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HEALTH CARE SOLUTIONS: INCREASING
PATIENT CHOICE AND PLAN INNOVATION
WEDNESDAY, MAY 11, 2016

House of Representatives,
Subcommittee on Health,
Committee on Energy and Commerce,
Washington, D.C.

The subcommittee met, pursuant to call, at 9:58 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Shimkus, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Long, Ellmers, Bucshon, Brooks, Collins, Upton (ex officio), Green, Engel, Capps, Schakowsky, Butterfield, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, Pallone (ex officio).

Staff Present: Adam Buckalew, Professional Staff Member; Rebecca Card, Assistant Press Secretary; Graham Pittman, Legislative

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Clerk; Chris Sarley, Policy Coordinator, Environment & Economy;
Jennifer Sherman, Press Secretary; Kyle Fischer, Minority Health
Fellow; Tiffany Gurascio, Minority Deputy Staff Director and Chief
Health Advisor; Samantha Satchell, Minority Policy Analyst; and
Arielle Woronoff, Minority Health Counsel.

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Mr. Pitts. The time of 10 o'clock having arrived, we will call the subcommittee to order. The chair will recognize himself for an opening statement.

The subcommittee is holding a hearing today to take a closer look at healthcare solutions centered on promoting patient choice and innovation in the design of health coverage.

Health care is the most personal of any political issue, and when Congress gets involved in health policy we are changing people's lives. Decisions we make in Washington can have a tremendous effect on the well-being of families and their budgets.

A country in which 45 million people went without health insurance was certainly in need of health reform. However, the Affordable Care Act is not the health reform this country needed. In fact, I believe it is a setback that makes true reform even harder to accomplish.

The first thing health reform should accomplish is to stabilize or reduce the cost of health care. The number one complaint people have about health care is the rising cost. And yet the ACA has done little to decrease healthcare spending. In fact, many Americans are paying higher premiums and deductibles for health insurance and care as a result of the law. We can do better.

We must make healthcare costs more transparent and give people the freedom to choose the insurance that they want with the benefits that they value most at a price that is fair. More government bureaucracy, regulations, and spending never successfully reduced the

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price of health care.

Yet that is exactly the premise of how health insurance is regulated today with top-down mandates that empower Washington and remove control over healthcare decisions from States and small businesses and families and individuals. And this has to be changed if we truly want bottom-up solutions that provide better care at lower costs for patients.

Some of the free enterprise solutions that I believe would truly help control costs and improve health care for all include portability, more pooling options, strengthening consumer-driven arrangements like health savings accounts, and innovation through less Federal benefit mandates.

Employer-sponsored insurance is a critical part of our healthcare system and must be protected, but for many their health insurance is too closely tied to employment. People who are laid off, fired, or have to quit working can find themselves uninsured at a time when they can least afford it. We need better options so patients can truly own a plan of their choosing on the individual market.

Before the President's healthcare law, I introduced the Small Business Choice Act, which would allow small businesses to form private health insurance cooperatives to buy insurance at lower rates while transferring catastrophic costs to a larger insurer, and the bill helps make small employers offer health insurance through a refundable tax credit of 65 percent, and self-employed people would save \$5,000 a year

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on health insurance, and other small firms would save more than 34 percent.

Similarly, association health plans, AHPs, could allow rotary clubs, professional associations, other groups, to band together across State lines, form their own health plans, increasing their purchasing power and lowering costs.

Health savings accounts should also be strengthened, and these accounts allow individuals to save money in an account they control, using the money to pay for everyday medical expenses. Only when major medical expenses are incurred does the insurance company step in after a high deductible paid out of the HSA is met. HSAs encourage individuals to make smart spending decisions, cost them less over time than traditional insurance.

We should never forget that innovation comes almost exclusively from the private sector. New drugs, therapies, cures will only be developed if the companies that develop them are able to commercialize them. Empowering Washington is not the way we are going to promote innovation and invention.

So our hearing today will examine options to reform insurance markets to better serve patients and examine better paths forward.

My time has expired. With that I recognize, Ms. Matsui, who is filling in as ranking member, for 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

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Ms. Matsui. Mr. Chairman, I would like to reserve the time for Mr. Green until he returns.

Mr. Pitts. All right. That is fine.

Does anyone else seek?

All right. We will go to our chairman of the full committee, Mr. Upton, for 5 minutes for an opening statement.

The Chairman. Thank you, Mr. Chairman.

Today's hearing is an important discussion on what Congress can do to help Americans across the country access better care at, indeed, a lower cost. Individuals and families across the country are seeing growing premiums and deductibles, yet are seeing provider networks narrow and restrict access to life-saving medicines and treatments. Folks in my State, as well as across the country, are frustrated. The healthcare system was turned upside down. Promises were not kept. Costs have gone up, while quality has often deteriorated.

So we have to chart a better path forward to reforming our insurance markets so that they can better serve the patients. That is what this effort is all about. We can strengthen health coverage by expanding plan offerings that allow for real choice, as well as incentivizing market innovation without the mandates.

I have laid out a number of ideas to do this in the Patient CARE Act that I authorized with Senators Hatch and Burr, and our committee members have laid out dozens and dozens of ideas that put the power to choose in the hands of patients.

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So let's establish another point from the start. House Republicans believe that no patient -- no patient -- should be denied coverage or experience coverage shortages simply because they are sick. There are various ideas of how to accomplish our goals without interrupting the health insurance market, including guaranteed issue and continuous coverage protections. Continuous coverage means that if a patient gets a new job or retires or switches plans because their family moves, whatever, they will not be charged more than the standard rates, even if they are dealing with a serious medical issue or, as we know it, preexisting condition.

Protecting our most vulnerable patients with preexisting condition safeguards is just as much about helping them keep health coverage as it is about creating an environment for them to get health coverage. Continued enrollment can lead to lower costs and stable markets, which gives consumers a pathway to choose more innovative options.

So today we are going to talk about ways to achieve this through market reforms instead of government mandates, by encouraging States to lower costs through premium reduction programs. Options like advanced high-risk pools can also open new access points to the market while helping keep patient costs down.

Headlines across the country confirm that patients are paying higher premiums and seeing fewer options. Patients are exiting the marketplace. Plans are leaving the exchanges. So simply put, we are

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6 years into the President's healthcare law, and it is not working the way people thought it might.

One disturbing fact that confirms the need for reform is that 19 of the 37 States on healthcare.gov -- 19 of the 37 -- saw double-digit premium increases for the second-lowest-cost silver plan. Even worse, three of those States saw benchmark rates go up to 30 percent. And S&P reported Monday that individual market costs jumped 23 percent in 2015.

That is why we are here today, to discuss the merits of idea for increasing patient choices and incentivizing plan innovation. I look forward to the witnesses' testimony and would yield to any Republicans on my side. I yield back the balance of my time.

[The prepared statement of The Chairman follows:]

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Mr. Pitts. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

I believe we all share a common goal. We want a healthcare system that is more affordable, accessible, and higher quality, a system that works for all Americans.

Now, how we achieve this goal tends to be a topic of intense debate, and it should be. The Affordable Care Act has greatly expanded access to quality, affordable health insurance in our country. There is, however, more that we can do to improve our health system for everyone.

I believe the ACA has been a success. Twenty million more people now have health insurance. Women, minorities, and young people in particular have experienced substantial gains in coverage. Since 2013, the uninsured rate amongst young adults has dropped by 47 percent. And together we should be discussing how we can build on this success to give even more Americans the peace of mind that quality health insurance provides.

The law also put in place important consumer protections that prevent insurers from discriminating against the most vulnerable, and it eliminated out-of-pocket costs for important preventative services, such as immunizations and cancer screenings.

While we know the marketplaces still need time and room to grow,

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we can't forget what the individual market was like before the Affordable Care Act. Double-digit rate increases on subpar plans were the norm. The ACA gave HHS and States the tools they need to monitor insurers and put a stop to these harmful practices.

This rate review program brings transparency to the process, greater stability to the market, and protects individuals from unreasonable price increases. It also resulted in subpar plans simply no longer being sold if they don't cover hospitalizations or prescription drugs or have limits on how much health care will be covered in a given year.

The medical loss ratio ensures that insurers spend at least 80 percent of premium dollars on actual health care and not executive bonuses or advertising.

The ACA also created an entirely new marketplace that expanded coverage to individuals who prior to the Affordable Care Act had little to no hope of finding affordable health insurance. Our witnesses today will talk about giving consumers more choices, but let's not lose sight of the fact that before the ACA, millions of Americans with preexisting conditions had no choices at all.

These marketplaces are still in their infancy and will continue to mature over time as insurers become more accustomed to calculating risk and as more individuals transition from grandfathered and grandmothered plans to marketplace plans.

Creating a competitive and successful market in a system as

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complex as our own is certainly no small feat. Millions of Americans count on this coverage and therefore we should do everything we can to make sure that these marketplaces grow even stronger.

And this hearing has the potential to be a starting point for a real discussion on bipartisan improvements that will strengthen the systems already in place and bring us even closer to high-quality, universal coverage. However, I also recognize that this hearing has the potential to be a continuation of a 6-year Republican assault against the Affordable Care Act and the millions of Americans who benefit from it.

The ACA's marketplaces put power back into the hands of consumers, gave everyone the right to buy insurance, and forced insurers to compete based on price and value. We can't return to a time when insurers competed to find the healthiest, least-expensive consumers and left millions of Americans to fend for themselves. I think we have a duty to overcome partisan politics and work together to come up with the best solutions, and I am hoping that we will use our time today to do just that.

And I would like to yield the remainder of my time to the gentlewoman from California, Ms. Matsui.

[The prepared statement of Mr. Pallone follows:]

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Ms. Matsui. Thank you very much.

The Affordable Care Act is improving millions of Americans' lives. Thanks to the ACA, nearly 18 million previously uninsured Americans no longer have to worry that they are one illness away from financial ruin.

The Affordable Care Act is intertwined into the fabric of our healthcare system. It is time to recognize the ACA as the law of the land so we can move forward with the business of ensuring that every American has the opportunity to live a healthy life. As members of the Health Subcommittee, that should be our mission.

Today we are talking about market reforms that increase transparency and access for patients. Because of the ACA, patients with preexisting conditions who never had a choice when it came to their health care now have options. These protections are particularly important for those over 30 million individuals in this country who suffer from rare or serious chronic diseases.

The ACA has helped millions of families gain access to quality, affordable coverage, and I do hope that our committee can work together to continue this progress to improve the health and lives of Americans.

I yield the remainder of my time back to the ranking member.

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[The prepared statement of Ms. Matsui follows:]

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Mr. Pitts. The gentleman's time has expired.

The chair now recognizes the ranking member of the subcommittee, Mr. Green, 5 minutes for an opening statement.

Mr. Green. Thank you, Mr. Chairman. And I will ask for dispensation because I was actually speaking to Bill Flores, the Chamber of Congress, and they asked too many questions. I may have been the only Democrat they heard from that day.

I want to welcome our panel. Good morning, and thank you all for being here today.

It has been almost 2-1/2 years since the full reforms of the Affordable Care Act went into effect. The third open enrollment period built off the successes of the first and second, and there is even reason to believe that the fourth open enrollment period will continue this trend. The marketplaces created under the Affordable Care Act are in their relative infancy. As with any other, almost every new market, particularly in the healthcare space, there will be changes and adjustments in the early years. Insurers will both enter and exit as they navigate the new landscape of millions of new consumers, protections, and requirements.

Medicare, when it was first created, experienced growing pains, as did Medicare Advantage and the part D plans. You will hear reports sounding the alarm that in 2016, 39 insurers left the Federal marketplace. While that -- maybe actuary reports fail to mention that in the same year, 40 insurers entered the marketplace.

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The number of issuers in every State has grown each year at a year-over-year average of 8 in 2014, 9 in 2015, and 10 in 2016. Nearly 90 percent of consumers that had coverage in 2015 had a choice of three or more insurers for the 2016 coverage.

The unfiltered facts clearly indicate that the marketplace is an attractive place for issuers to do business and for consumers to purchase quality, affordable insurance, many for the first time in their lives.

Health insurance is a product that Americans want and need. The Affordable Care Act is creating a system that lends truth to the principle that health care is not a privilege for the few, but the right for all Americans.

The Affordable Care Act has been resoundingly successful, but like any law, it is not perfect. As I have been known to say, if you want something done perfectly, don't ever come to Congress. That is why, after passing major reforms, Congress has very often revisited the legislation and come together to improve it.

While I don't expect us to agree on a lot of solutions debated during this hearing, it is a welcome departure from the politically motivated hearings we have had over the last 6 years which were only designed to score points and attack the law rather than look for ways to improve the exchanges on behalf of the American people. I am hopeful this is a genuine step toward getting back to the business of legislating. I thank the chairman for calling it.

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The core strength of the ACA is that it puts power back in the hands of consumers, contains key provisions, and requires insurers to compete based on their ability to offer high-quality insurance at an affordable price. In the pre-ACA world, the individual market was unstable, unfair, and inaccessible to many. Insurers competed to find the healthiest and cheapest consumers, and those with preexisting conditions were largely priced out. Women could be charged more just because of their gender, annual and lifetime limits hindered patients' ability to get care when they needed it, and people could be dropped from their plan when they got sick and needed it the most.

In the post-ACA individual market, where everyone has the right to buy insurance and choices are transparent and easy to compare, consumers make issuers compete based on price and value, and with any market, some insurers are adapting faster than others to the new landscape. This is the nature of competition.

Some insurers have already figured out how to succeed in the marketplace and they are growing and expanding their exchange business. Others will learn to adapt or else lose market share to those who already have. These are the features of a healthy market. This is the proof that ACA's market-based reforms are working.

There are definitely ways to improve the ACA, to expand coverage to more Americans, and to lower cost. I look forward to exploring these with my colleagues. And, for example, my friend and Texan, good friend Joe Barton and I have a requirement for 12-month continuous enrollment

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in Medicaid and CHIP. Continuous coverage brings down administration burden, provides for continuous care, and keeps folks healthier while bending the curve in the long run.

Again, I want to thank our witnesses for being here today, and I look forward to getting back to the business of legislating. Thank you.

[The prepared statement of Mr. Green follows:]

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Mr. Pitts. The chair thanks the gentleman.

As usual, all members' opening statements will be made a part of the record.

[The information follows:]

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Mr. Pitts. I seek unanimous consent to submit the following document for the record: a statement from the Committee For Economic Development. Without objection, so ordered.

[The information follows:]

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Mr. Pitts. We have one panel before us today. I would like to thank for coming. And I will introduce our panelists in the order of their giving testimony.

First, we have Dr. Scott Gottlieb, resident fellow, American Enterprise Institute; Mr. Avik Roy, senior fellow, Manhattan Institute; and Sabrina Corlette, research professor, Center on Health Insurance Reform, Georgetown University.

Thank you for coming today. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize your testimony.

So at this point, Dr. Gottlieb, you are recognized for 5 minutes for your summary.

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STATEMENTS OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE; AVIK ROY, SENIOR FELLOW, MANHATTAN INSTITUTE; AND SABRINA CORLETTE, J.D., RESEARCH PROFESSOR, CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY

STATEMENT OF SCOTT GOTTLIEB

Dr. Gottlieb. Mr. Chairman, Mr. Vice Chairman, thank you for the opportunity to testify here today.

My name is Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute. I previously worked at CMS and FDA and have experienced and evaluated the insurance market as a provider, as a policy analyst, and as an investor in the space, and it is from three perspectives I want to offer some thoughts today. We face some continuing challenges with respect to our current insurance market and some new pressures, and I want to focus not on how we got here, but what we can do about it.

Improving the existing market for insurance inside the State-based exchanges or transitioning to an entirely new framework for how we pool risk and help consumers buy coverage should include, in particular, four principles that I want to outline today.

First, more rating and regulatory flexibility for insurance products to enable more competition between different and, hopefully,

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more innovative plans. I believe that regulatory standards and how CMS is interpreting its own rules limit the ability of plans to offer innovative designs.

Because health plans must adhere to a narrow formula to fall within the discrete metal tiers, it leads to an environment where plans are designed from the top down, off actuarial targets, rather than based on a bottoms-up approach to build off principles that may lead to more innovation and coverage.

To these ends, insurers can be required to simply report the actuarial value of their plans so long as they meet a minimum level of coverage. Instead of making decisions based on rigid targets that are tied to metals, consumers can make choices based on the actual actuarial value of the plan.

I believe allowing more regulatory flexibility around rating and plan design would enable a wider selection of high-value options, such as value-based insurance designs or designs that reduce premiums and other costs for consumers that stay with an insurer over time.

Second, we need clear rules on open enrollment periods to enable a viable risk pool while using incentives rather than mandates as a way to keep people in the insurance market. We absolutely must maintain some exemptions for people who confront some discrete challenges obtaining coverage during open enrollment periods. But carefully defined enrollment windows can form a key element of rules that use incentives to encourage people to enter the insurance market

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and stay continuously insured, rather than relying on penalties to enable these same outcomes.

Right now the lack of tightly defined enrollment periods, verification requirements, and fluid exemptions largely forecloses the ability to use the requirement for continuous coverage as a way to create incentives for people to get into and stay in the insurance market.

Third, subsidies need to be tied more closely to risk, and risk adjustment must provide plans with incentives to enroll and improve the health of people with chronic conditions. In the plan that I helped co-author at AEI with my colleagues, we advocate a system of tax credits. These are set initially as a fixed-dollar amount based on age. Under our framework, older individuals would get larger subsidies reflecting their tendency to use more healthcare services.

Another option is to match the magnitude of the tax credits more closely to the varying insurance costs that real purchasers will face in a less regulated market. This second option would make the tax credit amounts more open-ended initially in response to the premiums that may vary with age, geography, and perhaps some form of preexisting risk. This initial floating cost subsidy structure could then be adjusted in later years to set a ceiling on maximum tax benefits to curb overspending and add additional subsidies for more economically or medically vulnerable populations.

Any approach should be coupled to proper risk adjustment so that

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health plans have an incentive to enroll individuals with certain preexisting conditions and improve their health.

The credit the health plans receive can be adjusted prospectively based on a defined set of healthcare conditions and a methodology that the insurers agree to in advance, since they are the ones who know best where the economic sensitivities are.

Fourth, and finally, we need to contemplate policies that offer incentives for new plan formation and alternatives to the hospital-led consolidation of providers that are driving up costs. With respect to health plans, there has been no new net health plan formation since 2008. By this, I mean new health carriers. I believe that a big culprit is the caps on the operating margins, which makes it hard for new plans to enter the market even with some of the concessions that are made available to startup plans.

On the provider side, we need to consider policies to create alternatives to the consolidation of physicians around local hospitals, which is increasing in a number of markets and is giving a single health system the sort of monopoly position that is driving up costs.

Our healthcare reform should be aimed at increasing choice and competition as a way to give consumers more options and more opportunities to access affordable coverage. I hope that these concepts I outline here today can advance some of these goals, and I am grateful for the opportunity to testify before the committee.

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Thanks a lot.

[The prepared statement of Dr. Gottlieb follows:]

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Mr. Pitts. The chair thanks the gentleman.

I now recognize Mr. Roy, 5 minutes for your summary.

STATEMENT OF AVIK ROY

Mr. Roy. Chairman Pitts, Ranking Member Green, and members of the Health Subcommittee of the Energy and Commerce Committee, thanks for inviting me to speak with you today. My name is Avik Roy. I am a senior fellow at the Manhattan Institute where I conduct research on health care reform.

In my remarks, I will focus on two areas. First, I will discuss flaws in the design of the ACA's insurance exchanges. Second, I will describe the principles and policies that Congress should consider in order to achieve better reform.

The ACA has reduced the number of uninsured, but its premiums on the exchanges have been so high that enrollment in the exchanges has been poor. 2016 enrollment was around 11 million, far below the CBO's original 21 million estimate.

The exchanges were built on a theory called the three-legged a stool. First, the law would impose a raft of regulations to transfer costs from the sick to the healthy. Second, it would impose an individual mandate in order to force the healthy to purchase this highly costly coverage. Third, it would lessen the burden of the mandate for the poor using subsidies.

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The problem is that the legs of the three-legged stool in the ACA were poorly designed. The regulatory leg is too long, driving up the cost of nongroup coverage. The mandate leg is too short, allowing healthier individuals to avoid buying costly coverage. And the subsidy leg is too wobbly to correct the imbalances of the other two legs.

By far, the law's most damaging regulation is its age-based community rating, forcing insurers to charge their oldest customers no more than three times what they charge their youngest. This has more than doubled the cost of health insurance for younger individuals in most States. Because the individual mandate's fines are so small relative to the cost of this coverage, young people are staying out. For most Americans, the ACA's subsidies don't offset far higher premiums. As a result, exchange enrollment for people with incomes above 250 percent of the Federal poverty level is well below 20 percent.

Furthermore, the ACA's subsidy system has proven to be extremely convoluted. It requires people to estimate their future income on a rolling monthly basis and then pay the government back if the Treasury Department determines that they have overestimated their eligibility.

In 2014, MI published *Transcending ObamaCare*, a health reform plan that would cover more people than the ACA but with far less Federal intervention than either current or prior law. Here are some key concepts from that plan that Congress should consider.

The most important thing Congress can do is to repeal the ACA's

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three-to-one community rating age band, which makes coverage unaffordable for young people. This discriminatory policy is the single greatest driver of the exchange's poor performance. Repeal of the age band can be paired with transitional funding for the near-elderly such that current enrollees can keep their current plan.

If the age band is repealed, a reformed system can preserve guaranteed issue and prohibit medical underwriting. In other words, it can protect those with preexisting conditions without an individual mandate. The mandate can be replaced with late enrollment penalties, a shorter open enrollment period, and the option of insurance contracts of 2 to 5 years instead of only 1 year on the current ACA exchanges.

Congress should put patients back in charge of their own healthcare dollars wherever possible. It should maximize personal choice and improve the flexibility of health savings accounts. It should repeal the ACA's tax increases, especially those like the health insurance tax, the medical device tax, and the drug tax, that directly translate into higher premiums.

Finally, Congress should replace the ACA's convoluted subsidy system with transparent, means-tested, age-adjusted tax credits. Some have proposed a uniform tax credit in which the poor and the wealthy receive the same financial assistance. That approach is unwise in my view because it severely limits the amount of assistance we can provide to the poor.

In 2017, the average exchange subsidy per subsidized enrollee,

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according to CBO, will be \$4,550. By contrast, one uniform tax credit proposal that has been widely circulated would offer a subsidy of \$2,100 to those in middle age regardless of need. That difference would be highly disruptive to the poor and the sick and result in millions fewer insured.

Instead, an ACA replacement should preserve a sliding scale of means-tested tax credits but do so based on income from the previous tax year. That way the IRS has verified income data with which to base its tax credit calculations.

Based on our fiscal modeling, the reforms described above, combined with others, could reduce Federal spending by \$10 trillion over the next three decades and increase the number of individuals with health insurance by 12 million over and above current law, and they would reduce the cost of single health insurance policies by 18 percent by 2021.

The ACA's shortcomings should not discourage Congress from striving to achieve the law's stated goal, affordable health coverage for every American. That objective remains as important as ever.

Thanks again for having me. I look forward to your questions and of being of further assistance to this committee.

[The prepared statement of Mr. Roy follows:]

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Mr. Pitts. The chair thanks the gentleman.

Ms. Corlette, you are recognized for 5 minutes for your summary.

STATEMENT OF SABRINA CORLETTE

Ms. Corlette. Thank you, Chairman Pitts and Ranking Member Green. Thank you for the opportunity to testify today.

I am going to make two primary points. First, the Affordable Care Act has led to an unprecedented expansion in access to affordable comprehensive health insurance. And second, 6 years in, we have new opportunities to build on and strengthen the law in order to ensure its benefits can be truly universal.

The last time I sat before you, it was just after the launch of the ACA's health insurance marketplaces. Many were questioning whether the law would work. What a difference 2 years makes. Since the rollout of the ACA, we have strong evidence of improved access, the ACA has expanded health insurance coverage to 20 million people, and as a result, the number of uninsured Americans is at its lowest level in 5 decades with almost 90 percent of people now covered, an end of health status discrimination. Up to 122 million Americans with a preexisting condition now have peace of mind that if they leave work to care for a loved one, start a new business, or go back to school, they will no longer be denied access to affordable health insurance.

Improved quality of coverage. The ACA's reforms have improved

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not only access to coverage, but the quality. The vast majority of people newly enrolled are satisfied with their new health insurance plan and the doctors in it.

And bending the cost curve. The ACA has contributed to an unprecedented slowdown in healthcare cost growth. Further, several of the payment and delivery system reform experiments launched by the ACA are offering some hope that we can reduce waste, lower costs, and maintain the quality of care for patients.

To understand how far we have come, it is helpful to pause and remember where we were before the ACA. Back then, the individual insurance market suffered from a lack of access. As many as 40 percent of applicants were denied coverage because of a preexisting condition.

Inadequate coverage. Before the ACA, in most States insurers were permitted to permanently exclude any preexisting conditions, and many excluded maternity coverage, mental health, and prescription drugs as a matter of course. Deductibles of \$10,000 or more were not uncommon, and many policies came with lifetime or annual caps on benefits.

And coverage was often unaffordable. Before the ACA, 70 percent of people with health problems reported it very difficult or impossible to find an affordable plan.

At the same time, none of the nightmare scenarios that some ACA opponents predicted have come to pass. The ACA has not caused employers to drop coverage for their workers, nor has it resulted in

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reductions in employment. On the whole, coverage trends for ESI have remained stable.

No law is perfect, and the ACA is not perfect. Six years in, I encourage members of this subcommittee to consider some pragmatic improvements, including providing incentives to States to expand Medicaid. In 19 States, families just below the poverty line are denied access to coverage because they don't make enough money to be eligible for the marketplace tax credits. Congress should adopt the President's proposal to allow any State that expands Medicaid to receive a 100 percent match for the first 3 years.

Fix the family glitch. Congress can and should clarify the law to ensure that working families are able to access the tax credits.

Improve affordability. Even with those tax credits and cost-sharing reductions, many low- and moderate-income Americans face very high costs when they purchase insurance. I encourage Congress to reduce the amount of income families are expected to contribute and to improve cost-sharing support.

Support outreach and enrollment assistance. As many as 16 million Americans are eligible for but not enrolled in either Medicaid or subsidized marketplace insurance. Many just don't know about the availability of these coverage options and the financial help, and they need assistance through the enrollment process. A relatively small investment in funds could ensure that more people are enrolled in the coverage that is right for them.

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And make the plan shopping experience as easy as possible. The marketplaces need a stronger infrastructure to support eligibility determinations and the plan shopping experience. This should include improved call centers and appeals processes, as well as better Web-based tools.

The ACA has ushered in much-needed reforms that have dramatically improved access to affordable, high-quality coverage. In just 2 short years, these changes have helped to reduce the percentage of uninsured to its lowest point in over a generation, and that is a huge accomplishment. However, we are also beginning to see areas in which we can build on and improve the law to make it work better for more people.

I look forward to the discussion of how best to achieve that. Thank you.

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[The prepared statement of Ms. Corlette follows:]

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Mr. Pitts. The chair thanks the gentlelady, thanks each of our witnesses for your testimony. You have each provided thoughtful testimony. And so we will now begin questioning. I will recognize myself for 5 minutes for that purpose.

Mr. Roy, we will begin with you. You have advised several high-level officials and candidates on health policy. Would you please describe some of the commonalities in the health reform plans offered by conservatives?

Mr. Roy. Yeah. So I was also a co-author of the plan that Dr. Gottlieb mentioned that was published by the American Enterprise Institute. So to take that plan as an example and the plan that we published at the Manhattan Institute as two examples, both of them the common element is replacing the ACA with a system of tax credits in which patients control their own healthcare dollars.

The challenge with the ACA is twofold. One, a lot of discrimination against younger and healthy enrollees. And, two, the fact that there is very limited choice in the type of health insurance you can buy.

And so the key commonalities here are to offer tax credits that help the uninsured afford coverage, but to make sure that people have a much wider range of choices in how they purchase coverage and the type of coverage they buy, and also to make sure that they have the opportunity not simply to use insurance to pay for health care, but to use health savings accounts.

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Mr. Pitts. Thank you.

Dr. Gottlieb, in addition to being a physician, you have counseled various healthcare companies and firms on Federal policy. Would you please talk about any of the components of previous or current alternatives to the Affordable Care Act that you are convinced will increase choice and competition?

Dr. Gottlieb. I will just touch on one. I think in terms of new health plan formation and new carriers entering the market, probably the single biggest obstacle has been the caps on the operating margins of plans, and I am talking here about the caps on the MLR. Because a new plan is going to have to spend a higher amount of its revenue on its overhead at the outset, and by capping the operating margin, you are discouraging capital formation, new carriers from entering the market.

If you look at what has happened since 2008, there has been no new net health plan formation, and by that I mean new carriers. So when we talk about new health plans entering the market, we are talking about existing insurers just entering exchanges with differently named products but not new health insurers.

And the analysis I am talking about actually goes back to last year, and it incorporated all the co-ops and the provider-sponsored plans. A lot of those -- some of those have exited the market.

So I would submit that it is probably the case, that there has been a net formation of new healthcare carriers since 2008.

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Mr. Pitts. Would the result or the effect of such components result in lower costs for patients?

Dr. Gottlieb. Well, I think the opportunity for new plans to enter the market is going to result in more competition between different insurers and ultimately is going to lead to lower costs. I think when we look at premium costs, in particular for individuals, we have to look at it on a weighted basis, meaning that we look at the average premium increase, but we need to look at premium increases on the basis of where people are enrolling.

And it is the case that premiums are going up for the plans that have the highest enrollment because they are the ones facing the biggest losses in the market right now. I think by creating more competition between different plans, ultimately you are going to create more competition between premiums as well.

Mr. Pitts. Thank you.

Ms. Corlette, you mentioned that, quote: "Even with the ACA's premium tax credits and cost-sharing reductions, many low- and moderate-income Americans face very high cost when they purchase insurance," end quote.

Absent more government mandates, more Federal spending, what would you propose that would help these patients receive care at a fair cost?

Ms. Corlette. Thank you, Mr. Chairman.

So one of the problems is that health insurance itself is an

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extremely expensive product. The average family premium for an employer-based plan is in the neighborhood of \$17,000 a year. So I think you are absolutely correct to point out, and as I pointed out and others have in their testimony, the Federal Government can't pick up that entire tab.

So the key is to get at what is driving that \$17,000 cost for a family policy, which is extremely expensive. And that, frankly, goes to the fact that we have an inefficient delivery system. We are spending 30 percent of healthcare DDP on wasteful and unnecessary care.

So, frankly, my proposals for getting at cost containment in health insurance would really target the delivery system and the way we pay for the delivery of those healthcare services.

Mr. Pitts. Thank you. My time has expired.

The chair now recognizes the ranking member, Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

Again, I want to thank our witnesses.

Mr. Roy, some of us were on the committee when we were drafting the Affordable Care Act in 2008 and 2009. I know it is something that somebody in academia may not understand, but we actually have to legislate, even when it is a majority of Democrats, just like a majority of Republicans.

The Affordable Care Act was built on our traditional insurance system that was started during World War II and continued, where in

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our country, unlike the countries we rebuilt in World War II that created some type of national care, whether it be Japan, Germany, France, Europe. And so we were building on that. So free enterprise was involved in it. And that is why the Affordable Care Act, it is not government -- of course we regulate insurance, but it is based on that. And that was the decision made, that we would use this tried-and-true method, even though I think it is not as effective as other plans. But that is why we have this.

Of course my biggest issue in my home State of Texas is that Texas has not expanded Medicaid, leaving more than 1.2 million vulnerable low-income Texans without coverage. In fact, in our district, I have 50,000 constituents in an urban district in Houston who would have Medicaid if the States expanded it. I hope that my State will expand it, and I am willing to work with them. I have said this for a number of years. For every one dollar my home State would pay in Medicaid expansion, it would earn back \$1.30 in new economic activity.

But the hearing today is about private insurance and ways to make it stable. It is clear that marketplaces are working, and the individual insurance market increased in size by 46 percent in the first year of enrollment alone. We need to continue to improve, however, and insurance markets function best when there is a large number of customers to spread the risk and keep costs down.

Before we consider revising or backtracking on the progress we have made, one important thing we can do to stabilize the individual

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insurance market is to grow it. The more people enrolled, the greater the risk pool, the more stability we will see. There are more than 10 million Americans who are uninsured and eligible for marketplace coverage. Seven million of those were eligible for tax credits to help them pay their premiums.

Ms. Corlette, initial research shows that Americans have a wide variation in knowledge of the options available on the ACA's exchanges and the assistance that can be made available. Could you discuss some of the harder-to-reach marketplace populations?

Ms. Corlette. Yes. Thank you.

So estimates are that we have between 29 and 31 million uninsured Americans, and many of them are uninsured because, as you point out, Congressman, they are in the Medicaid coverage gap.

Mr. Green. So that includes Medicaid?

Ms. Corlette. It does. But also some are just simply ineligible. They may be undocumented or they have other sources of coverage.

But among those who are eligible for the marketplaces and would benefit the most from the financial assistance that is available, a recent study found that many live in families receiving EITC or other public benefits, such as SNAP. Many also have a school-age child in the home. These are avenues that the Federal Government could take advantage of to do targeted outreach, to educate these individuals not only about the coverage that is available, but also the financial

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assistance that can help make that coverage affordable.

Mr. Green. Okay. One of the issues I hear, and I heard it just this morning with a group of insurers, can you discuss the benefits of the medical loss ratio? Of course, let me explain my background. I managed a small business, and at one time it was hard to even get companies to offer us insurance for our small business.

But the medical loss ratio, the 80 percent of that premium has to go to health care. And, to me, most employers would say we are getting a return on our money. And could you talk about the importance of that benefit?

Ms. Corlette. Yeah. Sure. The medical loss ratio basically says that of the premiums a health insurance company collects, 80 percent, or in the case of a large group 85 percent, has to go back towards the benefits that they are supposed to be covering. So it is an important consumer protection. Before this standard went into effect, you would see in the market companies with loss ratios of 50 percent, 60 percent. That means the company was pocketing close to half of the premium that they were collecting from the consumer or the small business. So the medical loss ratio is really just designed to bring more value to the purchaser.

Mr. Green. Thank you, Mr. Chairman. I will yield back my time.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the vice chair of the sub, Mr. Guthrie, 5 minutes for questions.

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Mr. Guthrie. Thank you.

And these questions are for Mr. Roy. We have instances of people purchasing health insurance under the ACA when they are sick, and it distorts the market for other people participating. Patients need to get access to care. That is important. But we also want patients to keep their coverage. There have been various ideas put forward about the best ways to help patients keep care and give market stability.

Medicare part D incentivizes participation by using late enrollment assessments. Patients are encouraged to join Medicare part D during their initial enrollment period because if they choose not to, their premium will be slightly higher. Do you believe this same model would be useful in the private health insurance market?

Mr. Roy. Yes, Mr. Guthrie, I think that that is one of the points I was making in my prepared remarks where I discussed the fact that we don't need an individual mandate to have a system that works to protect people who have preexisting conditions, expand access, and be nondiscriminatory towards the healthy, while also discouraging people from dropping in and out of the system just when they are sick.

If you have late enrollment penalties and other techniques, such as a tight open enrollment period, perhaps longer insurance contracts, those are all options on the table that help incentivize people voluntarily to be involved in their insurance continuously.

Mr. Guthrie. Similarly, and you have covered some of this, but according to CMS, the part D late enrollment assessment is 1 percent

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of the national base beneficiary premium times the number of full, uncovered months a beneficiary did not have part D or credible coverage.

I think we can agree that Medicare part D is one of the most successful Federal healthcare programs. Could this reasonable guardrail also help improve private care programs?

Mr. Roy. Absolutely. So one of the reasons why that particular provision is useful is that it modulates the late enrollment penalty based on how far away you are from the open enrollment period. So that way if you are really trying to game the system or the economic equivalent of that, the penalty is larger in that way. The penalty is well calibrated to the severity of how much you are going in and out of the system. So it makes the penalty as light as it needs to be but as effective as it needs to be to discourage that dropping in and out of the system.

Mr. Guthrie. Okay. And then another question. Another market lever to discourage people from only buying health care when they are sick is waiting periods. Let's say a patient gets a tough diagnosis and they rush to buy health care for the first time. Could a one-, two-, or three-month waiting period for a plan to become active encourage people to enter private markets while they are healthy instead of waiting until they are sick?

Mr. Roy. Yes, it could. And, again, one thing that would tie with that is longer insurance contracts. So if you have an open enrollment period every year, you still create a lot of incentive for

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adverse election because people can change plans every year based on their health status. But if they have the option to, say, buy a 2-year health insurance plan or a 5-year health insurance plan at a discount relative to what buying five 1-year plans would cost, you can incentivize people again to stay in a long-term relationship with their insurer where the insurer then also has an economic incentive to work with that patient over time to do things like wellness and compliance.

Because the challenge is, if you have a 1-year insurance contract, then the insurer worries, well, if I invest a lot of time making this patient healthy, what if he signs up for somebody else's plan next year? Then I don't really get the benefit economically from having helped this patient.

So encouraging insurers to have long-term relationships with their patients and long-term contracts with their patients would do a lot to align the incentives of the patient and the insurer.

Mr. Guthrie. Thank you. I appreciate the answers to those questions.

And I yield back my time.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman, Dr. Schrader, 5 minutes for questions.

Mr. Schrader. Thank you, Mr. Chairman.

I appreciate the panel. It is nice to be talking about something other than full repeal of the Affordable Care Act and thoughtful

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discussions out here. So I like that.

I guess the first opening question would be, I would be curious, actually the panel itself, Mr. Gottlieb in particular perhaps, I know the age thing has been talked about, we talked about that way back when we did the ACA, but what about lifestyle adjustment for premiums? That was something we considered very strongly early on. I know the President was interested in that. There is smoking, exercise, bunch of different variables. Sometimes hard to quantify, and we don't want to be discriminatory as we do that.

Now, that seems to me another thoughtful way, to be a good incentive, quality health care is a good result. Is there any discussion on that in the academic circles at this point?

Dr. Gottlieb. Yes, a lot of discussion. I think a lot of the approaches we are talking about here today aren't just, frankly, prohibited by the law, they are prohibited by the regulation.

The challenge isn't just some of the prescriptive regulation in the law itself, but, frankly, the way the regulations have been written by CMS I think have been overly prescriptive in areas that would deem certain things like what you are suggesting to be discriminatory.

Ultimately in the plan that we put forward with the American Enterprise Institute, we move towards a system where you could have subsidies based as a fixed percentage of the cost of the premiums, and you would ultimately cede back to the States more flexibility to allow plans to adjust premiums on a whole host of things, such as age,

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geography, maybe even some measure of preexisting condition. And then people, individuals, would get a subsidy that would be a fixed percentage component of that. And then you could go in if you wanted to as a matter of Federal law and increase the subsidies for certain individuals, including perhaps subsidizing certain kinds of risk in the marketplace and certain kinds of individuals with preexisting conditions.

But we would envision a more flexible framework that would allow for what you are suggesting. I will tell you I think the way the regulations have been written, in a very prescriptive manner, there is very little that wouldn't be deemed discriminatory.

Mr. Schrader. Ms. Corlette, comment on that?

Ms. Corlette. Yeah. Sure.

So of course the Affordable Care Act already does include rating provisions that allow insurers to charge smokers or people who use tobacco up to 50 percent more than somebody who doesn't. It also allows employers to charge up to 30 percent more for people who don't meet certain wellness targets.

I would say that the research that is out there to date on that suggests that linking achievement of a certain health target or changing a behavior, linking that to an increase in premium or a higher deductible is actually not very effective in changing behavior. What researchers found is that people are much more responsive to sort of more discrete short-term incentives. You know, maybe it is a gift card

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or a discount at the gym or something like that. Those tend to be much more effective strategies for getting people to lose weight or change other behaviors.

We would be happy to discuss other alternatives with you.

Mr. Schrader. Mr. Roy, a comment?

Mr. Roy. Yeah. I am less enamored of lifestyle-based health insurance pricing, and the reason why is that it is hard to enforce. Are you actually going to check and see, is the insurer supposed to check to see whether the patient is going to the gym one time a week versus three times a week, or smoking one pack a day versus half a pack a day?

I believe that those pricing mechanisms are very difficult to do in a rational way, and I think it is simpler to have a system where you have a means-tested schedule and an age-based schedule. You can publish it in a table, in a book, and people can know every year after they file their taxes exactly what tax credit they qualify for, and you make it very simple for people, very transparent for people, and that eliminates the waste, fraud, and abuse that we are seeing in the way the subsidies are administered now in the exchanges.

Mr. Schrader. Ms. Corlette, there has been a lot of discussion about the special enrollment periods and people taking advantage of that. CMS recently came out with some rules. Do you think those rules get to at least a bunch of what the concerns have been here recently?

Ms. Corlette. Yes, I think they do. Although I would just say

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I think the solution is not fewer people taking advantage of SEPs. It is actually we need more people taking advantage of SEPs. One of the problems is that only 15 percent of people eligible for these special enrollment periods are actually taking advantage of them.

And there is nothing about the triggering events, right, that would suggest this should be a sicker population. It is people having a baby or getting married or leaving a job. That happens to healthy people. It happens to sick people. But it is the sicker people that are motivated, right, to find out about the opportunity.

So I do think that, coupled with documentation requirements, which I think are perfectly legitimate to ask people to verify what is going on in their lives, but we also need to be doing more aggressive outreach and education to all people who are eligible for SEPs.

Mr. Schrader. I yield back. Thank you, Mr. Chair.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the gentleman from Missouri, Mr. Long, 5 minutes for questions.

Mr. Long. Thank you, Mr. Chairman.

Mr. Gottlieb, last week I had a manufacturing tour in my district back home and saw several manufacturing facilities, which is vital to my part of the country. And we had a little shoot-off with the Democrats yesterday, Republicans against Democrats shooting skeet and trap. And one of the things I saw was a clay pigeon mold that I have never seen before where a lot of those are made to mold the clay pigeons

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right in my district.

Another thing that I saw was DMP, Digital Monitoring Products Company, bank-monitoring products. It is a 41-year old company. A 41-year old company. They are adding 74,000 square feet and doubling the size of their engineering department. So manufacturing is really, really important in my area.

Another company that I went to see has done all of the work on the new African History Museum that they are putting up here on Washington, on the windows and all the structure there. They have also done all the work up here on the Native American Museum. They are doing one of the largest projects ever up in Manhattan right now. All the tall glass you will see on all those big new buildings going up in that section are coming out of my district.

So manufacturing is huge in my district. So I will preface my remarks with that.

Today large companies are able to use the size of their workforce to negotiate better rates with healthcare plans. Many healthcare thought leaders have suggested that individuals and small businesses should have the same benefit. In fact, before the enactment of the Affordable Care Act reforms, the Missouri Association of Manufacturers was able to operate two health consortiums providing quality health care to over 2,500 lives spread among 81 businesses, large and small, just as those that I described a minute ago on my tour last week.

On this issue of pooling, do you think that allowing individuals

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to join together to increase their purchasing authority would help lower costs?

Dr. Gottlieb. I think I would favor all kinds of pooling arrangements, including allowing small business to band together, including the concept of association health plans. There is nothing inherently wrong with pooling on the basis of State-based exchanges. I wouldn't want to see a marketplace where that is the only way that people can pool together.

Just as an aside --

Mr. Long. Now, what do you mean, the only way they can pool together?

Dr. Gottlieb. Well, right now, I mean, the way the law is trying to force the market, the only way you can pool individuals is either to self-insure or to go on the State-based exchanges. The kinds of construct you are talking about or the kinds of construct that the chairman introduced with respect to association health plans wouldn't be allowable in today's marketplace. There are really only two places to pool risk outside of government programs, it is on the State-based exchanges or if you self-insure.

You know, there is now a secular shift towards self-insurance by small businesses who previously probably were too small to self-insure but are self-insuring to try to get out from some of the mandates and the regulation. I think one thing that should concern this committee and concern all of us is we are seeing efforts on the part of CMS now

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to apply more of their regulation to the self-insured businesses. And so you are seeing CMS regulation in certain instances potentially supplant ERISA law.

Mr. Long. Well, when you say small companies can self-insure, pool, I guess they pool within themselves. But I am talking about all these manufacturers in Missouri were pooling amongst other manufacturers to come up with very good rates for their people.

Would the concept of individual health pools, or IHPs, make rates more competitive, in your opinion?

Dr. Gottlieb. Right. Absolutely. What it would do is it would allow small businesses to band together and negotiate for insurance contracts as self-insured businesses and put them on par with a large business. A large business that employs tens of thousands of people is getting better rates from the insurance companies who administer their products. It would allow self-insured small businesses to do the same thing.

Mr. Long. So just like corporations and labor unions do, you think that they should be able to pool together?

Dr. Gottlieb. Yes. And just like small businesses are able to pool together to purchase office supplies in the marketplace and do other things like that, yeah.

Mr. Long. And finally, could these individual and association plans lead to more patients getting health care?

Mr. Gottlieb. I think that they would lead to more businesses

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being willing to self-insure. We are already seeing that in the marketplace, that businesses that are right on the cusp of having enough employees in order to reliably self-insure and take that actuarial risk are doing it. I think it would lead to more businesses being willing to do that.

We are also seeing innovation in companies that are forming to help very small businesses self-insure. So if you create the mechanism you are suggesting, it is going to just expand the ability of small businesses to do that.

Mr. Long. Okay. Thank you.

I think for the first time in 6 years I have time to yield back.

Mr. Pitts. The chair recognizes the gentlelady from California, Mrs. Capps, 5 minutes for questions.

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RPTR GENEUS

EDTR ROSEN

[11:00 a.m.]

Mrs. Capps. Thank you very much, Mr. Chairman. I appreciate our witnesses being here today for your testimony.

And I would like to just bring into this conversation more of the California experience with health reform. As we have seen time and time again, our healthcare markets hinge on the buy end and efforts at the State level. The network has a direct influence on the patient experience in finding and getting quality affordable health insurance.

As of June 2015, 1.3 million people in California are actively enrolled in health insurance, and our uninsured rate has been cut in half. In a time where there is a lot of rhetoric about how we must deregulate our health system, California has used smart regulation -- this is my opinion, but they believe it too -- to take a solutions-based approach to health reform. Our State exchange has required health insurance companies to build consumer tool that encourage participation and transparency, and such tools help with outreach by letting consumers compare plans in an apples-to-apples way by looking at out-of-pocket costs and quality.

So in using all the tools at our disposal to regulate the market and be active purchasers of health care, California has emerged as the leader in this space and has succeeded in providing important

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healthcare services to citizens.

Ms. Corlette, how do these State tools and others protect consumers?

Ms. Corlette. Yeah, absolutely. So California is leading the way on many fronts, and I think is showing many of the other State-based marketplaces how to do things that can really help consumers have a better shopping experience.

So, for example, one thing California does is require the benefit designs to be standardized, and that is good for two reasons: One is, it really helps consumers make apples-to-apples comparison among the plans, and allows them to focus on price and network and really important differentiators between the carriers.

The second thing it does is it really limits the ability of the insurers to design discriminatory packages that can discourage enrollment by sicker people. So, for example, we saw in other States where insurers were putting all of the HIV-AIDS drugs on the very highest specialty tier, including generics. Well, that was clearly designed to try to discourage those individuals from enrolling.

So standardized designs are used pretty commonly in private exchanges, like Ayon and Mercer and Towers Watson, they require benefit designs to be standardized because it helps consumers make those comparisons. So California is doing that, and I think they have found it very useful.

Mrs. Capps. Not that we are doing everything perfect in

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California, that is for sure. But is there a way that we can -- and I will put it this way: We need to learn in California from other States, and the successes that they are having. Is there -- are there ways other States could adopt these same practices for States who don't take these steps? You know, what are their consumers faced with? And should the Federal exchange be doing anything about this? This is a lot to dump on you in one question, but if you don't mind.

Ms. Corlette. Yeah, sure. So a number of other States are looking at, or have standardized benefit designs. They have also been implementing things like out-of-pocket costs calculators that not only tell you what your premium is going to be, but if you are high risk or low risk or medium risk what your total out-of-pocket spend might be during the year to come. And that is really important for consumers to be able to compare plans.

Another thing that the Federal marketplace is going to be bringing online, which I think could be useful, goes to the issue of network design and helping consumers discern whether or not a network is narrow, medium, or broad, because right now there is no easy way to tell. And many consumers are willing to make the trade-off between price and the narrow network, but you need to at least know what you are looking at, and so those kinds of tools can really help.

Mrs. Capps. I still have a minute. And that question is a little bit open-ended. Would either Mr. Roy or Dr. Gottlieb, would you like to respond to that particular question?

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Mr. Roy. Sure, I am happy to. Thank you. I have a bit of a different view about the California experience. California actually had the most robust nongroup health insurance market in the country prior to the ACA, where individuals enjoyed a broad range of choices and diversity in the kinds of plans they could purchase. The reason why the uninsurance rate has gone down in California is not because of the regulations that have made health insurance in California cost more than double in many cases what it cost before. The reason is the subsidies, which, of course, help people afford these much higher premiums.

So I think it is great that there is financial assistance for the uninsured to purchase health insurance, but I think that the regulatory scheme that California imposes has actually dramatically increased the cost of health insurance. As an example, I can give you specifically, in Kaiser, a plan in Sacramento, that exactly the same plan with exactly the same network, exactly the same cost-sharing provision, exactly the same actuarial value, costs double as a result of the ACA's regulations than it did before. So that is a big problem in California. And, yes, people at below 200 percent of the Federal poverty level are getting a lot of financial assistance. But as you go up that income scale, the increased premiums are being -- are pricing a lot of people out of the market, and that is why enrollment in the exchanges nationally and in California has fallen well short of expectations.

Mrs. Capps. Well, I am going to have another round since I

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started that, Mr. Chairman. But I will yield back my time.

Mr. Pitts. The chair thanks the gentlelady and now recognize the gentlelady from North Carolina, Ms. Ellmers, for 5 minutes of questions.

Mr. Ellmers. Thank you, Mr. Chairman.

And my questions are for you, Dr. Gottlieb. As you know, plans are starting to exit the Federal marketplace. Namely, one that has been highly publicized is United Health Group. United will be pulling out of 26 States because they project a \$650 million loss this year. Some supporters of the status quo have tried to downplay this, arguing that United was not a major player in the Federal exchanges. But their departure from the marketplace has the potential to significantly limit competition in some markets where patients may only have two, or maybe even one option for plans to purchase.

So my question is, should consumer advocates be concerned about this trend, or as this is happening in these markets, and will it limit choice based on what is left in the market?

Dr. Gottlieb. And so, I don't think United's exit was trivial, because United has the potential of dramatically expanding its footprint. They lost over, I think, \$1.2 billion over 2 years, and they exit the market, and it is not growing its footprint either. I think is what even more concerning is the Blues who have dominated the market to date are also experiencing losses, and we are seeing some signals that some of the Blues' plans may exit.

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The observation that is worth making in my view is that as these plans do exit the market, the plans that are growing their footprint in the market, and actually offering the best price, and quite frankly, are the Medicaid plans. And I think that is because this is becoming a much more Medicaid-like benefit, where plans are competing on network design and formulated coverage alone and trying to cheapen the benefit, and the plans with the experience in the market of offering cheap benefits, cheap enough to offset the high costs of the regulation in this scheme are the Medicaid carriers, and they are, in fact, the ones that are growing their footprint quite dramatically. I think Molina doubled their footprint in the market. Centene came close to that this year, and they are also, frankly, making money, too. The few plans that are making money are the Medicaid plans.

Mr. Ellmers. You know, thank you for -- that is actually along my line of questioning. And you point out the Blue Cross, and that is going -- that is going to be significant in North Carolina, where we do only have a couple of insurers participating. And Blue Cross is -- has announced that they will be. You know, I am very concerned about this, because we have got to do everything we can for these patients to get good healthcare coverage, and they are offering the coverage that they have been satisfied with. They may have had to have cancelled whatever plan they had before in order to get on it, but they have become accustomed to it, and now, even that is ending.

So that is my line of questioning here. Again, pointing out that

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Centene and their Medicaid-like plan said they would be likely turning a profit in the exchanges.

In fact, they say about 90 percent of Centene's exchange enrollees are subsidy eligible and have incomes at the level that leaves them moving in and out of Medicaid. So United, who is offering broader networks and better coverage, has dropped out of 26 States, while Centene, who offers narrower networks and higher deductibles, has projected that they will be profiting in the exchanges.

So there, again, you know, as this -- do you see this as a trend, or, in your opinion, is this a trend? And does this not demonstrate that basically, as I would put it, this current law is almost a race to the bottom for patient coverage?

Dr. Gottlieb. Well, I think it is a race to a Medicaid-like benefit. I mean, not to oversimplify, but I think the issue is that all the traditional tools -- and I agree with -- that it is a problem. All the traditional tools that insurers use to try to manage costs have largely been regulated away. I mean, not all but many of them. And the only way that insurers can manage costs in this exchange market is to cheapen the benefit. The only way to cheapen the benefit is either you own the doctors and you try to regulate what they do very closely, or you network with very few doctors, very cheap doctors, doctors who don't see a lot of patients in the community, and you offer a closed formulary and you start tightening up your formulary design, and the plans with the experience doing that and the plans that have

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the cheap networks are the Medicaid carriers, and that is why we are going to see them continue to grow their footprint.

Mr. Ellmers. So, basically -- and I have only got a limited time left. So, basically, what this is going to do is limit care, limit access to care?

Dr. Gottlieb. And limit choice of plans, unfortunately. And I think the real thing that should concern individuals are when the Blues plans are experiencing losses and start pulling out of this market.

I raised this issue with folks in the administration about the Medicaid carriers growing their footprint, and the response was, well, they haven't really dominated the exchanges. It has been the Blues plans that have dominated the exchanges. And that is true, but we are seeing a lot of pain on the Blues plan as well. And when they start dropping out, I think that really is going to signal a downward spiral here.

Mr. Ellmers. Thank you.

And I yield back the remainder of my time.

Mr. Pitts. The chair thanks the gentlelady.

I want to apologize to the gentlelady from California, Ms. Matsui. I missed you in the queue. You were here. You should have been recognized earlier.

The chair recognizes Ms. Matsui for 5 minutes for questioning.

Ms. Matsui. Thank you, Mr. Chairman.

And I want to thank the witnesses for coming here today.

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The passage of the Affordable Care Act eliminated exclusion of over 129 million Americans living with preexisting conditions from receiving affordable health insurance. These preexisting conditions include not only rare diseases, but also common diseases, like asthma or diabetes.

Ms. Corlette, can you talk about the experience of those with preexisting conditions attempting to purchase insurance in individual markets before the ACA?

Ms. Corlette. Sure. Absolutely. I will just say that the individual market was a very inhospitable place before the ACA. People with preexisting conditions were frequently denied access, up to 40 percent were denied outright a policy. It was frequently unaffordable, because rating factors related to their health status or gender or age, could sometimes be as much as nine times the amount of the unhealthy person. They found it often unaffordable to get a plan, and then that coverage was what we used to call Swiss cheese coverage; preexisting conditions were often excluded.

So, for example, a breast cancer survivor would be told that no oncology services would be covered under the plan. Or if you had incidences of asthma, you would be told that no upper respiratory conditions would ever be covered under the plan. Those are the kinds of things that are now thankfully in the past.

Ms. Matsui. Thank you. I also want to consider this, because protection against preexisting condition discrimination is important

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for the over 30 million individuals in this country who suffer from rare or serious chronic diseases, and they are kind of in another situation too, which is even more difficult. These diseases can be debilitating, not only to the patient's health, but also to a family's financial stability, especially when diseases inhibit the ability of a patient to work. Patients sometimes need to rely on the goodwill of third-party nonprofit charity organizations to help them access the care they need. We need to preserve the ability of patients to rely on third-party payments from charities. And I am working with CMS to do that.

The ACA has been very good for millions and millions of Americans, and we are looking to see how we might improve that, too. And this is an area we are looking at because of the serious financial instability of the patient's family. So I do hope that we can work with you as we move forward on that. And thank you.

And I yield back the rest of my time.

Mr. Pitts. The chair thanks the gentlelady and now recognize the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. Lance. Thank you very much, and good morning to the panel.

I am concerned about the fact that exchange participants, based upon their 2015 plans, did not necessarily continue for 2016. A recent study, as I understand it, has found that only one-third of exchange participants kept their plan year to year. And I think this reveals significant market instability.

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Could the panel comment on that?

Mr. Roy. Yes. So I would say it is not entirely about market instability. I mean, if you are going to have a 1-year insurance contract, people are free to shop year over year for the plan that is the best plan for their needs, and it might be that the prices have evolved in a different way. You know, just like you might not fly the same airline next week as you did last week, you might have a different plan next year than you did this year.

So much of this is quite natural. But I do think that instability is important insofar as, again, the insurance company does not reap the economic reward from making you healthy over the long term if you are switching plans year over year over year.

So maybe it is good for some people to have plans where they switch year over year, because that helps create the price discipline, that encourages insurers to compete for your business and be held accountability for the premiums they charge, but it would be nice for there to be an option in the individual market for people to shop for plans with longer time horizons so that, again, for a discount, perhaps those insurers would say, Hey, if you sign up with me for 5 years, your insurance would cost 20 percent less, but we will be able to work together to make sure you stay healthy in the long run.

Mr. Lance. Would anyone else in the panel like to discuss this?
Yes, Ms. Corlette.

Ms. Corlette. Yes. Sure. I think the factor to keep in mind

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is historically the individual market was called the residual market, and that is simply because the primary source of coverage for most people under 65 is through their employer.

Mr. Lance. Yes.

Ms. Corlette. And, certainly, for people of lower income, they may come in and out of Medicaid. So one of the reasons we are seeing a lot of transition in the marketplaces is because people might be gaining coverage because they get a job, or because they dip below the poverty line and so they are then eligible for Medicaid. So that is just an important factor to keep in mind when you think about these marketplaces.

Mr. Lance. Thank you.

Doctor.

Dr. Gottlieb. I think your observation reflects the fact that the plans that experience the largest enrollment are the ones that increase their premiums the most in a subsequent year, because they are the ones that experience the biggest losses. And that is why when we are looking at the premium increases over the course of this year, we really should enrollment-adjust them, and think about the premium increases on enrollment adjustment basis, because it is going to be the case that the plans that take the biggest premium increases will be the ones that have the biggest enrollment, and then that is going to cause a subsequent churn that you are talking about in the subsequent years.

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I think the other -- the other trend that is worth watching is that this is becoming a market, I think, that is increasingly narrow to a very narrow income demographic, and that is people who are eligible for the cost-sharing subsidies because of the high costs. We talk about the premiums and the subsidies for the premiums, but the out-of-pocket costs are very, very high in a lot of these plans.

And so, the only people for whom this is economically attractive, if you will, increasingly are going to be those who fall around 200 percent of Federal poverty level who qualify for the cost-sharing subsidies. And I think we talked at the outset about there hasn't been, sort of, the dumping, if you will, from the employer market into the exchanges. I think we are going to start to see that, start to see people who work for large employers who fall within that income range find themselves in the exchanges, and lose their employer-provided coverage, and it could, potentially, make the American health care less egalitarian overall.

Mr. Lance. Thank you. And would anyone else on the panel like to comment on what doctor has just said regarding the narrowed market?

Mr. Roy. Yeah. You know, one thing I might add, too, is that we have been talking a lot about preexisting conditions, and there's been enormous amount of disruption of the individual market for health insurance because of the claim that we needed to do all the disruption to protect people against preexisting conditions. And that is not actually true. It turns out, actually, the CBO did a study where they

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asked the long-term uninsured why they didn't have coverage. 71 percent said it was because the insurance cost too much, the premiums were too high. Only 3.5 percent said that they are -- that because of a preexisting condition or other health status-related issues were denying them coverage.

We also have the evidence from the Affordable Care Act's own preexisting condition insurance program, a high-risk pool that was designed to be a bridge between the enactment of the ACA and 2014, when the guaranteed issued regulations came into effect. That provision allowed anyone who had been -- could demonstrate that they had been denied coverage by an insurer because of a preexisting condition, anyone, any person who could prove that could sign up for this program. Only 250,000 people in the entire country signed up for this program. And we disrupted health insurance for 300 million people, allegedly, because we needed to fix health insurance for these 250,000.

So it is really important to understand that if -- we should address the problem of preexisting conditions, but there are a lot more -- a lot more efficient ways to do so that don't disrupt coverage for the people who had it under the old system.

Mr. Lance. Thank you.

My time has expired.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from Maryland, Mr. Sarbanes, 5 minutes for questions.

Mr. Sarbanes. Thank you, Mr. Chairman. Thanks to the panel.

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Just on that last point, there is a distinction between people that were being outright banned or denied coverage based on a preexisting condition, versus people whose premiums were being adjusted significantly or a lot higher based on the fact that they had a preexisting condition. So the observation by 90-something percent that it was the cost that was the barrier to them could still be linked to the preexisting condition situation, I would imagine, in a lot of cases.

The question I have, and I will start with you, Ms. Corlette, is I have heard some increasing discussion about these -- the high-deductible plans and the impact that is having on the affordability, but also a discussion of how there is a wide variation in the kinds of benefits or services or products, for example, drugs, that are exempted from the deductible, and how that can affect affordability and behavior and access and so forth.

And I think, for example, California is an example -- is a State where they have been pretty proactive in looking at that issue of where the exemption should be for certain kinds of services to try to make the coverage more affordable and more useful, frankly.

So could you start a discussion among the panel about that deductible issue, because I think it has implications potentially for some improvements that we could do with guidance in that area?

Ms. Corlette. Yeah. I am so glad you asked that question. So two quick points about deductibles. One is I find it ironic that a

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lot of people who right now are complaining about the high deductibles on the marketplaces are the same people who have been calling for more high deductible health plans generally.

The second thing is, you know, we have to think about where we were before and where we are today. I mean, pre-ACA, deductibles were as high as 10-, \$15,000 sometimes. So the financial protection that exists in the marketplace right now is way better than it was previous to the ACA.

But to your point, you know, when you tell a lower income family that they have a 5- or \$6,000 deductible, it doesn't matter, right? That is still a huge amount of money for them to lay out before they can get healthcare services.

There is a couple of things that are really helpful and important. Number one is, of course, the ACA provides first dollar coverage for preventive services and important screening. But, interestingly, California is a State that is doing this and other States are looking at it as well, is encouraging, or in some cases, requiring insurers to cover important primary care services, generic drugs, some urgent care before somebody has to pay up the deductible. So that allows a consumer to get more upfront value than they otherwise would, and I think that is an innovation that we should be looking at more broadly.

Mr. Sarbanes. Anybody else?

Mr. Lance. Yes. So, you know, Ms. Corlette made the -- thought it was curious that people might critique the high deductible in the

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ACA. So let me try to explain why people do that.

The problem is that, in theory, high deductibles are good, because if you have the option of a low deductible and a higher premium and a high deductible and a lower premium, some people, naturally, might want a lower premium and a high deductible. If people are truly trying to seek protection from bankruptcy due to medical bills, the most affordable way to do that is through a high-deductible plan combined with a health savings account.

The problem with the ACA is the deductibles are higher, and the premiums are higher, too. So people are paying 50 percent more for their monthly premium and the deductible is 2,000, \$3,000 higher than it was before because of all the regulations and mandates in terms of how those insurance products have to be designed. And this is why the regulatory scheme of the ACA has been a major focus of criticism, because it is directly responsible for the fact that people are not only just paying higher deductibles, they are also paying higher premiums.

Dr. Gottlieb. So I will just comment. I think, you know, the idea of a high-deductible plan, some sort of a conservative theology, if you will, was that the high deductible was tied to a lot of consumer selection on the more routine care. And here you have a regulatory scheme that mandates a lot of first dollar coverage for ordinary, routine care, but still is coupled to a high deductible, and that is not really a high-deductible consumer-driven plan. And what is

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happening is because the insurers have to cover first dollar of a lot of the routine stuff, and, you know, they can't take premium increases; they can't offset those costs in other ways, they are offsetting it by, in my view, narrowing the coverage for the catastrophic fees. Exactly a place we want the most generous coverage. And that is being coupled -- as you mentioned, drug formularies that is being coupled, for example, and it is manifesting in the form of closed drug formularies, where you have very narrow lists of drugs on formulary, and all the drugs that aren't on the formulary aren't covered at all. And what consumers spend out of pocket for those medicines doesn't count against your out-of-pocket maximums, so their deductibles are completely on their own.

And I would say, I think all the silver plans on the Affordable Care Act are closed drug formularies. I have gone through and I have looked at 30, 40 plans, and published this data, and they were all closed plans, and I just assume that it is almost all the silver plans are closed formularies. That is really a new development in the marketplace. We never saw closed formularies used so predominantly. The only place we really saw that was in Medicare Part D and Medicare Part D coupled it with a lot of regulations and modeled formulary protected classes.

And I don't -- I will just sum up by saying I don't think the health plans are doing anything wrong. I think they are taking flexibility where they still have it. A lot of the flexibility that they have to

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or they have traditionally used to try to manage costs have been taken away from them, and the few places that it is left, they are exercising it.

Mr. Sarbanes. Thank you.

Mr. Pitts. The chair thanks the gentleman, and recognize the gentleman, Dr. Murphy, 5 minutes for questions.

Mr. Murphy. Thank you, Mr. Chairman.

It is a sad thing to me when I look at, as we reflect on this committee, and also the Committee on Oversight and Investigations has looked over the last few years of the kind of spending we have had on the Affordable Care Act. We have had it for advertising, Web sites that didn't work. I think Oregon spent a couple of hundred million and finally, they decided since they didn't sign anybody up and it was filled with political corruption; it wasn't going to work. We have seen half the co-ops fail, administration costs. Secretary Sebelius went back to the insurance companies and said, Hey, we need some more money from you to donate to keep it going. And none of that money went for even a single Band-Aid. Nothing helped there. So we have got to find a different approach on how we are handling health care.

Now, one of the things I want to talk about are the high-risk pools, and particularly, invisible risk pools. I think, Mr. Roy, you have talked about these things. I want to see if you can elaborate. So are high-risk pools still today a fair pathway for helping to cover some of our sickest friends and neighbors?

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Mr. Roy. They can be, but they face a lot of limitations. And I think that to the degree that we have talked about high-risk pools, we have to understand the risks of high-risk pools. So, for example, the AEI proposal proposes giving States funding for high-risk pools as a bridge for those who are very sick and don't get coverage for the traditional market. The challenge is that once States, State governments, just like State exchanges can be messed up, if State governments are running high-risk pools, they have incentives, an incentive to overpromise and underdeliver. They say, Oh, we are going to expand this high-risk pool to everyone because the politicians will have to pay the bill for that and the voters will have to pay for --

Mr. Murphy. I understand.

Mr. Roy. -- or 20 years down the road. So --

Mr. Murphy. So where would they pay that, on the back end, then.

Mr. Roy. Well, yes. So like if you sign people up, but most of the health costs happen 10 years down the road as those patients age, and have higher medical costs as a natural combination of their aging and their health care. It is just -- it creates -- once the government is actually determining the price of a risk, a lot of things can go wrong. I think I argue -- I would argue it is actually simpler to preserve guaranteed issue, but get rid of the distorting and discriminatory regulations in the ACA exchanges that make guaranteed issue unaffordable. So you can actually preserve guaranteed issue in a very simple way that doesn't require the use of high-risk pools, have

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everyone in the same insurance market, and that way, the people who are high risk, the people with diabetes, people with chronic conditions, have a broader choice of health insurance plans than they would have on the high-risk pool.

Mr. Murphy. Dr. Gottlieb, do you agree with that approach?

Dr. Gottlieb. I think we talk about high-risk pools as an interim step. My view is that I think with proper risk adjustment, that would be able to be done prospectively, and a subsidy structure, that you allow some adjustment for risk, you can achieve what you are aiming to achieve with high-risk pool and help underwrite the increased risk of certain individuals with chronic conditions much more effectively in a viable pool.

Mr. Murphy. Let me ask this, too, then: As someone who has identified, so we know that people who are healthy are trying to avoid buying insurance, and then they start to get sick and they want to buy insurance, the same as people who have cars. They don't want to buy insurance until they get in an accident. But what happens here also is when you look at the incredible cost if these are not managed. So Medicaid, 55 percent of Medicaid spending goes to 5 percent of the population. And according to multiple reports, one of them Tom Insel, former head of NIMH, he said virtually all of them have mental illness. And, yet, what happens is we maintain a system where medical records are kept separate but equal, which means, you can't get information and know the higher risk, but the person who has a chronic illness and

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depression, for example, doubles, triples, quadruples the cost, if it is not treated. And so I am concerned about what we are talking about here is just a mechanism to pay for this, but not a mechanism to change this.

And how do we look upon this? If someone is identified then with a chronic illness, with a mental illness, they are really beginning to coordinate and integrate care, which I think is the absolute key to deal with it more cost effectively.

Mr. Roy, Dr. Gottlieb, and Ms. Corlette, if you could comment on that.

Mr. Roy. Yeah, I mean, they are all related, because the reason why we don't have a patient-centered healthcare system in which hospitals and doctors and insurance companies would have the incentive to really cater to the patient's needs in those regards, is because the patient doesn't control the health care dollars. In every other sector of the economy, the consumer controls the dollars, and that is why businesses go out of their way to cater to the consumers' interests and the consumers' needs. In health care, the government controls the dollars.

Mr. Murphy. But they are concerned about their own health. I think in these cases, if it is not explained to them that you really have to coordinate these services together and enforce the position that they would be talking to each other across boundaries.

Mr. Roy. Sure. But insurance companies and healthcare

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entrepreneurs, healthcare IT companies that integrate their patient records across providers, they can provide those services. And part of the challenge is that we have a culture in this country of patients who aren't engaged in their health care and the value of their health care because they are not paying for it directly. If they are paying for it directly, if they are choosing their own insurance plan and paying for care through, like, HSAs and able to shop, yes, you are not going to deal with the person who is like the schizophrenic who really isn't -- doesn't have the necessary mental capacity and there, you need more of a role of the State to help navigate the healthcare system for those individuals, but a lot of the inefficiencies with those high utilizers is driven by the fact that they have zero economic incentive to save that money.

Mr. Murphy. I agree to some extent. But I know I am out of time here. But I would also like to opine this, that you are right to some extent, but it is also an issue of if it is not managed by these companies, if there is no incentive for those companies to really manage and coordinate that person's care, then -- together, then you end with increasing costs, the State or Federal Government is just going to pick up. And this is where I think we look at ways of financing this program inefficiently, but not really fixing it.

I know I am out of time, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman. Now we are going to recognize the gentlelady from Illinois, Ms. Schakowsky, for 5 minutes

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of questions.

Ms. Schakowsky. Mr. Roy, I don't even know. I am not going to spend my time disagreeing with you, because the idea that if only people had more control, that we would dramatically reduce. People can't afford the health care that they need, not that government is controlling it. But I am not even going there with you.

According to a 2014 study done by HHS, the rate review requirement included in ObamaCare saved consumers nearly \$1 billion on insurance premiums in 2013. However, currently, the Secretary of HHS only has the authority to review rate increases, not modify, approve, or deny them. Many States have taken the extra step of enacting legislation to provide their insurance department with the authority to deny or modify unreasonable health insurance premium rates.

Evidence shows that when insurance regulators have the authority to do so, consumers pay less. I am from a State that does not have that authority. In 2013, the Maryland Health Commission used such authority to modify the proposed rates for all nine carriers, who submitted plans for the Maryland health connector. The commissioner reduced the propose rate increases of all existing plans, one by more than 66 percent. And that is why I have introduced the Health Insurance Rate Review Act, which grants the Secretary of Health and Human Services the authority to deny or modify unreasonable premium rate increases in the States where insurance regulators don't have the authority.

So, Ms. Corlette, would you expand -- would expanding -- here is

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the question: Would expanding rate review authority help to control the cost of premiums?

Ms. Corlette. Thank you, Congresswoman, for that question. So the evidence is really strong that having an independent reviewer of insurers' rates, proposed rates, the assumptions they are making, the claims they are making about trend and cost, et cetera, is a critical consumer protection, and it has saved consumers millions of dollars.

And it is a particularly critical function in areas that there is not a lot of competition among insurers. I would say that there are a number of States that are doing a really, really good job of this, but others where they either lack the authority or the resources to do it, and in that case, the Federal Government can be an important backstop.

Ms. Schakowsky. What States would you cite as examples of who is doing a good job?

Ms. Corlette. Who is doing a good job? I think that in Rhode Island and Oregon and Washington State, those are a few that come to mind immediately. Maine also has a good track record that are very proactive in how they are looking at insurers' claim.

Ms. Schakowsky. Let me also ask you this: I also strongly support creating a public option to be offered in the marketplace. We discussed this during the development of the Affordable Care Act, and we actually passed one in the House. A robust public option would increase marketplace competition, lower premiums for consumers, lower

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the Federal deficit, all this has been documented. It is estimated the consumers would save between 5 and 7 percent on their premiums through a public option health plan; moreover, the Congressional Budget Office previously estimated a public option would save \$158 billion in Federal spending over a 10-year period. I introduced legislation in the Public Option Deficit Reduction Act, which would create a publicly administered insurance plan that would be available in every marketplace, would be designed to include robust provider networks, and more affordable deductibles.

So, again, Ms. Corlette, would availability, in your opinion, of a public option provide consumers with a more affordable plan and help to create more competition in the marketplace?

Ms. Corlette. Yeah, I think that the public option could really help keep costs lower, not only would it likely have lower administrative costs than a commercial insurance company, but it could also use its market power to ring lower prices out of providers. And also could be a really important backstop in rural or underserved areas where it is hard to get insurers to come in and compete. So for those reasons, I think it is definitely worth bringing back on the table.

Ms. Schakowsky. Okay. And I yield back. Thank you.

Mr. Pitts. The chair thanks the gentlelady, now recognize the gentleman from Illinois, Mr. Shimkus, 5 minutes for questions.

Mr. Shimkus. Thank you, Mr. Chairman. This has been a great panel, so I appreciate you all coming. I think people know that we

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have a system in place. Some people think it is the best thing since sliced bread, some people have concerns. I think everybody believes there are changes that could be made. So I think this is going to be a start of a -- hopefully, a lot of discussions.

The -- because what I -- there was a section of our citizens that got help, and that was the Medicaid expansion for people who didn't have access to care. But I am told all the time, it is never refuted, that people are paying more and getting less coverage now than they had before, if they had a standard policy beforehand. I acknowledge that Medicaid expansion did cover some uninsured. And even those who have it -- and also the promise to hospitals who are part of the negotiations, was that they would save costs, and there would be less access to emergency rooms. Now they have -- they have more people going to emergency rooms, and it is because of these high deductible plans.

So there are a lot of problems and promises that were made that weren't kept on, what, \$2,400 a year savings for a family of four, premiums would go down, copays would go down. If you like your policy, you keep it. If you like your doctor, you keep it. All those were not satisfied.

So I wanted -- so we are talking about tweaking and trying to fix -- I wanted -- part of this is the cost sharing issue that we have been talking about, too, and how you incentivize. I am not a big supporter, and I am not a supporter of federally mandated plans without

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flexibility. But I do know that the cost sharing is based upon the silver and 60 percent amount.

Would it make -- Dr. Gottlieb, would it make sense to shift that bronze to a 50 percent, and not based upon the silver percentage? Would that help at all?

Dr. Gottlieb. Well, I note that people have also talked about creating a copper plan for younger healthier people. It is probably going to be the case that a lot of the bronze plans end up pulling out of the market and insurers ship more towards the silver plans this year for a variety of reasons, not the least of which is the bronze plans ends up having to pay back the most amount of money because they ended up attracting the healthiest individuals.

I think the problem stems from the rigid regulatory structure around the rating system and the fact that you can't vary the actuarial value more than 2 percent up or down from these metal tiers. I think what we should be thinking about doing is providing much more rating flexibility to the insures so they can offer wider variety of different kinds of plans and offer different schemes, things like value-based insurance designs.

Right now what they do is they try to develop a plan to meet an actuarial target, rather than to develop a plan that sort of optimizes a set of circumstances.

Mr. Shimkus. And even in part of the value-based, or even the hospitals are going to be now incentivized to have quality care and

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quality care measures, which financially would be a value-based system.

Would it not be?

Dr. Gottlieb. I think as providers take actuarial risk, we are moving towards that. And that is maybe one of the, sort of, good benefits of the consolidation that is underway of the healthcare system. I have been critical of consolidation. You know, the -- with respect to the rating and the tiers and the metals, there was a view that by having discrete metals, it would make it easier for consumers to understand actuarial value. But, in fact, I am not -- I think the evidence shows consumers don't necessarily understand actuarial value in relation to the metals. And we should think about conducting some real vigorous research around whether or not consumers can be educated around just what it means to -- what the actuarial value means so we can provide number the number to the consumers, not just the metal. I think the Healthcare.Gov Web site is doing a better job of translating what actuarial value means in some practical settings. There are better tools to help people understand that. We can move towards a more flexible framework.

Mr. Shimkus. And let me end up with this statement saying to you, Dr. Gottlieb: This auto enrolling debate, helpful, harmful, or is there an incentive to, if you auto enroll, people are losing idea of cost and coverage by just letting it roll? If you auto enroll one policy down because they weren't engaged in making the decision, would that force a closer scrutiny of the policy?

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Dr. Gottlieb. Well, we talk about auto enrolling in the plan we put out through AEI. What we do is we provide a minimum subsidy level that is going to be enough, going to be sufficient for people to auto -- for States to be able to auto enroll individuals in a basic plan. We give the flexibility of States to do that.

Now, the reality is in our scheme, you are going to end up being auto enrolled into a basic healthcare plan that is only going to provide catastrophic coverage, so a lot of people are not going to like it. But we do talk about the concept in our plan.

Mr. Shimkus. I talk about catastrophic coverage all the time, and I think that is where we need to be.

Thank you, Mr. Chairman. I yield back.

Mr. Pitts. The chair thanks the gentleman, and now recognizes the gentleman from New York, Mr. Engle, 5 minutes for questions.

Mr. Engel. Thank you, Mr. Chairman. I thank you and the ranking member for holding today's hearing.

Let me just say, you know, when you take a massive bill like the Affordable Care Act, of course, there are going to be problems with it. Major bills like this, whether it was Medicare or Medicaid or other large bills, you see how they work, and then you tweak them. You change things. You improve things. But, unfortunately, we haven't been able to do that. The majority seems to be more intent on trying to get us to repeal it 62 or 63 times, which really wastes everybody's time. We really should all put our heads together on both sides of the aisle

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and do some commonsense fixing. Not repeal it, because we really believe this Act is here to stay, and we believe that this is something that benefits people, because Ms. Corlette's testimony is a very apt reminder of the practices that were routinely employed prior to the passage of the Affordable Care Act.

Let's state them, again: Denying insurance for people with preexisting conditions, forcing certain populations to pay exorbitant rates, applying lifetime limits to care. These practices, if you are over -- if you are under 26, you couldn't stay on your parents' plan. These practices were once commonplace in the individual insurance marketplace.

So we have made this point numerous times, and I think it is important to, again, remind ourselves what the status quo used to be and how it affected people, people like our constituents, our families, and our friends. And as Ms. Corlette mentioned, like any law, the ACA is not perfect. But it has made a world of difference for those millions of Americans who were once denied coverage or couldn't afford it, and I think we need to keep working to ensure it continues to make a difference for millions more.

Ms. Corlette, you notice that the ACA has allowed States to implement new delivery systems reforms, a space which New York has been tremendously successful. New York's delivery system reform incentive payment program is laying the groundwork to ease payers' and providers' transitions from a fee-for-service system to one in which

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reimbursements are based on value, not volume. Through this program, often referred to as DSRIP, New York will be able to allocate more than \$7 billion in Medicaid savings towards improvements to its healthcare system over the next several years.

So would you talk a little more about the kinds of delivery system reforms that have been spurred by the ACA, and how those reforms might benefit the health system as a whole?

Ms. Corlette. Yes, absolutely. I mean, I talked earlier about how health insurance is such an expensive product. And one of the reasons health insurance is so expensive is because the delivery of care and the way we pay for care is often irrational. So some of the things that the Affordable Care Act did was really launch some experiments, primarily using Medicare, but also Medicaid, and I think Covered California is an example of how a State could maybe use its marketplace to also get at some of these payment and delivery system issues.

So some examples are encouraging expansion of patient centered medical homes, where care is truly coordinated and there is a real emphasis on primary care for people with chronic conditions, bundling payments for a particular medical procedure, so that, in some cases, providers are actually taking on some risk if they over -- overdeliver services. That is another example. ACOs, accountable care organizations, again, where providers are taking on some risk; if they are over budget and not delivering quality of care, then they take a

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financial hit.

So those are just a few examples of some of the demonstration projects and other things that are being launched, and New York is a great example of a State that is taking it up and run with it.

Mr. Engel. Thank you.

Mr. Shimkus had asked a question to one of the other panelists about actuarial value. I am wondering if you would like to comment or respond to that question?

Ms. Corlette. Yeah, sure. So the actuarial value targets are built around the bronze, silver, gold, platinum level plans. And, I mean, we talked a little bit earlier about how consumers are making trade-offs, right, between higher deductible, lower premium, higher premium, lower deductible. And that, it simply -- these are signals for consumers to be able to help them make those trade-offs in a clear and understandable way. And as far as I can tell, they are working. Predominantly, people are enrolling in the silver level plans, but, you know, with 86 percent of people reporting satisfaction with their coverage in the marketplaces, it sounds like I think people are generally happy with their choices.

Mr. Engel. Thank you.

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman. I now recognize the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman. This has been a

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productive discussion today. I was a cardiovascular and thoracic surgeon before coming to Congress, so, obviously, it is near and dear to my heart. The one thing we are not talking about, though, is the cost of the product, itself, is too expensive. I mean, that is not what this is about. You addressed some of that.

The only way that we are going to get a handle on this is, you know, is we are looking at ways to cover a product that continues to be too expensive itself, and so in some future hearings, hopefully we can address that. There is no price transparency in health care, very minimal from a consumer perspective, and it is third-party payer. The consumer doesn't care what things cost, essentially, because they are not paying the bill for the most part.

Quality transparency, which is improving. The Society of Thoracic Surgeons, my society, has had a database for almost 25 years that I participated in. The expansion of has is leading to some consumer-driven type health care, Healthy Indiana plan is the way we are covering our Medicaid population that is leading to decreased cost in that space, because consumers have a little bit of their own skin in the game. And we need to further incentivize preventive care by paying for it better because the people don't get sick, it doesn't cost you any money.

So that is my lead-in. I would also like to say some of the mentioned problems in the marketplace that were just mentioned were recognized by both sides of the political aisle. Everybody recognized

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preexisting conditions was the problem. Everybody -- all of those -- it is everything else that the ACA did that was -- that was the issue. We could have solved those problems in a different way, in my opinion.

The average Federal exchange premiums jumped 12.6 percent for bronze plans, and this is 2015. 11.3 percent for silver plans. Deductibles were up by -- were up by \$500 in the silver plans. The reality is the people I talked to, healthcare costs are going up for everyone. And I think even though, in fairness, there are some people that are happy -- many people that are happy with their insurance coverage, there are also complaining about the costs.

The Gallup Poll recently said that healthcare costs are at the top of American families' financial concerns, number one.

So that said, you know, a lot goes into rates; experience, trends, reinsurance, taxes, benefits, medical loss ratio, many of which are mandates in the ACA.

Ms. Corlette, in your testimony, you note Congress should approve affordability. I think we all would agree with that. You say that we can achieve that through premium cost-sharing arrangements. Can you identify -- and this would be for the full panel, but I will start with you. One, government mandate that could be eased today that would alleviate costs? You may not be willing to mention, to say --

Ms. Corlette. Yeah, I have to take a minute to think about that. But I would happily cede to my counterparts while I am thinking about

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it.

Mr. Bucshon. Yeah, I mean, I think since I am one of the last to ask questions, some of them have been answered, right? The 3-1 age premium limit is a big one, the MLR is a big one. Others?

Ms. Corlette. I would only point out that by expanding the age rating by -- you would be lowering costs for younger people, but raising them for older people. So, you know, there are winners and losers when you do that.

Mr. Bucshon. Except for the fact that that is limiting the ability of younger people to enroll because the costs are too high for them to enroll in the plan in the first place. So -- Mr. Roy.

Mr. Roy. Correct.

So in my written testimony, I provide a written illustration of this fact that, actually, the narrow age spans in the ACA end up increasing the cost of health insurance for older individuals as well, because the younger people don't enroll, which increases premiums for everyone in the end through adverse selection. So I definitely would highlight that, as you mentioned.

One thing I would bring up, since the goal is -- you know, you started in your question about -- talking about, well, there are things in the ACA that we should change, and there are things that we should change, and there are things we should change to reform the way we pay for health care, and we absolutely do that as the core problem.

But one area that I would highlight that we haven't talked about

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today that is outside the scope of this today's hearing, but I would encourage you to consider is hospital consolidation. The fact that hospitals are consolidating and taking market power in a particular locality and using that market power to basically dictate prices to insurance companies, which insurance companies and Medicaid is simply forced to pass on in the form of higher premiums. That is a huge problem. There's a lot we could be doing to address the problem of hospital consolidation.

Mr. Bucshon. I am running out of time.

Yeah, and we are not even talking about the tax treatment of hospitals and the more complicated situation that we are in. Hospitals and insurance companies are building all the new glass buildings in every city that I visit, including my own. And it is getting harder and harder to justify to the constituents that their costs are going up, but yet, it appears that some of the providers of those things are doing quite well.

I am out of time. I yield back.

Mr. Pitts. The chair thanks the gentleman, now recognize the gentleman, Mr. Cardenas, 5 minutes for questions.

Mr. Cardenas. Thank you very much, Mr. Chairman. And I really appreciate the opportunity to have this hearing. I hope, and it appears to me that maybe we are starting to speak more about how we can legislate and improve on the environment that we have post-ACA instead of just talking about how we should go back to a world before

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ACA. But here we are. So thank you very much, Mr. Chairman and colleagues.

I am baffled that we would point out that healthcare costs keep rising, but it is my understanding -- forget about my understanding. Could you answer the question, prior to the Affordable Care Act being passed, were healthcare costs going up in the United States in overall consumption, overall GDP, et cetera, et cetera? Was it on the rise before the Affordable Care Act even got enacted?

Mr. Roy. Healthcare costs have risen every year since time immemorial, but one thing that is important, I think the question, sir, that you are trying to get at is, has the rate of growth in healthcare costs increased or decreased? And there's been, since 2003, a decline in the rate of growth in the increase of healthcare costs and healthcare spending that has continued with accelerated and exacerbated by the global recession. And so, now we are starting to see just in the last year, actually, the growth in healthcare spending and healthcare costs have turned up again. So there has been a significant increase in the growth rate of healthcare costs since the ACA's spending provisions went into effect.

Dr. Gottlieb. I would just add to that and echo that. When you look at the analyst reports being put out and what the healthcare companies are reporting right now, they are reporting clearly at the end of what we call an underwriting cycle, where healthcare costs declined as consumption, but yet, it declined during the recession and

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now you are seeing healthcare consumption go back up, and costs are going back up with it, and that is what the insurers are reporting. So that should be concerning. I think we are going to see an acceleration in healthcare inflation in the coming years.

Mr. Cardenas. But weren't we seeing double digit year over year healthcare costs going up prior to the Affordable Care Act being enacted? Go ahead.

Ms. Corlette. Yes, sir. Before the Affordable Care Act was enacted, we were seeing double digit cost increases year over year, and since the ACA was enacted, we have seen lower costs growth year over year.

Mr. Cardenas. And before the ACA was enacted, what would happen to somebody if they had a precondition? Say somebody had previously cancer, and it was in remission, and then all of a sudden they found themselves out of the insurance market? Say, you know, I want to get insurance. What would happen before the ACA was enacted? Would somebody likely, really, honestly, be able to get insurance with that precondition? Go ahead.

Ms. Corlette. Likely not. And I would point out, too, that there's been a lot of discussion today about how much more expensive these health insurance products are post-ACA. Well, one reason health insurance was cheaper before the ACA is they didn't cover sick people. So, yes, you can offer cheaper product if you don't allow any sick people --

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Mr. Cardenas. If you legally exclude sick people.

Ms. Corlette. Right. And if you don't cover benefits and if you don't cover mental health or prescription drugs, yes, the product will be cheaper. Will it be -- provide the kind of financial protection that you and I and all of us with employer-based coverage are used to and expect? No.

Mr. Cardenas. Also, let me ask you a follow-up. Prior to the Affordable Care Act passing, say somebody did get cancer and they wanted treatments and, thank God, they actually were cured, what was the likely deductible that that family or individual was likely going to be saddled with, with a full-fledged chemotherapy, maybe even some operations removing some tumors, et cetera, et cetera, et cetera? What was the likelihood of that individual or family being saddled with their own portion of the costs, even if they had insurance?

Ms. Corlette. I mean, financial stress is one of the biggest issues for cancer patients and their families, and not only is it -- can lead to medical bankruptcy and those kinds of things, but it also can really lead to worse health outcomes because of the trauma and stress of dealing with those financial costs.

Mr. Cardenas. But what were the likely costs? Was it 5,000, maybe 10,000, 20,000?

Ms. Corlette. No. If you have a, you know, cancer that it could be tens of thousands, hundreds of thousands of dollars depending on the kind of --

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Mr. Cardenas. Now, since the ACA has been passed, that same scenario, how much would that person be saddled with after all of -- all of that remediation and all of the treatments?

Ms. Corlette. I am really glad you mentioned that, because one thing we haven't discussed is that the ACA provides a critical financial protection in terms of an out-of-pocket maximum --

Mr. Cardenas. We are running out of time. What is that?

Ms. Corlette. It is roughly \$7,000 a year that it would be maximum you would have to pay.

Mr. Cardenas. Thank you. And also, look, I have a daughter. She is educated. She is a professional, so is her husband, both working. And when they had to go out and buy their own insurance, they were complaining. And when I asked them how much they were paying for this healthy couple, young couple, they were in their late 20s, they were complaining about the costs. And having been a former employer myself, I said, what are you complaining about? How much would it be? It was like a couple hundred bucks a months for them to get that coverage with a maximum deductible, 7,000, et cetera, et cetera, et cetera.

And I was sitting there going, you know what, complaining about your health care cost is a matter of perspective, and some Americans are so dammed spoiled, including my own family, that they don't even get the fact that we are in such a better place today.

Thank you, I yield back.

Mr. Pitts. The chair thanks the gentleman. I now recognize the

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gentleman, Mr. Bilirakis, 5 minutes for questions.

Mr. Bilirakis. Thank you, Mr. Chairman. I appreciate it. Thank the panel for their testimony today as well.

Mr. Roy, in your testimony, you mentioned the convoluted tax credit system leading of incidents of waste, fraud, and abuse.

Today, we have more confusion during tax time as people need more tax forms. A means-tested tax credit that penalizes midyear pay raises, and as recently as January, the IT report that CMS can't, they cannot verify premiums paid before paying premium tax credits to insurance companies.

Can you elaborate on some of these problems, and what we should do? Is there a better alternative to the current tax credit based-premium assistance program, the system? Is there a better way?

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RPTR BAKER

EDTR CRYSTAL

[11:56 a.m.]

Mr. Roy. Absolutely. And you correctly highlighted some of the examples of how problematic that system is.

One thing you often find is that people whose incomes are, say, 200 percent of the Federal poverty level, their incomes are volatile. They are often working odd jobs and being freelancers, so their income goes up and down.

So if they have to estimate what their income might be for the next month, and then it turns out they estimated that inaccurately and the subsidy they received is inaccurate because of that, theoretically, by law, the Treasury Department is supposed to go after them and recover what excess subsidies they received and vice versa.

That is an incredibly cumbersome system, and it also leads, incentivizes people to underestimate their income in order to receive subsidies, knowing that the Treasury Department doesn't really enforce that clawback provision as often as they should.

So this is a serious problem, and the best way to deal with it is through a statutory change that, as I discussed in my written and oral testimony, would use the previous year's taxable income as the basis for whatever assistance you provided in the following year.

Now, that of course would not 100 percent match with your daily

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or monthly income, but that is the tradeoff for a system that is much more easily enforced where there would be very limited waste, fraud, and abuse, compared to the system we have today where there is enormous -- as you mentioned, the OIG reports and other reports have estimated that there have been billions of dollars of misplaced subsidies and misallocated subsidies as a result of the very cumbersome, technocratic system that the ACA imposed.

Mr. Bilirakis. Dr. Gottlieb, do you have any thoughts on a better premium system, subsidy system?

Dr. Gottlieb. This is the reality of -- look, we have never done this before. We have never tried to provide middle class consumers a subsidy based on income that changes as their income grows. And trying to create that framework is going to lead to very odd structures like the clawback, and people might underestimate their income just to get the float for the coming year, not to mention what Avik mentioned with respect to the fact that there isn't real enforcement in terms of clawing back that money, so you are getting a lot of wasteful spending.

This is why we advocate an age-based subsidy and a subsidy structure that allows the subsidies to be tied to a looser rate-setting environment where premiums can adjust based on risk. And I know there is a lot of criticism of an age-based subsidy because people who are in lower-income brackets might not get enough of a subsidy to be able to go into the market in as robust of a fashion as they are under the

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current scheme. These are the tradeoffs. I mean, an age-based subsidy and a risk-based subsidy will eliminate the need to have these really odd tax consequences that we have right now that I think aren't going to be fully enforceable.

Mr. Bilirakis. Thank you for those suggestions.

Dr. Gottlieb, you testified here in 2014 about the problems of narrow networks in the ACA. At the time, I used a very real example of the Moffitt Cancer Center, which is just outside my district -- the only NCI-designated cancer center in Florida, by the way -- only being available at that time in 1 out of 12 ACA plans in Florida.

It seems to me that the people most disadvantaged by the law may be the sick patients with serious, chronic, complex medical conditions. Unfortunately, the problem of narrow networks seems to be growing, unfortunately.

Can you talk about the growth of closed pharmacies, the continued narrow networks, and how we may build a system with more patient choices?

Dr. Gottlieb. The insurers are doing what they can to try to control costs in the marketplace that I think where the pool has ended up much more skewed than what people anticipated. So they are trying to cheapen the benefit, and they are doing that by continuing to narrow the networks and close drug formularies.

CMS is starting to apply more oversight on the networks and network adequacy right now. They are not applying as much oversight

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on the formularies. And so you are seeing very restrictive formularies. I went through and systematically looked at about 25 plans for the coverage around drugs for multiple sclerosis. I found that most plans excluded 6 or 7 of the 12 top drugs that you use to treat the disease, and that is a disease where you want to provide maximal flexibility to patients in treatment selection.

I think these are just the consequences of a very prescriptive regulatory scheme that takes away a lot of the other tools insurers might have to try to manage costs. They are going to manage costs through the only vehicles they have, and this is all that we have left them. And so I think you will continue to see increased ratcheting down to the extent that CMS is going to allow it under regulation.

Mr. Bilirakis. Mr. Roy, any thoughts?

Mr. Roy. Yeah. So I think that it is part of a continuum of problems with when you have a cumbersome system and you don't have the right enforcement, what are you going to do? I mean, you basically have to go through a various complicated -- the IRS doesn't audit people's monthly income statements.

So, again, the simplest way to deal with this is, if you go by the previous tax year's income, and then you have an age-adjusted subsidy along with it, then what you can do is -- it is very transparent. People can know ahead of time, okay, here is my age, here is my income in the previous tax year, here is the assistance I am going to get.

And then you pair that with a regulatory system that gives people

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the flexibility so that insurers have the freedom to offer young people and healthy people plans that are affordable to them that accurately represent the expected healthcare consumption they might have in a given year.

Mr. Pitts. The gentleman's time has expired. Thank you.

That concludes the questions of the members present. We will have some additional questions from members. We will submit them to you in writing. I ask that you please respond.

[The information follows:]

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Mr. Pitts. Terrific panel today. Thank you so much.

Members have 10 business days to submit questions for the record.

That will be close of business on Wednesday, May 25.

[The information follows:]

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Mr. Pitts. Without objection, the hearing is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]