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ONE HUNDRED FOURTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
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MEMORANDUM

June 8, 2016

To: Subcommittee on Health Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Advancing Patient Solutions for Lower Costs and Better Care"

On **Friday, June 10th, at 9:15 a.m., in Room 2322 of the Rayburn House Office Building**, the subcommittee will hold a legislative hearing titled "Advancing Patient Solutions for Lower Costs and Better Care."

I. AFFORDABLE CARE ACT – HEALTH INSURANCE MARKETPLACES

The Affordable Care Act (ACA) established state and federal insurance marketplaces to increase access to high quality health insurance coverage.[1] After the third open enrollment season this year, 12.7 million Americans had selected or were re-enrolled in plans offered on the state or federal marketplaces.[2] On the federal marketplace, approximately 42 percent of plans selected this year were made by new consumers entering the market. As a result of increased marketplace access and other relevant provisions in the ACA, 20 million Americans have obtained health insurance since 2010.[3] Further, the uninsured rate for non-elderly adults has

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[1] U.S. Department of Health and Human Services (HHS), *Key Features of the Affordable Care Act by Year* (Aug. 13, 2015) (online at http://www.hhs.gov/healthcare/facts-and-features/key-features-of-aca-by-year/index.html).

[2] Centers for Medicare and Medicaid Services (CMS), *Health Insurance Marketplace Open Enrollment Snapshot – Week 13* (Feb. 4, 2016) (online at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-04.html).

[3] HHS, *Health Insurance Coverage and the Affordable Care Act, 2010-2016* (Mar. 3, 2016) (online at https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf).

declined by 43 percent since the implementation of the exchanges.[4] To date, the country's overall uninsured rate for healthcare coverage has fallen to a historic low of nine percent.[5]

II. SUMMARY OF DISCUSSION DRAFT OF H.R. ____, TO AMEND TITLE XXVII OF THE PUBLIC HEALTH SERVICE ACT TO CHANGE THE PERMISSIBLE AGE VARIATION IN HEALTH INSURANCE PREMIUM RATES

The ACA limited age rating by insurers to 3-to-1, meaning insurers cannot charge older individuals premiums that are more than three times as much as younger individuals. This legislative draft by Rep. Brooks (R-IN), would change the age rating default to a 5-to-1 ratio, so that insurers can charge older individuals' premiums that are, or exceed five times as much as the premiums paid by younger individuals. The bill, as drafted, allows states to set other, broader age rating ratios without limit.

III. DISCUSSION DRAFT OF H.R. ____, TO AMEND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT TO BETTER ALIGN THE GRACE PERIOD REQUIRED FOR NON-PAYMENT OF PREMIUMS BEFORE DISCONTINUING COVERAGE UNDER QUALIFIED HEALTH PLANS WITH SUCH GRACE PERIODS PROVIDED FOR UNDER STATE LAW

A. Background

In order to help Americans afford their health insurance premiums, the ACA provides advanced premium tax credits (APTC) to individuals and families who earn up to 400 percent of the federal poverty level on a sliding scale based on income. Approximately 85 percent of those covered under the ACA receive an APTC to make coverage more affordable.[6]

Under current law, if an individual who receives an APTC fails to pay his or her premium, he or she enters a 90-day grace period.[7] The grace period is intended to help lower-income Americans and those gaining insurance for the first time to maintain their coverage. It is also intended to help reduce churn in the individual market and achieve continuity of care.[8] During the first month of the grace period, the individual remains insured, and the insurer is

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[4] *Id.*

[5] Centers for Disease Control and Prevention (CDC), *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January –September 2015* (Feb. 2016) (online at http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201602.pdf).

[6] CMS, *March 31, 2015 Effectuated Enrollment Snapshot* (June 2, 2015) (online at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-02.html).

[7] 45 C.F.R. § 156.270(c) (online at https://www.gpo.gov/fdsys/pkg/CFR-2013-title45-vol1/pdf/CFR-2013-title45-vol1-sec156-270.pdf).

[8] Health Affairs, *Health Policy Brief: The 90-Day Grace Period* (Oct. 16, 2014) (online at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_128.pdf).

required to pay any claims incurred. After the first month, insurers may pend all claims to providers. If the individual fails to pay his or her premium for the full 90-day period, they lose their coverage.

B. Summary of Discussion Draft

This legislative draft by Rep. Flores (R-TX), would shorten the grace period such that if an individual with an APTC misses one monthly premium payment, in part or whole, that individual would lose their insurance coverage and would not be able to gain coverage until the next open enrollment period.

IV. DISCUSSION DRAFT H.R. ____, TO AMEND TITLE I OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT TO REQUIRE VERIFICATION FOR ELIGIBILITY FOR ENROLLMENT DURING SPECIAL ENROLLMENT PERIODS IN PPACA INSURANCE PLANS, AND FOR OTHER PURPOSES

A. Background

The ACA put in place an annual open enrollment period during which individuals may purchase health insurance. The ACA also allows for certain Special Enrollment Periods (SEPs) for those who are eligible to purchase health insurance outside of the designated open enrollment period. The individual market has traditionally been transient in nature as people move into and out of sources of coverage, such as job-based plans and Medicaid. Thus life changes triggering an SEP often occur outside of open enrollment leading some people to "churn" in and out of marketplace plans during the year.

Initially, the Administration had allowed for more than 30 SEP categories. In recent months, the Administration has reduced and streamlined SEPs to six major categories in response to issuers' concerns that SEPs may have been subject to abuse. In addition, CMS will require all consumers who enroll or change plans using an SEP for the five most popular SEP categories (loss of minimum essential coverage, permanent move, birth, adoption/foster care placement, and marriage) to provide proof that they were eligible for these SEPs. These SEPs make up about 75 percent of SEP usage. Also, the Administration has announced that individuals requesting a "permanent move" SEP will have to prove they had minimum essential coverage for one or more days in the 60 days preceding the permanent move.

B. Summary of Discussion Draft

This legislative draft by Rep. Blackburn (R-TN), requires that an Exchange verify an individual's eligibility for a SEP *prior* to that individual's attainment of coverage. This process would be set out by the Secretary of HHS through an interim final rule. No resources for this verification process have been included in the draft's provisions. Additionally, the draft would require the Secretary to conduct a study on SEP utilization, including the number of individuals who attempted to enroll in SEPs, the number of individuals who were not allowed to enroll in SEPs, and the reasons for those disallowances.

V. H.R. 3463, ALIGNING CHILDREN'S DENTAL COVERAGE ACT

A. Background

The ACA included pediatric dental as one of the essential health benefits (EHBs), but the law also allowed pediatric dental to be sold separately on the Exchange. As long as there is a standalone dental plan offered on the Exchange, plans without pediatric dental can be sold on the Exchange and still be considered Qualified Health Plans (QHPs). Outside the Exchanges, the rules are different—that is, in order to be considered a QHP, the law required plans outside the Exchanges to offer pediatric dental. CMS tried to address this difference in the EHB final rule by implementing a "reasonable assurance" standard, which requires health plans to include the pediatric dental benefit OR the issuer must be "reasonably assured" that any enrollee in an otherwise EHB-compliant plan that does not offer pediatric dental is enrolled in an Exchange-certified dental plan.

B. Summary of H.R. 3463

This bill, introduced Reps. Griffith (R-VA) and DeGette (D-CO), would ensure that stand-alone pediatric dental coverage can be offered outside of the Exchanges in the same manner as it is offered inside the Exchanges. This bill would amend the ACA to say that if a standalone dental plan is offered off the Exchange, any other health insurance plan offered in that market will not be treated as failing to meet EHB requirements solely because it does not offer pediatric dental benefits.

VI. H.R. 4262, TRANSPARENCY AND ACCOUNTABILITY OF FAILED EXCHANGES ACT

A. Background

The ACA gives each state the option of establishing its own state-based health insurance marketplace, known as a state-based marketplace or exchange.[9] Although several states have faced technical challenges in implementing state-based marketplaces (SBMs), at present 12 states plus the District of Columbia operate state-based marketplaces. An additional four states operate their own marketplaces but utilize the federal website. Seven state-partnership marketplaces use the Healthcare.gov platform while the state is responsible for consumer assistance. Finally, 27 states use the federal Healthcare.gov. platform.[10]

[9] CMS, *State Health Insurance Marketplaces* (online at www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html).

[10] Kaiser Family Foundation, *State Health Insurance Marketplace Types, 2016* (online at http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/#note-).

Section 1311 of the ACA provides grant funding for states establishing state-based marketplaces.[11] These grants are limited to the extent that Section 1311 requires that marketplaces must be self-sustaining by January 1, 2015, and further provides that no grant shall be awarded after January 1, 2015, for states to establish marketplaces.[12]

The technological difficulties faced by a number of SBMs in both the first and second enrollment seasons are well-documented. In the first year of open enrollment, some states struggled to stand up the technology that would be needed to enroll individuals successfully in qualified health plans.[13] In the second year of open enrollment, some states improved functionality, but others continued to struggle with IT challenges.[14] Certain states switched to using the federal IT platform, Healthcare.gov. For more information please see the Oversight and Investigations subcommittee September 29, 2015 memorandum.

B. Summary of H.R. 4262

This bill, which was introduced by Rep. Allen (R-GA), currently has 59 Republican cosponsors. It requires "States" that terminate or transfer operations of their Exchanges to submit a report to Congress and the Secretary of HHS that includes the results of an audit explaining how the grant funds were used. The bill also requires that any unobligated funds be returned to the Treasury and any acquired property be given to the General Services Administration. Notably, there are no funds in 1311 grants left to be obligated; that is, there are currently no unobligated funds, as 1311 grants are not able to be awarded after January 2015. Generally speaking, any unspent grant funds are returned to the Treasury in the longstanding HHS grant close-out process.

VII. WITNESSES

Douglas Holtz-Eakin
President
American Action Forum

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[11] Congressional Research Service (CRS), *Federal Funding for Health Insurance Exchanges* (Oct. 29, 2014).

[12] Patient Protection and Affordable Care Act, Pub. L. No.111-148, §1311 (2010).

[13] *See*, e.g., *Nevada Will Join Federal Healthcare.gov Exchange*, Washington Post (May 21, 2014) (online at www.washingtonpost.com/blogs/govbeat/wp/2014/05/21/nevada-will-join-federal-healthcare-gov-exchange/); *Oregon's Exchange Closing After a History of Tech Woes,* Modern Healthcare (Mar. 9, 2015) (online at www.modernhealthcare.com/article/20150309/NEWS/150309912).

[14] *In Vermont, Frustrations Mount Over Affordable Care Act*, New York Times (June 4, 2015) (online at www.nytimes.com/2015/06/05/us/in-vermont-frustrations-mount-over-affordable-care-act.html?_r=0); *MNSure Year 2: Better, But Problems Persist*, Twin Cities.com (Feb. 2, 2015) (online at www.twincities.com/politics/ci_27569977/year-later-mnsure-is-better-but-not-good).

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