their effectiveness in improving both quality and affordability;
- *Leveraging Data and Technology:* Investing in data- and technology-driven innovations to reduce costs, enhance quality, and improve outcomes, including expanding the use of remote monitoring, at-home solutions, telehealth, and other innovative approaches to health-care delivery;

- *Additional Options:* Promoting an adequate and diverse health-care workforce; reducing and resolving medical malpractice disputes; and supporting initiatives at the state level to meet quality- and cost-related goals.

In addition, any discussion about health-care costs must include a strong focus on pharmaceutical costs and the need for market-based solutions to ensure that consumers have access to affordable medications. A March 2017 analysis by AHIP's Center for Policy and Research concluded that 22 cents of every dollar spent on health insurance premiums goes to pay for prescription drugs—outpacing the amount spent on physician services, inpatient hospital services, and outpatient hospital services.¹ Prescription drug prices are out of control, and this is a direct consequence of pharmaceutical companies taking advantage of a broken market for its own gain. When drug companies are effectively granted extraordinary protections through the patent system or market exclusivity protections in federal law, they can set any price they choose—and raise prices at any time for any reason. To put it simply, they have a monopoly on medications. And the result is that everyone pays more, from patients, businesses and taxpayers to hospitals, doctors, and pharmacists.

As the committee explores strategies for reducing prescription drug prices, we urge you to consider our recommendations for effective, market-based solutions in three areas:

- *Delivering Real Competition:* Promote a robust biosimilars market and ensure that providers and patients have unbiased information about the benefits of biosimilars; provide the necessary resources for the Food and Drug Administration (FDA) to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited generic competition; prohibit anti-competitive tactics such as “pay for delay” settlements and “product hopping”; preserve the Inter Partes Review (IPR) process through the U.S. Patent and Trademark Office; require brand manufacturers to share information and scientific samples to promote the development of generic drugs; and ensure that the Orphan Drug Act's incentives are used by those developing medicines to treat rare diseases—not as a gateway to premium pricing and blockbuster sales beyond orphan indications.
- *Ensuring Open and Honest Price Setting:* Require pharmaceutical manufacturers to disclose information regarding the intended launch price, the use of the drug, and direct and indirect research and development costs; examine and address the impact of drug coupons and co-pay card programs (and related charitable foundations) on overall pharmaceutical cost trends; and assess the impacts of the growth in direct-to-consumer (OTC) advertising, particularly broadcast advertising, and evaluate the best approaches for conveying information to consumers.
- *Delivering Value to Patients:* Support private and public efforts to provide information to physicians and their patients on the comparative and cost-effectiveness of different treatments; promote value-based payments in public programs like Medicare for drugs and medical technologies, based on agreed-upon standards for quality and outcomes; and address existing statutory and regulatory requirements (e.g., Medicaid best price rules) that may inhibit the development of pay-for-indication and other value-based strategies in public programs.

Legislative Solutions Are Needed to Provide Relief to Consumers and Stabilize the Individual Market

The individual insurance market has been a challenge for many years—both before and after the ACA. Certainty regarding key government policies and other improvements is needed to ensure that the individual market delivers lower costs and more choices.

Just 7 weeks from now, November 1st will mark the beginning of the 2018 Open Enrollment Period for coverage offered through the ACA Exchanges. Less than 6 months from now, health plans will begin the process of building products for the 2019 plan year. As a result, we strongly believe that any legislative stability package considered by Congress must continuously cover at least a 2-year period—2018 and 2019. Otherwise, market uncertainty will persist, and Congress will need to re-

¹“Prescription Drugs Are Largest Single Expense of Consumer Premium Dollars,” AHIP, March 2, 2017, <https://www.ahip.org/health-care-dollar/>. This AHIP estimate understates the actual impact of prescription drugs on insurance premiums, as drugs administered in hospital inpatient settings were excluded.

visit these same exact issues early next year. Below we suggest several steps that can be taken in the short-term to ensure that Americans have real choices of quality, affordable coverage options.

- *Provide funding for cost-sharing reduction (CSR) benefits that help lower-income individuals afford the care they need:* This funding is important in the remaining months of 2017 and through at least the next 2 years. Nearly 85 percent of consumers who buy coverage through a health-care exchange receive tax credits to help them pay their premiums.² Well over half—and as much as three quarters—of these consumers receive additional assistance to lower their deductibles and cost-sharing for the care they receive. The Congressional Budget Office (CBO) estimates that terminating CSR funding after December 2017 would cause premiums for silver plans to be 20 percent higher in 2018 and 25 percent higher by 2020. This would have the additional consequence of increasing the federal budget deficit by \$194 billion from 2017 through 2026.³
- *Establish a premium stabilization program to improve market stability:* A federally funded premium stabilization program would offset some of the costs of patients who have the most complex health conditions and need the most care. This will put downward pressure on premiums and help keep coverage affordable for more healthy people who buy their own coverage. Depending on the size of the program, this could reduce premiums in the individual market by 10 percent or more.⁴ There has been broad bipartisan support in Congress for such efforts.
- *Provide relief from burdensome, anti-consumer taxes and fees that raise health care costs:* Eliminating taxes and fees, such as the tax on health insurance, will reduce premiums and promote affordability. Congress provided relief from the health insurance tax for 2017, but it is slated to return next year. A recent Oliver Wyman study estimates that under current law, a total of \$267 billion will be assessed and collected as a result of this tax over the next 10 years (2018–2027). The same study projects that stopping the tax on consumer health insurance would lower premiums by an average of \$158 per member in 2018 in the individual market.⁵
- *Promote innovation and state flexibility:* Many Governors and state insurance commissioners have called for more flexibility and control over their markets. This flexibility can be provided with improvements to the ACA’s Section 1332 waiver process, including shortening the federal review time, creating a fast-track option, and establishing a process to waive the requirement for new state authorization legislation in an emergency. Changes to expedite the Section 1332 waivers should be balanced with requirements for state legislation within 2 years. Policymakers should maintain guardrails to ensure that 1332 waiver proposals provide coverage that is at least as comprehensive and as affordable for as many people as without the waiver and does not result in separate health insurance markets—one for healthy individuals and another for those with significant health conditions.

We also want to highlight several additional policies and considerations that will help promote a more stable individual market for consumers and families:

- *Ensure any legislative reforms are extended for an adequate duration:* As Congress considers legislation to stabilize and reform the individual market, these proposals should span at least a 2-year period (*i.e.*, through 2019). This would ensure that reforms are in place long enough to promote public confidence and allow adequate time for states and health plans to implement them. It will also avoid the need for Congress to revisit these issues in early 2018.

² ASPE Research Brief, “Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace,” October 24, 2016, <https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>.

³ 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>.

⁴ Congressional Budget Office, “Private Health Insurance Premiums and Federal Policy” (page 16), February 2016, https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf.

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

- *Consider changes to premium tax credit eligibility to level the playing field:* In states that did not expand Medicaid, Americans with incomes below 100 percent of the federal poverty level (FPL) do not receive premium tax credits to help them afford their coverage. These Americans should also have access to premium tax credits.
- *Avoid policies that could further destabilize the individual market:* Policymakers should avoid legislative proposals that would introduce new elements of risk for the individual market. For example, repealing the individual coverage requirement without a strong alternative incentive to maintain continuous coverage would drive up premiums, increase the number of Americans without health insurance coverage, and exacerbate adverse selection and market instability. As noted above, policies that seek to segment insurance markets and narrowly divide risk pools would also contribute to market instability, especially for individuals with greater health-care needs. Instead, policies that encourage personal responsibility and help keep coverage accessible, available, and continuous should be promoted.

Regulatory Steps Also Are Needed, Along With Legislation, to Promote a Stable Market

The following administrative actions, in tandem with legislative policies, will help promote a more stable individual market in 2018 and beyond:

- *Continue to enforce the individual coverage requirement to promote a balanced risk pool:* Insurance markets are strong and stable when everyone participates—those who need the coverage to access needed care as well as those who purchase coverage in case they need care in the future. If the coverage requirement under current law is not enforced, costs will increase while choices will decrease because fewer younger, healthier individuals will be incentivized to get coverage.
- *Continue to conduct marketing, outreach, and education before and during open enrollment to ensure consumers understand their coverage options and encourage broader participation of healthy individuals:* In addition to broad participation, stable health insurance markets require that consumers enroll for a full plan year and maintain 12 months of coverage, as opposed to enrolling only when they need care. Marketing, outreach, and education are critical to ensure that all consumers are aware of the upcoming open enrollment period, understand the new timeline, and enroll by the deadline. This is especially critical for 2018 open enrollment due to the new earlier deadline to enroll.
- *Issue regulations regarding third party payments so health plans are not required to accept premium payments from entities with a financial interest in the enrollment, while improving transparency to allow payments from appropriate charities:* Consumers should be enrolled in the health insurance program that best meets their needs, not because it offers higher payments to some providers. Those who are eligible for public programs (e.g., Medicare and Medicaid), which offer additional benefits and services, should not be inappropriately steered into the commercial insurance market and health plans should be permitted to reject third party payments in such situations. Similarly, prescription drug co-pay cards are decreasing overall affordability by promoting greater use of high-priced branded drugs where lower cost generic alternatives may be clinically appropriate.
- *Extend prior coverage requirements to all special enrollment period (SEP) qualifying events to minimize inappropriate movement in and out of the individual market risk pool:* Prior coverage is currently required for a limited number of qualifying events and is not sufficient to encourage consumers to maintain continuous coverage throughout the plan year. The Secretary should extend this requirement to all SEP qualifying events, with certain exceptions (e.g., newborns) and require state-based marketplaces to implement similar pre-enrollment verification of SEP eligibility.
- *Prevent enrollment or reenrollment of Medicare enrollees in qualified health plans (OHPs) through the exchanges:* While individuals enrolled in Medicare are not eligible to receive subsidies, they are currently not prevented from enrolling in coverage, or renewing coverage, through the exchanges. Inappropriate enrollment of Medicare-eligible beneficiaries in the individual market results in higher premiums for all individuals enrolled in the individual market. It also means Medicare beneficiaries could be paying for unnecessary or duplicative coverage and receiving tax credits for which they are not eligible and must repay upon

filing taxes. The exchange should prevent enrollment or reenrollment of individuals enrolled in or eligible for Medicare and conduct periodic checks to identify current QHP enrollees who become eligible for or enroll in Medicare. This would ensure that consumers enroll in the program that is designed to meet their needs and avoid inappropriate payment of tax credits for ineligible enrollees.

- *Change the rules around individual market dental coverage to ensure a streamlined shopping experience for consumers:* The ACA requires coverage offered in the individual market to provide essential health benefits, including pediatric oral health benefits. Currently, families shopping in the Exchange for a dental benefit have several coverage choices and options between stand-alone dental plans and qualified health plans that embed this dental benefit, but this is not the case when shopping outside of the Exchange. To level the playing field for stand-alone dental plans with pediatric benefits, the same rules should be applied to Exchange plans and off-Exchange plans.

Principles for Longer-Term Improvements to Ensure a Stable, Competitive Market

Looking beyond the immediate and urgent priority of stabilizing the individual market, additional steps are needed to ensure a stable, competitive market that delivers real choice, high quality, and affordable care. When Congress resumes the debate on long-term health reform, we ask you to consider the following key principles.

1. *Bring down the cost of care and coverage:* As we discussed earlier, bold steps are needed to bring down the cost of care for families. More market competition, better coordination, using evidence-based medicine, and prioritizing value can deliver the affordable coverage and quality care that every American deserves.
2. *Preserve a strong Medicaid program:* The individual market and Medicaid are closely related with respect to the partial overlap in the populations they serve. For example, many low-wage employees do not have access to employer-sponsored coverage and need help accessing affordable coverage; if their incomes fall due to loss of employment or other reasons, Medicaid becomes an important safety net. Conversely, individuals with Medicaid who move up the economic ladder may lose eligibility and need affordable coverage in the individual market. Given how the two markets interact with respect to a diverse and often vulnerable population, Congress should ensure that federal policies are designed to ensure both the long-term stability and affordability of the individual market and continued strength and long-term sustainability of the Medicaid program, which delivers real value to more than 70 million Americans. This includes providing states with adequate resources to administer an efficient, effective program that helps beneficiaries improve their health.
3. *Guarantee access to coverage for all Americans—including those with pre-existing conditions:* No individual should be denied or priced out of coverage because of their health status. As modifications to existing insurance reforms are considered—e.g., such as greater state flexibility to adopt wider age-bands to make coverage more affordable to younger adults—those with pre-existing conditions should continue to be protected. To ensure coverage is more affordable for everyone, these protections must be coupled with strong incentives for individuals to maintain continuous coverage.
4. *Implement more effective risk pooling programs:* An improved and reformed risk-adjustment program and permanent federal funding for state-based risk pool programs, such as reinsurance, will improve risk sharing and deliver more market stability. The permanent risk pooling and mitigation programs in the Medicare prescription drug benefit (Part D) are another example that have been proven to work and promoted that program's success and high rates of beneficiary satisfaction.
5. *Expand consumer control and choice:* Consumers and patients need more control over their health care. Nearly 20 million Americans have Health Savings Accounts (HSAs) because they deliver affordable coverage and more consumer control. We need to expand HSAs so consumers can accumulate savings for the future, buy affordable coverage today, and take a more active role in making decisions about their care.
6. *Promote state innovation and appropriate state flexibility:* Consumers do not want one-size-fits-all approaches. That is why states should have more flexibility to develop affordable and lower premium individual market plans. Building upon any initial steps taken in the current short-term stabilization effort, the longer-term

debate should focus on giving states additional flexibility around coverage requirements, state benchmarks, Section 1332 waivers, premium payment grace periods, risk pool mechanisms, and plan designs that promote innovations in care delivery, such as value-based insurance designs. We caution, however, that state flexibility should not come at the expense of consumers with pre-existing conditions or greater health needs and their coverage.

7. *Preserve, protect, and expand employer-sponsored coverage:* Employer-sponsored health benefits are essential to the American economy. This system serves as a bedrock of stability and encourages employers to offer robust health plans with low deductibles while allowing workers the freedom and flexibility to invest more money in their families and communities. The current tax treatment of employer-sponsored health benefits should not change. Strengthening and supporting employer-sponsored health benefits, rather than eroding or taxing them, should be a priority of the Congress.

Conclusion

We thank the committee for considering our recommendations on these critically important issues. While the individual health insurance market faces significant challenges, we are committed to helping advance solutions that deliver short-term stability and long-term improvement. We look forward to continuing to work with Congress in a good faith and bipartisan manner to improve and protect the health and financial security of consumers, families, businesses, communities and the nation.

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION (ASHA)

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I, Gail Richard, President of the American Speech-Language-Hearing Association (ASHA), appreciate the opportunity to provide comments to the Committee on health-care costs and coverage in the individual private health insurance market.

ASHA is the national professional, scientific, and credentialing association for 191,500 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Our members work in health-care settings to habilitate and rehabilitate the language, hearing, swallowing, cognition, and communications skills for individuals across the life span.

Overview

While policy provisions are needed to enhance the Health Insurance Marketplace (health insurance “exchange”) it is critical that the efforts are focused on ensuring continued access to affordable, quality health care for consumers. In order to contain costs and provide meaningful, comprehensive coverage, the Marketplace, as well as insurers and providers contracting with private health plans, must have predictability and assurance that government requirements, regulations, and financial support will remain steady and secure.

The unpredictability of the regulatory and financial environment makes stabilization of both costs and coverage difficult to achieve in the exchanges. However, expansions of coverage into every county in every state demonstrates the commitment of insurers and providers, including audiologists and speech-language pathologists, to meet the health-care needs of consumers. Therefore, Congress should continue to work with Governors and State Insurance Commissioners to ensure that all Americans have access to affordable health insurance coverage regardless of where they live.

ASHA urges the Committee to take action to reform and improve the private health plan markets in order to meet the needs of the millions of Americans who rely on the exchanges for health insurance coverage.

Cost Considerations

Cost-Sharing Reductions. Uncertainty about continued funding for cost-sharing reductions (CSRs) is contributing significantly to market uncertainty and volatility. If these subsidy payments cease, insurers would withdraw from the market to avoid financial losses, which would leave their enrollees without coverage. The most significant way that the Trump Administration and Congress can help to stabilize the exchanges is to commit long-term funding to CSRs. Cost sharing subsidies are nec-

essary to make health-care services affordable for individuals with low income, and to stabilize the exchanges.

Reinsurance. ASHA suggests Congress consider extending the reinsurance program through 2019 to help stabilize the exchanges. The goal of the Patient Protection and Affordable Care Act's (ACA's) temporary reinsurance program was to stabilize premiums during the early years of new market reforms (*e.g.*, guaranteed issue). The reinsurance program transfers funds to individual market insurance plans with higher-cost enrollees. This reduces the incentive for insurers to charge higher premiums due to new market reforms that guarantee the availability of coverage regardless of health status. As reinsurance is based on actual cost rather than predicted, reinsurance payments will also account for low-risk individuals who may have unexpectedly high costs (such as costs incurred due to an accident or sudden onset of an illness).

Section 1332 Waivers. ASHA agrees that states can develop innovative approaches with the potential to strengthen health insurance for all Americans. An example is the current Administration's approval of Alaska's 1332 waiver to implement the Alaska Reinsurance Program for 2018 and future years. Under Alaska's Reinsurance Program, Premera, the state's only exchange insurer, filed for a 7.3% premium increase for 2017 (down from the estimated 42%). Several other states are also pursuing a 1332 waiver proposal for reinsurance. For example, Oregon passed H.B. 2391 to fund a reinsurance program and is now applying for a 1332 waiver to leverage funding. To leverage state flexibility to meet their residents' needs, Oregon also passed H.B. 2342, which gives the State's Department of Consumer and Business Services emergency powers to enact market stabilization rules if the life or health of Oregonians are threatened. Essential Health Benefits (EHBs) are consumer protections that cannot be undermined and would be saved through this emergency order.

Pre-Existing Condition/Continuous Coverage. ASHA is aware that the Administration and Congress have expressed an interest in deciding whether the policies that promote continuous enrollment in health insurance coverage are a necessity. Currently, the ACA insurance market reforms do not require the maintenance of continuous, creditable coverage in order to avoid pre-existing condition exclusions; nor does it impose waiting periods in order for an individual to enroll and use Marketplace health insurance coverage. ASHA advises against the development of policies that link pre-existing condition exclusions to a continuous coverage requirement.

Under a continuous coverage requirement, individuals who miss a one-time open enrollment period and/or those who experience a period of being uninsured, could face medical underwriting without limits, which would effectively lock many of these individuals out of affordable coverage. Middle and lower-income individuals are more likely to have gaps in insurance coverage due to changing employment, life, and/or financial circumstances. They are the least likely to be able to pay for medically underwritten coverage that would have higher premiums, fewer covered benefits, higher cost-sharing requirements, or a combination of all. As a result, they are the most vulnerable to becoming uninsured and going without access to care under a continuous coverage requirement. For example, an individual who has a pre-existing condition, which might affect their ability to maintain employment for a certain period due to a health crisis, could lose coverage as a direct result of their pre-existing condition. Their pre-existing condition could make it impossible for them to maintain employment; thus, making it impossible to maintain coverage.

Coverage Considerations

Essential Health Benefits: Coverage for Rehabilitative and Habilitative Services and Devices. The ACA's requirement that individual and small group markets cover EHBs in 10 benefit categories ensures that patients have access to basic coverage. ASHA strongly supports the preservation of the EHBs, particularly the EHB category of rehabilitative and habilitative services and devices. Rehabilitation services and devices are essential in helping Americans retain, improve, or reacquire skills and functions that may have been lost or diminished due to an injury, illness, or disability. Americans who need habilitation services and devices rely on their health-care coverage to: (a) acquire skills and functions that were never learned due to a disability, and (b) retain those skills so that they can live as independently as possible.

One of the criticisms of the EHB requirement is that it significantly increases premiums. However, evidence suggests that factors such as community ratings may actually have more of an impact on premiums than EHBs. Moreover, Milliman pro-

vides an estimate of 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, with per member per month premium costs of approximately \$1.48 for 2014. These estimates are based on current levels of coverage, eligibility and benefit design. An analysis from the Urban Institute and the Robert Wood Johnson Foundation indicates that EHBs covered under the ACA, if removed, will not trim the cost of monthly premiums by very much. Instead, they would add a considerable, if not insurmountable, increase in costs, which would be assumed by policyholders. According to the analysis, rehabilitative and habilitative care represent only 2% of the premium. ASHA remains steadfast in its support for the continued coverage of rehabilitative and habilitative services and devices within the individual insurance market.

Conclusion

ASHA appreciates the Committee's attention to this important issue. Currently, more than 18 million Americans rely on the exchange plans to meet their health insurance needs and more than a 100 million more in private health plans are impacted by the structure, requirements, and general stability of the exchanges.

Thank you for the opportunity to provide this statement for the record. ASHA looks forward to continuing to work with the Committee and Congress to find an enduring solution to affordable health-care coverage for all Americans. For more information, please contact Ingrida Lusic, ASHA's director of federal and political advocacy, 202-624-5951 or ilusic@asha.org.

ASIAN AND PACIFIC ISLANDER AMERICAN HEALTH FORUM (APIAHF)
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The Asian and Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the September 12, 2017 hearing before the Senate Committee on Finance entitled "Health Care: Issues Impacting Cost and Coverage."

We believe it is time for Congress to put aside attempts to repeal the Affordable Care Act (ACA) and instead take needed steps to ensure that all Americans are able to afford and access health insurance that meets their needs. APIAHF is the nation's leading policy organization working to advance the health and well-being of over 20 million Asian Americans (AA), Native Hawaiians and Pacific Islanders (NHPI) across the U.S. and territories. From our work with AA and NHPI communities, we understand the role the ACA has played in improving access to health insurance. Since 2010, the uninsured rate has fallen from 15.1 percent to 7.5 percent in 2015 for AAs and from 14.5 percent to 7.8 percent for NHP is, higher than any other racial group.¹

Fund Consumer Outreach and Assistance

The results of the ACA's four open enrollment periods have demonstrated that health insurance enrollment is not always straight forward particularly for populations who may never have had coverage before, are new to private coverage or the U.S. health-care system, and/or have limited English proficiency or health literacy. These communities, due to higher poverty, lower English proficiency levels and other disparities, face barriers to both knowledge about their health insurance options and more complex eligibility scenarios when they enroll. For example, 47 percent of uninsured eligible AAs and NHPIs were limited English proficient before the first ACA open enrollment period.²

Since 2012, APIAHF and partners have outreached to, educated, and enrolled nearly 1 million AAs and NHPIs in more than 56 languages through Action for Health Justice, a national collaborative of more than 70 AA and NHPI national and local community-based organizations and health centers. We and our partners have seen firsthand that assistance is critical to encouraging enrollment, particularly for

¹ American Community Survey Table S0201 (2010 and 2015 1 year estimates).

² Wendt, Minh et al., "Eligible Uninsured Asian Americans, Native Hawaiians, and Pacific Islanders: 8 in 10 Could Receive Health Insurance Marketplace Tax Credits, Medicaid, or CHIP," Department of Health and Human Services Offices of Minority Health and the Assistant Secretary for Planning and Evaluation (March 18, 2014), https://aspe.hhs.gov/system/files/pdf/180311/rb_UninsuredAANHPI.pdf.

younger and healthier populations who may not seek out health insurance by themselves.³ The Navigator program, in particular, plays a critical role in providing enrollment assistance to populations who would otherwise not know about the ACA or have the knowledge or skills needed to enroll in coverage. In this way, the Navigator program helps to ensure stable marketplaces by maximizing enrollment. Therefore, we urge Congress to robustly fund Navigators and other outreach, enrollment assistance and advertising efforts by the U.S. Department of Health and Human Services. Congress should ensure that, in addition to improved funding for outreach and enrollment, CMS specifically uses some of those funds for outreach to racial and ethnic minorities and to those who are limited English proficient.

Permanently Fund Cost Sharing Reduction Payments

The ACA's Cost Sharing Reductions (CSR) for lower-income consumers in the marketplace have been critical to ensuring deductibles and copays are not barriers to care for those who cannot afford them. Sixty-five percent of AAs and 70 percent of NHPs uninsured in 2010 and eligible by income for subsidies, were also eligible for CSRs.⁴ The Congressional Budget Office estimates that ending CSR payments to insurance companies would add uncertainty in the insurance market and increase premiums by as much as 25 percent, particularly for unsubsidized consumers.⁵ Congress must take immediate action to permanently appropriate funds for CSR payments.

Improving Affordability

While the ACA has led to nearly 20 million people gaining coverage, including 11 million from communities of color, we still have work to do to make sure health insurance is affordable for everyone.⁶ Many AA and NHP groups struggle with poverty compared to whites. For example, Pakistanis (16.6 percent poverty rate), Hmong (26.1 percent poverty rate), and Marshallese (40.6 percent poverty rate) all had higher rates of poverty compared to whites (12.9 percent) in 2015.⁷ Given these continuing barriers, Congress should take a number of steps to improve affordability in the private market:

- Resolve the "Family Glitch" that bars access to tax credits to families where employer sponsored insurance is affordable for individual policies but unaffordable for dependent coverage.
- Increase access to lower deductible plans, such as by increasing the value of tax credits for higher metal plans or by increasing the income threshold eligibility for cost sharing reductions.
- Create a stabilization fund that offsets the risks of expensive patients for insurance companies, encouraging greater competition in the marketplace.

Renew Funding for the Children's Health Insurance Program (CHIP)

Funding for CHIP expires on September 30, 2017. We urge Congress to fund CHIP for 5 years, as recommended by the Medicaid and CHIP Payment and Access Commission, with no policy riders reducing access to health care.⁸ Failing to continue CHIP funding will put 3.7 million children at risk of losing their CHIP coverage.⁹ CHIP is an important program for AA and NPHI communities, and alongside Medicaid, covers 28 percent of AA children and 40 percent of NHP children. In large part due to these programs, AA and NHP kids have achieved a 95.9 percent in-

³Asian and Pacific Islander American Health Forum et al., "Improving the Road to ACA Coverage: Lessons Learned on Outreach, Education, and Enrollment for Asian American, Native Hawaiian, and Pacific Islander Communities" (September 2014), http://www.apiahf.org/sites/default/files/2014.10.14_Improving%20the%20Road%20to%20ACA%20Coverage_National%20Report.pdf.

⁴APIAHF calculation of 2010 ACS PUMS data.

⁵Congressional Budget Office, "The Effects of Terminating Payments for Cost-Sharing Reductions" (August 15, 2017), <https://www.cbo.gov/publication/53009>.

⁶Bowen, Garrett and Anuj Gangopadhyaya, "Who Gained Health Insurance Coverage Under the ACA, and Where Do They Live?", Urban Institute (December 2016), <http://www.urban.org/sites/default/files/publication/86761/2001041-who-gained-health-insurance-coverage-under-the-aca-and-where-do-they-live.pdf>.

⁷APIAHF analysis of 2015 ACS data.

⁸Medicaid and CHIP Payment and Access Commission, "MACPAC Recommends 5-Year CHIP Funding Extension" (December 15, 2016), <https://www.macpac.gov/news/macpac-recommends-5-year-chip-funding-extension/>.

⁹Medicaid and CHIP Payment and Access Commission, "Report to Congress on Medicaid and CHIP" (March 2017), <https://www.macpac.gov/wp-content/uploads/2017/03/March-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf>.

sured rate.¹⁰ Access to quality medical and preventive care through CHIP is essential for children from these communities. For example, the rate of new diagnoses of Type 2 Diabetes in Asian American and Pacific Islander children rose 8.5% annually between 2002–2012, compared to 4.8% amongst all youth.¹¹

As health-care leaders, we look to Congress to ensure consumers are able to find and enroll in affordable health coverage. In addition to these priorities, we strongly believe that civil rights in health care must be protected. As Congress works to improve the stability of the health insurance markets, we urge you to also continue to ensure access to health care is not denied due to discrimination on the basis of race, gender, national origin, gender identity, sexual orientation, or age. Congress must conduct strong oversight to ensure that existing federal civil rights protections, including Section 1557 of the ACA and Title VI of the Civil Rights Act of 1964, among others, are enforced.

For questions, contact Amina Ferati, Senior Director of Government Relations and Policy, ferati@apiahf.org (202–466–3550).

BLUE CROSS BLUE SHIELD ASSOCIATION

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to comment on issues impacting health-care cost and coverage and what can be done to stabilize premiums and help individuals purchase coverage in the individual health insurance market.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies that collectively provide health-care coverage for one in three Americans. BCBS companies have an 85-year history providing coverage across all markets in their local communities and are major providers of health coverage in the individual market and in the majority of Exchanges.

BCBSA commends Chairman Hatch, Ranking Member Wyden, and other members of the Senate Finance Committee for holding this important hearing on issues impacting health-care cost and coverage.

BCBS companies believe that Americans are best served by a competitive private health insurance market that offers consumers the choices they want at a price they can afford. Over the past decade, there have been great strides in expanding access to health insurance, but premiums and out-of-pocket costs are too expensive for many Americans, particularly in the individual market. It is critical that policymakers take action to stabilize the individual insurance market; return more authority to the states; and focus directly on addressing the underlying drivers of health-care costs, which are rising at unsustainable levels for individuals, families, employers, and taxpayers.

Current Challenges Facing the Individual Market

The individual market today is facing significant challenges and uncertainty. Premiums and cost-sharing have increased dramatically and consumers will have fewer health insurance options in 2018. The national average premium for a silver plan in 2017 for a 50-year old non-smoker is \$6,888—about 29 percent higher than 2015—with advance premium tax credits covering about 80 percent for those who are eligible.¹

Today, about 84 percent of individuals who purchase coverage on the Exchanges get advance premium tax credits, while approximately 57 percent get help with out-of-pocket costs like deductibles and copays through the Cost Sharing Reduction (CSR)

¹⁰ Elizabeth Cornachione, et al., “Children’s Health Coverage: The Role of Medicaid and CHIP and Issues for the Future,” Kaiser Family Foundation (June 27, 2016), <http://www.kff.org/health-reform/issue-brief/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future/>.

¹¹ Lenna L. Liu, MD, MPH, et al., “Type 1 and Type 2 Diabetes in Asian and Pacific Islander U.S. Youth,” *Diabetes Care*, Vol. 32 (Suppl. 2) (March 2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2647693/>.

¹ HealthPocket 2015, <https://www.healthpocket.com/healthcare-research/infostat/early-trends-2015-obamacare-premiums#.WahaYT6GMnQ>. HealthPocket 2017, <https://www.healthpocket.com/healthcare-research/infostat/2017-obamacare-premiums-deductibles#.WahTvD6GN EY>.

program.² The CSR program serves millions of working, middle-income families making up to \$60,750 for a family of four who otherwise cannot afford to pay deductibles that average around \$7,500 for a silver plan if they do not have the benefit of CSRs.

However, nearly half of enrollees in the individual market do not qualify for premium tax credits. This contrasts with the employer market, where the average employer contribution was more than 82 percent for self-only coverage and 71 percent for family coverage in 2016.³ As costs rise in the individual market, more of those who purchase coverage on their own are no longer able to afford health insurance and are forced to find other sources of coverage or go uninsured. The major driver of rising premiums is the cost of covering people with significant medical needs. While the ACA took an important step by providing access to everyone regardless of medical condition in the individual market, the cost of individuals enrolled in the individual market has increased substantially given the lack of an adequate balance of people enrolled to assure affordable premiums. Health-care costs for new individual market enrollees were on average 19 percent higher than the group market in 2014 and 22 percent higher in 2015.⁴ Individual enrollees also had higher rates of certain conditions—such as hypertension, diabetes, depression, coronary artery disease, human immunodeficiency virus (HIV), and Hepatitis C—as well as higher use of medical services across all sites of care (*e.g.*, inpatient, emergency, prescriptions, etc.).⁵

Insurers have faced significant regulatory uncertainty and higher-than-expected risks, which has directly led to financial losses. In 2015, insurers lost \$6.6 billion on individual ACA coverage—\$495 per person per year. While there was slight improvement in 2016, insurers still lost \$4.7 billion or \$310 per person per year.⁶ In this environment, fewer insurers are participating. As a result, consumers will have access to only one health insurer in more than 40 percent of U.S. counties in 2018. By comparison, in 2014, only 17 percent of counties had only one insurer offering coverage in the Marketplaces, and nearly 50 percent of counties had three or more insurers participating.

Immediate Action Needed to Stabilize the Individual Health Insurance Market

In light of these challenges, Congress and the Administration must take immediate steps to stabilize the individual health insurance market and make it more affordable for consumers. This includes:

- **Providing immediate clarity on cost-sharing reductions.** Congress should act immediately to provide certainty about funding for the CSR program, at least through 2019, in order to bring down premiums, increase choice and competition among insurers and decrease costs for taxpayers. Failure to provide immediate clarity on CSRs would further destabilize the market—not only for the nearly 6 million people who rely on CSRs, but also for all 18 million people in the individual market who could see premiums rise by as much as 20 percent according to some estimates. It would also cost taxpayers \$2.3 billion more in 2018 as federal expenditures for tax credits increase.
- **Ensuring a smooth and effective Open Enrollment period for 2018.** Beginning on November 1st—less than 2 months from now—17 million Americans will begin re-enrolling in coverage in the individual market for 2018. Aggressive outreach to consumers is critical to a successful Open Enrollment period.

BCBSA believes all Americans should be able to obtain health insurance regardless of any medical conditions. However, in order to have an affordable health insurance system in which everyone can obtain coverage regardless of their health status, there must be a balance among those enrolled that includes healthier individuals along with those who need significant care. Congress and the Administration should take steps that will make the market more affordable and sustainable by assuring:

² CMS 2017, Effectuated Enrollment Snapshot, <https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf>.

³ Kaiser/HRET 2016, Employer Health Benefits Survey, <http://kff.org/report-section/ehbs-2016-summary-of-findings/>.

⁴ BCBSA Health of America Report, March 2016.

⁵ *Id.*

⁶ NAIC Supplemental Health Care Exhibits for 2016 and 2013. Does not include entities that file exclusively with the CA Department of Managed Healthcare.

- **Broad-based funding for those with significant medical needs.** Five percent of people who buy coverage in the individual market now represent almost 60 percent of health care claims' costs. A sustained federal funding mechanism to support the cost of caring for those with serious health conditions is essential to make premiums more affordable for everyone. A \$3 billion federal investment would fund a \$15 billion dollar program for those with costly medical needs that would reduce premiums by about 15 percent.⁷
- **Reduced ACA taxes and fees, including a permanent repeal of the health insurance tax (HIT).** In 2018, the HIT is estimated to add \$500 to the cost of a family policy.
- **State flexibility to stabilize markets, increase choices, and lower costs.** States best understand their local health-care markets and are in the best position to protect consumers and ensure insurance plans meet their needs. We support making it easier for states to innovate to establish more flexible rules and foster a more competitive and stable market for health insurance that expands access to comprehensive coverage with adequate federal funding.
- **Tax credits and rating rules encourage a balanced risk pool.** In order to create a more balanced mix of enrollees and bring down costs, it is critical that premiums be made more affordable for everyone, especially younger, healthier people who may not value health insurance. The current 3 to 1 age rating limitation requires younger consumers to pay much more on average in premiums than they spend on medical care. Rating rules that give younger people more value for their premium dollar would help create a more balanced risk pool and would lower costs for everyone. At the same time, Congress should age-adjust the premium tax credits to encourage younger people to buy coverage. It is important that tax credits remain sufficiently funded and adjusted for income and geography to help those with moderate incomes and in higher-cost areas purchase coverage.
- **Stable, fair, and less burdensome regulations.** Health insurers, like any other business, cannot operate sustainably or offer affordable products under continually changing governing rules. The rules and regulations governing the individual market should be streamlined and finalized with sufficient time for health plans to incorporate changes into products and pricing.

Avoiding Actions That Cause Additional Harm

At the same time, it is also critical to avoid any actions that may disrupt the market for comprehensive coverage. For example, Congress and the Administration should take steps to ensure:

- **Powerful incentives for individuals to maintain continuous coverage.** It is important for people to maintain coverage throughout the year. Those who do not stay covered continuously drive up costs for everyone because they buy coverage when they need medical care and then often drop it again. Under current law, the individual mandate is the key incentive for individuals to maintain coverage. While the individual mandate has not been fully effective in ensuring individuals maintain coverage year-round, it should be enforced unless and until Congress can enact a package of reforms to adequately assure a balanced risk pool.
- **No market disruption from entities that are exempt from comprehensive insurance rules.** Policymakers should not undermine the individual market by promoting the use of health care sharing ministries, individual membership associations, or other entities that are not subject to the comprehensive regulations that now apply to individual health insurance. To assure effective competition and prevent adverse selection, requirements must apply equally to all competitors selling insurance in the market. In addition, it is critical that product lines such as short-term limited-duration insurance continue to be regulated in a manner that prevents adverse selection while allowing them to meet the needs of persons with true short-term needs.
- **Patients are enrolled in the appropriate insurance program and insurers are not forced to accept premium payments from financially interested third parties.** Health plans are seeing substantial increases in financially interested providers inappropriately steering patients from Medicare and Medicaid to

⁷Oliver Wyman recently reported that a \$15-billion reinsurance program would be about 80 percent offset by savings in tax credit expenditures, http://health.oliverwyman.com/transform-care/2017/08/analysis_impact_of.html.

private individual coverage to boost their own reimbursement. This practice results in higher premiums for everyone else.

Promoting Policies That Bend the Cost Curve

While the health-care debate in Washington has focused mainly on coverage issues over the last 8 years, there is an urgent need to shift attention to addressing the cost of care. The U.S. is spending more than \$3 trillion a year on health care, straining budgets for families, businesses, and taxpayers. The cost of medical care, which includes caring for chronic or long-term medical conditions and the rising cost of prescription drugs, is the single biggest factor behind overall U.S. health-care costs, accounting for 90 percent of spending. To improve affordability—which will benefit all stakeholders, including states that seek to reform their health-care markets—we recommend the following:

- **Accelerate away from fee-for-service (FFS) to new payment and delivery models that incentivize value.** BCBS companies are spearheading innovative approaches to rewarding providers not for volume but for achieving good outcomes. The federal government should create and sustain an environment that promotes, rather than hinders, private sector experimentation by giving private sector payers flexibility in aligning their innovative models with Medicare payment reforms, strengthening Medicare Advantage, and creating safe harbors for payers, providers, and suppliers who implement innovative models.
- **Enable providers to provide value-based care, especially in new delivery models** (*e.g.*, medical homes, ACOs), through data-rich tools and analysis. Policymakers should advance interoperability by giving top priority to advancing a use case for reciprocal exchange of integrated clinical and administrative data between payers and providers, eliminating barriers to exchanging data, and empowering providers with actionable data will enable providers—working in partnership with payers—to make better decisions that improve patients' outcomes.
- **Leverage consumers' power to drive change and make health-care choices that best fit their needs.** Policies like expanding HSAs and giving payers more room to innovate with value-based insurance designs will help steer consumers towards high-value providers. It is critical that private payers, not government, take the lead in giving consumers clear, meaningful information about local price variation, cost-sharing, quality metrics and other factors to choose providers that will deliver the best care at the best price for them.
- **Address the key drivers of health-care costs.** Accelerating drug spending, site of care payment imbalances, defensive medicine, and anticompetitive provider consolidation are major cost drivers that need to be remedied. For drugs, this includes providing greater transparency into drug valuation, promoting competitive practices such as shortened exclusivity periods, and ensuring flexibility in formulary design. For site of care, this includes equalizing public and private payments to ensure payers do not spend more for the same treatments in different settings. For defensive medicine, this includes medical malpractice reform. And for consolidation, this includes rigorous enforcement of anticompetitive behaviors, and safeguarding against policies that could lead to further provider concentration that drives up costs.

Conclusion

The individual market continues to face significant pressures and uncertainty—making health insurance more expensive for everyone and resulting in limited consumer choice as fewer insurers and consumers participate in the market. Keeping premiums affordable is crucial to increasing participation and coverage among healthier individuals who help balance the overall risk pool and stabilize the market. BCBSA urges Congress to take immediate action to stabilize the individual market and make it more affordable and sustainable for consumers.

CENTER FOR FISCAL EQUITY

Chairman Hatch and Ranking Member Wyden, thank you for the opportunity to submit these comments for the record to the Committee on Finance. As usual, we will preface our comments with our comprehensive four-part approach, which will provide context for our comments.

- A Value-Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure very American pays something.

- Personal income surtaxes on joint and widowed filers with net annual incomes of \$100,000 and single filers earning \$50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25%.
- Employee contributions to Old-Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance, and survivors under age 60.

Under our proposal, Medicare, Medicaid, and subsidies for private insurance will be through the Net Business Receipts Tax (or Subtraction VAT). This would also include the unearned income payroll taxes passed as part of the Affordable Care Act.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border—nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal—covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two consumption taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit, and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

Employees would all be covered and participants in government funded remedial education programs would receive coverage and tax credits through the training providers health plan as if they were employees. No more separate Medicaid programs for the poor who are able to learn or work.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid-range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets.

Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages—although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes.

For this reason, a higher minimum wage is necessary so that lower-wage workers are compensated with more than just their child tax benefits.

We believe that our current insurance system adds no value to health care. Theoretically, insurance pools everyone's costs and divides them up with everyone paying a monthly share, regardless of the risk they pose.

The profit motive has given us differential premiums based on risk and age. Indeed, the age-based premiums in the last attempted health reform were so unaffordable to older Americans in individual plans that the bill could not pass the Senate. Single payer plans, funded through the NBRT, would not have this feature and insurance companies doing claim processing for the government would be paid an adequate profit with little risk.

Short of that, an NBRT subsidized Public Option would allow sicker, poorer, and older people to enroll for lower rates, allowing some measure of exclusion to private insurers and therefore lower costs. Of course, the profit motive will ultimately make the exclusion pool grow until private insurance would not be justified, leading-again to Single Payer if the race to cut customers leads to no one left in private insurance who is actually sick.

The NBRT can provide an incentive for cost savings if we allow employers to offer services privately to both employees and retirees in exchange for a substantial tax benefit, either by providing insurance or hiring health-care workers directly and building their own facilities. Employers who fund catastrophic care or operate nursing care facilities would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but not so much that the free market is destroyed.

This proposal is probably the most promising way to arrest health-care costs from their current upward spiral—as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise.

While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

NATIONAL ASSOCIATION OF MANUFACTURERS (NAM)
733 10th Street, NW, Suite 700
Washington, DC 20001

Chairman Hatch, Ranking Member Wyden, and members of the committee, thank you for the opportunity to submit a statement about the issues impacting the cost and coverage of health care. The National Association of Manufacturers (NAM) appreciates the effort you are undertaking to bring attention to ongoing health-care issues.

On behalf of the NAM, the nation's largest industrial trade association and the voice of 12 million men and women who make things in America, I am writing to urge continued action on issues left unresolved during the Senate's July consideration of legislation on health care. The Senate Committee on Finance have held many critical hearings and discussions on health care and today's hearing is an important signal to those impacted by escalating health-care costs.

Manufacturers continually rank rising health-care and premium costs as a top business challenge. The past several years under the Patient Protection and Affordable Care Act (ACA) has made it more difficult and costly to provide these important health-care benefits. Over 175 million Americans—nearly half of the nation—rely on employer-sponsored health coverage. As leading health-care stakeholders, employers continue to face increasing health-care costs, partially driven by the ACA. The permanent elimination of the medical device tax, the health insurance tax, the pharmaceutical tax, and Cadillac tax would go a long way to assist manufacturers in helping to contain costs.

Earlier this year, NAM board member Joe Eddy from Eagle Manufacturing testified before the House Committee on Education and the Workforce and offered an important manufacturing perspective related to health-care costs and coverage. The taxes, paperwork, fees, and mandates under the ACA cost Eagle almost \$1,000 per year per employee, not including the hiring of an additional human resources professional to manage health care and new requirements. Additionally, coverage changes were part of the many shifts brought about by the ACA according to Mr. Eddy's testimony. Health-care choices available to manufacturers and other business owners became more limited in certain regions, further adding to costs and uncertainty. Unfortunately, Eagle's experience is all too familiar for many manufacturers and employers around the country. For consideration of your committee, a copy of Mr. Eddy's testimony is attached to this statement and I request its inclusion for the record because it strongly resonates with the goals of today's hearing.

In the absence of positive legislative action that corrects the many failings of the ACA, the health insurance tax (HIT) and the medical device tax will go into effect in 2018 and the Cadillac tax in 2020. According to an August 2017 report by Oliver Wyman,¹ the HIT could raise the cost of premiums by an additional \$540 for em-

¹http://health.oliverwyman.com/transform-care/2017/08/analysis_HIT_impact.html.

ployees' families receiving health benefits from fully insured larger employers. Small business owners and their employees could shoulder an additional \$500 for family coverage as a result of the HIT. Manufacturers believe immediate relief from the HIT is in order.

Similarly, 2-year relief of the onerous 2.3-percent excise tax on medical devices is soon to expire at the end of 2017 and full repeal of this tax is urgently needed. The temporary suspension of the medical device tax was smart policy in 2015. Unfortunately, it took thousands of job losses and adverse economic and competitiveness impacts to the medical device industry to temporarily reverse this misguided ACA tax 2 years ago. Manufacturers urge the Senate not to wait and repeal the medical device tax before the end of the year.

The negative impacts of the 40-percent excise tax on high-cost health-care plans are well documented.² While this tax on employee benefits, also known as the Cadillac tax, has been delayed until 2020, health plan cost increases that follow historical averages, will put average health insurance plans for employees in harms way of the Cadillac tax, even if not a Cadillac plan. As the health-care cost curve continues to rise, such anticipated cost increases of health insurance and the associated ACA tax on benefits will eventually impact nearly every employee benefits package in the manufacturing sector.³ Manufacturers urge the Senate to fully repeal this adverse tax and firmly oppose using the Cadillac tax to pay for broken ACA programs.

To ensure employers can continue to provide competitive health-care benefits to their workers, the Senate should abstain from weakening the Employee Retirement Income Security Act of 1974 (ERISA) or modifying the tax treatment for employer-sponsored health care. The economies of scale that have come to define employer-sponsored coverage create a vehicle to design benefits that are more flexible, innovative and efficient, but this only works if health care innovation is encouraged and permitted. Employers can no longer be strangled by additional regulations or the burdens of 50 different ways to comply. Any legislative actions to undermine ERISA or change the tax treatment of employer-sponsored health care would further raise costs and could hamper the ability of employers to provide health-care benefits.

As your committee continues to address the consequences of the ACA and considers removing federal hurdles that hinder growth and innovation, the NAM looks forward to working with you to reduce additional compliance burdens, advance the potential of wellness programs, increase Health Savings Account (HSA) limits, establish association health plans, realize the full potential of outcomes-based health-care arrangements and further encourage overall improvements to health-care delivery and systems that manufacturers support as significant consumers of health care.

Despite the continued cost increases and challenges in providing health care, approximately 98 percent of NAM member companies offer health benefits. Manufacturers believe quality health benefits support a healthy workforce, attract and retain talent, but moreover, NAM members believe offering health insurance is the right thing to do for employees. However, employees are spending more of each paycheck on health care and the rising costs of premiums paid by employers continue to erode any gains in wages. The NAM appreciates the opportunity to share the manufacturing perspective with your committee. Reducing excessive taxes to ensure that manufacturers can continue to provide these benefits must be a primary goal moving forward.

While many of these taxes have been temporarily suspended, the uncertainty of future premium increases and additional health-care costs resulting from the ACA only continue to curtail innovation and economic growth. The impacts of a volatile health insurance market, legislative uncertainty and anticipated onerous health-care taxes cannot be underestimated. Manufacturers appreciate your continued legislative focus to chart a new course for health care and unlock the stranglehold of the ACA on manufacturers.

Attachment: February 1, 2017 Testimony of Joe Eddy, President and CEO of Eagle Manufacturing, before the U.S. House Committee on Education and the Workforce

² <http://healthaffairs.org/blog/2016/04/25/about-that-cadillac-tax/>.

³ <http://www.nam.org/Issues/Health-Care/EBT-One-Pager--December-8--2015.pdf>.

**Testimony of Joe Eddy, President and CEO, Eagle Manufacturing Company
On Behalf of the National Association of Manufacturers**

Before the U.S. House Committee on Education and the Workforce

Hearing on “Rescuing Americans From the Failed Health Care Law and
Advancing Patient-Centered Solutions”

February 1, 2017

Good morning, Chairwoman Foxx, Ranking Member Scott, and distinguished members of the committee. Thank you for the opportunity to appear before you and for holding this hearing today.

My name is Joe Eddy, and I am president and CEO of Eagle Manufacturing Company in Wellsburg, West Virginia. I am on the Board of Directors of the National Association of Manufacturers (NAM) and also serve on its Small and Medium Manufacturers Group.

The NAM is the nation’s largest industrial trade association and a voice for more than 12 million men and women who make things in America. The NAM is committed to achieving a policy agenda that helps manufacturers grow and create jobs. Manufacturers appreciate your attention to the burdens of the Affordable Care Act (ACA) that are impacting the competitiveness and growth of manufacturers around the nation. My story is not unique; it is one of many experiences that manufacturers have experienced over the past several years.

Eagle Manufacturing Company is a family-owned business established in 1894. We employ 195 employees and are a prime manufacturer of safety cans, safety cabinets, secondary spill containment products, poly drums, and material-handling products. At Eagle, we design and manufacture all of our own products. We are a respected brand name for consistent quality and value, and all of our products are “Made in the USA.” We supply nearly every industrial and commercial sector: contractors, manufacturers, utilities, military, professional, government, printing, chemical, fabricators, transportation, textile mills, automotive, agricultural, medical, oil and gas, and electrical. In 2015, Eagle received the NAM’s Sandy Trowbridge Award for Excellence in Community Service, and last year, Secretary of Commerce Penny Pritzker awarded us the President’s “E” Award for Exports, the highest recognition any U.S. entity can receive for making a significant contribution to the expansion of U.S. exports.

Manufacturers have a proud tradition of providing health insurance for their employees. More than 98 percent of NAM members offer health benefits to their employees. At Eagle, our tradition has been to cover 100 percent of medical costs for our employees. We have done this because it’s the right thing to do for our employees and our community. No government policy or mandate leads us to provide this generous benefit. We often hear that people specifically want to come to work at Eagle because of our reputation of taking care of our employees. We live by our mission statement: “Protecting People, Property, and the Planet.”

Unfortunately, the past few years under the ACA have made it more difficult to live up to the standards we have set for ourselves. Rising health-care costs have forced us to make some difficult choices, and the ACA has further limited our options. In 2009, prior to the ACA, we were paying about \$13,500 per year per employee, and by 2013, those costs increased to more than \$15,800 per year per employee. At that time, I was tasked with specifically looking at the added costs to the company resulting from the impacts of the ACA because our health-care costs were on the rise and posing a risk to the company’s financial health. The taxes, paperwork, fees, and mandates cost us almost \$1,000 per year per employee, and this does not include the hiring of an additional human resources professional who specifically manages health care and all the new requirements. As much as we work to keep costs down, our plan now costs more than \$22,800 per year per employee, so we are at even more risk if the “Cadillac” tax is not repealed. In addition, as a fully insured company that works directly with insurance brokers to purchase employee health plans, we are exposed to the health insurance tax in 2018.

We do not think our benefits are excessive; they are necessary to attract, retain, and maintain a strong, quality, and healthy workforce. Unfortunately, the cost of health care remains a top business concern for both large and small manufacturers based upon quarterly survey results conducted by the NAM that focus on manufacturing sentiment. While the overall business outlook is improving, there has been

limited relief in sight to address escalating health-care costs. Since being added to the NAM survey 2 years ago, it has been listed as a primary business concern each quarter. Rising health-care costs impact all facets of any company hiring new workers, maintaining competitive pay rates and making capital investments as well as researching and developing new products.

Part of the challenge that the ACA ushered in was the paradigm shift in health-care choices available to manufacturers and other business owners. Options that were once available to us became more limited over time. More specifically, the insurance that we had for more than 10 years was no longer available. It put a whole new meaning to the oft-repeated words of the previous President, "If you like your health-care plan, you can keep it." Many of our employees had to find new doctors, and we had to learn to manage a new system. Furthermore, the new product we purchased was more expensive, driving our health-care costs up an additional \$4,000 per year per employee. Unhappy with the outcomes of this change, we switched carriers again to another insurer. We are hopeful that our situation has stabilized. Businesses such as ours need flexibility and competitive options so that we can always find the best and most cost-effective plan for our employees.

But the most challenging part of the ACA is the effect it has had on our employer employee relations. As I mentioned earlier, Eagle Manufacturing has 195 employees, but it should be noted that 150 of those are unionized through the United Steelworkers Union. We have traditionally had a strong relationship with the union and those employees. However, last year during contract negotiations, for the first time, we had to negotiate a cost-sharing arrangement with the union because of the untenable rise in health-care costs facing Eagle. It was a difficult choice, and I am proud that for the competitiveness and well-being of the company, the union agreed. Employees now contribute \$35 per pay period (\$910 per year) toward monthly health insurance premiums. As you would imagine, those were not easy negotiations. It broke down the trust and partnership between the company and our employees. For our non-union employees, we now have to charge \$50 per pay period (\$1,200 per year) for their co-share.

The years following ACA passage have been costly, disruptive, and distracting from the things we are good at doing as manufacturers. Moreover, the dose of uncertainty delivered to us more than 7 years ago still has not been fully resolved. We look forward to working with you to help address these mounting issues, and I appreciate the opportunity to share my experiences on behalf of my company and other manufacturers. In speaking for myself and others, we urge Congress to focus its efforts on solutions that will successfully eliminate the costliest and most problematic aspects of the ACA. The challenges ahead—a continued escalation of health-care costs paid by employers and employees through the anticipated "Cadillac" tax on comprehensive health plans, an excise tax on medical devices, a health insurance tax, and other administrative burdens—all demand immediate and thoughtful attention from Congress.

Eagle is very proud of our 123 years in West Virginia, manufacturing innovative, quality products for our customers. As a leader in the Wellsburg community, we strive to provide health-care benefits that allow for a strong, healthy workforce, but it is a struggle given the limits, restrictions, and mandates of the ACA. I know that my struggle is not unique and that other manufacturers around the country are facing the same challenges.

I very much look forward to working with you to find workable solutions that will help control outrageous costs and provide the flexibility for employers to continue to provide the benefits their employees deserve. Thank you for inviting me to testify before you today, and I am happy to answer your questions.

PARTNERSHIP TO FIGHT CHRONIC DISEASE (PFCD)

The Honorable Orrin Hatch
Chairman
Committee on Finance
United States Senate

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Re: Statement for the Record for Senate Finance Committee Hearing, "Health Care: Issues Impacting Cost and Coverage" on September 12, 2017

Dear Chairman Hatch, Ranking Member Wyden, and Senate Finance Committee Members:

The Partnership to Fight Chronic Disease (PFCD) applauds the Senate Finance Committee's continuing efforts to improve the quality of care for people living with chronic conditions. We particularly appreciate the inclusive, transparent, and bipartisan nature with which the Committee's Chronic Care Working Group (CCWG) worked to develop bipartisan recommendations to the Department of Health and Human Services and the proposed CHRONIC Care Act. We are submitting a statement for the record for the Committee's hearing, "Health Care: Issues Impacting Cost and Coverage" scheduled for September 12th and have attached a copy of that statement in case it may be of use during the hearing.

PFCD, a non-partisan coalition of hundreds of patient, provider, community, business and labor groups, and health policy experts active at the state, federal, and international level, advocates for policies that work to better prevent and manage the number one cause of death, disability and rising health-care costs: chronic diseases.

Given that treating people with chronic conditions accounts for 90 cents of every dollar spent on health care, any discussion on issues relating to health-care costs and coverage should include a focus on the burden of chronic illness.

PFCD welcomes the opportunity to continue working with the Committee to address these important issues.

Sincerely,

Kenneth E. Thorpe, Ph.D.
 Chair, Partnership to Fight Chronic Disease
 Robert W. Woodruff Professor and Chair
 Department of Health Policy and Management
 Rollins School of Public Health, Emory University

Statement for the Record of the Partnership to Fight Chronic Disease

The Partnership to Fight Chronic Disease (PFCD) is a non-profit, non-partisan coalition of more than 100 patient, provider, and community organizations, business, and labor groups, and health policy experts committed to raising awareness of the number one cause of death, disability, and growing health-care costs in the U.S.: rising rates of preventable and treatable chronic diseases.

Simply put, we cannot lessen rising health-care costs and the economic losses of poor health without addressing chronic disease. Tackling these challenges relies on a willingness to adopt policies that help Americans enjoy better health by preventing and managing chronic illnesses.

The increasing burden of chronic disease is the single most important threat to the health of American families and places major downward pressure on the U.S. economy. Today, more than one in two American adults lives with at least one chronic condition—such as diabetes, heart disease, or depression—and nearly one in three lives with two or more chronic conditions. We cannot lower health-care costs without addressing the epidemic of chronic disease. The burden of chronic disease is staggering. According to RAND Health's *Multiple Chronic Conditions in the United States*, 90 cents of every dollar spent on health care goes to treating people with a chronic condition. For each additional chronic condition a person has, his or her medical costs increase by more than \$2,000 a year on average. If nothing changes, chronic diseases will cost the U.S. \$92 billion 2015–2030 in medical costs and economic losses.

People living with more than one chronic condition spend more out-of-pocket on medical expenses, but medical costs are only part of the burden. Chronic diseases are the number one cause of death and disability in America. Major chronic conditions such as Alzheimer's can also lead to increased reliance on uncompensated care provided by family members, and lessen overall quality of life. Research also shows that the onset of a chronic condition is associated with a reduction in individual earnings, affecting both the individual and families. Any discussion on reducing health-care costs must include a focus on addressing the burden of chronic diseases in America.

Health-care costs are highly concentrated with 5 percent of the population accounting for more than half of all health-care spending. Often, these individuals have multiple chronic conditions and complex care needs that are not well met by the fragmented way health care is currently structured and delivered. This concentra-

tion in costs lends itself to targeted reforms to improve access to care, coordinate care and integrate services, and empower self-management. Compared to a person without any chronic conditions, spending is almost 2.5 times more for those with one chronic condition; 6 times more for people with 3 chronic conditions; and 13.5 times more for people with 5 or more chronic conditions.

Chronic diseases also place a tremendous burden on the U.S. workforce, reducing our competitiveness in the global marketplace. Nearly one in two working age adults (49 percent of those aged 45–64) has more than one chronic condition.

The growing burden of chronic disease drives health-care spending and is unsustainable. Without change, as the population ages, the number of people living with more than one chronic condition is projected to grow dramatically, driving medical spending, and hindering economic growth.

Lowering health-care costs requires reducing the burden of chronic disease. To be most effective, reforms targeted at realizing the opportunity from improved prevention and management of chronic disease should:

- Prioritize prevention and management of chronic conditions.
- Encourage continued innovation in treatment and delivery of health care.
- Improve access to recommended care.
- Promote health across generations.
- Translate knowledge into action.

Prioritize Prevention and Management of Chronic Conditions in a Value-Drive System

To lower health-care costs and lessen the human toll of chronic conditions, our health-care system needs to align incentives to encourage payers, providers, employers, and individuals to better prevent, detect, treat, and manage chronic diseases—both physical and mental—before they become acute, costly problems. There is a growing push toward value-based care delivery through which provider payment is based not only on services provided, but also on health and cost-related outcomes. If new payment models are designed correctly and recognize the importance of personalized care, they have potential to improve the management of chronic diseases, slow their spread, and prevent people from developing multiple chronic conditions.

Similarly, value-based contracting for drugs, devices, and other care components hold promise in enhancing quality while managing costs and increasing competition. Policy changes are needed to remove regulatory hurdles that prevent insurers and manufacturers from developing these arrangements.

As we move away from the misaligned incentives in the fee-for-service system to emphasize value, we must ensure that appropriate quality measures are in place to capture outcomes important to patients. Most currently available quality measures are disease-specific, provider focused, and process-oriented. There remains a gap of meaningful quality measures that capture patients with multiple chronic conditions. This leads to serious questions about whether quality will be improved for this population, or if patient health could be compromised in the pursuit of cost control. It will also be critical to ensure that this transformation is done in a way that allows for continued medical progress in the treatment of chronic disease.

Encourage Continued Innovation in Treatment and Delivery of Health Care

Our health-care system could also become more efficient and effective by adopting and supporting continued development of innovations that enhance quality and outcomes. Continued innovation in use of health IT to support improvements in coordinated care delivery and improved management of chronic diseases holds great promise. The value of innovation in medical treatments and technology also cannot be overstated in the fight against chronic disease. Biomedical innovation in America is the envy of the world, fueled by robust investments in research in both the public and private sector. The benefits include longer life with less disability and a strong job growth in health-care industries.

One of the hallmarks of the U.S. health-care system is the scope and pace of biomedical innovation and discovery. Continued progress depends upon having an environment that encourages and rewards advances in detection, treatment, and care delivery. Our understanding of human health and our growing arsenal of treatments are testaments to the benefits of a robust ecosystem for biomedical innovation that both needs and deserves protecting.

Proposals that undermine that ecosystem, including importing drugs from other countries and reference pricing for goods and services, carry significant risks for already vulnerable populations. For example, legalizing drug importation would make it far easier for harmful counterfeit and contaminated medicines to enter the U.S. drug supply. Because of the risks involved, the last four FDA Commissioners have expressed strong opposition to importation.

Instead, maximizing the potential of innovations in health IT to facilitate care coordination, patient engagement, and self-management, and integration of traditional medical care, behavioral health services, public health, and social supports holds significant benefits for patients and creates cost efficiencies while improving outcomes and overall quality.

Improve Access to Recommended Care

Americans must have an opportunity to obtain health insurance that supports access to care recommended to prevent and treat chronic diseases. Having health-care coverage is important, but does not necessarily mean care is affordable and accessible to the people who need it. Chronically ill Americans receive only about half (56 percent) of the recommended preventive care services.

Skipping appointments, not filling prescriptions, and testing less often than recommended represent missed opportunities to improve health that drive costs higher. Without affordable out-of-pocket costs, being covered doesn't improve access for people with complex health needs.

Accordingly, efforts to reduce preventable hospitalizations, readmissions, and other intensive care services should include improving access to chronic disease care by reducing out-of-pocket spending for people with complex health-care needs.

There are also rising concerns about shortages among primary care providers. Primary care is the "tip of the spear" in the management of chronic diseases. Many underserved areas in the country already have provider shortages, impacting health status in those communities. As of June 2014, there are approximately 6,100 geographic areas with primary care shortages with less than one physician for every 3,500 people, and projected primary care shortfalls range from 12,500 to 31,000 physicians by 2025. Fully integrating physician assistants and primary care nurse practitioners into the health care delivery system could assist with primary care shortages, though several states are projected to experience nursing shortfalls.

Promote Health Across Generations

America's economic prosperity hinges on the health of Americans across the generations. Good health habits established in childhood carry the promise of better health throughout life. However, when it comes to health improvement, we are failing our children. The prevalence of chronic health conditions among children in America has risen dramatically in a generation. For example, childhood obesity rates alone have more than tripled just since the 1970s.

Poor health status headed into adulthood not only increases health-care costs, but also presents challenges for employees and employers and hinders economic growth overall. For example, the U.S. Army estimates that 28 percent of applicants are rejected for medical reasons, including weight. Preventable and poorly managed chronic diseases also drive workplace health care costs, including productivity losses. Better management of chronic diseases like depression and addressing risk factors such as obesity and smoking could help qualified workers stay on the job, improving competitiveness of the American workforce.

Health promotion should not end at retirement, and Medicare has an important role to play in keeping America's seniors healthy. Preventive screenings, a "welcome to Medicare" physical, annual wellness visits, are important pieces of the puzzle, but treating and managing existing chronic conditions are also critical to ensure that patients don't develop multiple chronic diseases. For example, poorly managed diabetes greatly increases incidence of cardiovascular and kidney disease and increases disability relating to blindness and amputations. Medicare coverage of the Diabetes Prevention Program will help in reducing the burden of diabetes within Medicare and is an example of population-focused interventions that work to reduce risks for chronic conditions and associated costs while safeguarding patient access and quality of care.

Translates Knowledge Into Action

In communities across the nation, people have developed innovative programs that promote wellness and prevent and manage disease. We aren't doing enough to tap into that knowledge and to replicate nationwide those programs that work. Govern-

ment support to analyze programs for best practices, facilitate dissemination of lessons learned, and financial support to facilitate replication and adoption is critical to maximizing the potential of these efforts.

The need to replicate successful programs is particularly acute in underserved areas and with populations in which health disparities persist, lowering health status and leading to lost economic opportunities. Given the bi-directional nature of economic opportunity and health status, addressing chronic disease among populations of color offers significant promise in promoting income growth and reducing socioeconomic disparities.

Conclusion

Simply put, we cannot lessen rising health-care costs and the economic losses of poor health without addressing chronic disease. Tackling these challenges relies on a willingness to adopt policies that help Americans enjoy better health by preventing and managing chronic illnesses. It requires a multi-faceted approach that views health status as an asset both to the individual and our nation as a whole. Enhancing health requires investment and focusing resources on preventing and better managing chronic disease. It also requires adopting a different perspective on health care spending that assesses the overall value derived, including gains in quality of life, reduced disability, and economic gains.

We applaud your continued efforts to seek solutions to rising health-care costs and reducing the burden of chronic disease in America. We stand ready to help build on those efforts.

