



A not-for-profit health and tax policy research organization

**Testimony before the
Energy & Commerce Committee
Subcommittee on Health**

United States House of Representatives

**Rep. Joseph R. Pitts, Chairman
Rep. Gene Green, Ranking Member**

Hearing on

Advancing Patient Solutions for Lower Costs and Better Care

June 10, 2016

**Testimony presented by
Grace-Marie Turner
President, Galen Institute**

Advancing Patient Solutions for Lower Costs and Better Care

Energy and Commerce Subcommittee on Health

June 10, 2016

Grace-Marie Turner, Galen Institute

Chairman Pitts, Ranking Member Green, and members of the committee, thank you for the opportunity to testify today on five pieces of legislation designed to Advance Patient Solutions for Lower Costs and Better Care

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I served as an appointee to the Medicaid Commission from 2005-2006, as a member of the Advisory Board of the Agency for Healthcare Research and Quality from 2005 to 2007, and as a congressional appointee to the Long Term Care Commission in 2013.

The ACA was designed to provide people with choices of private insurance, with states at the forefront of organizing this new system of coverage. States have had decades of experience in regulating health insurance, but a battery of ACA rules overrides state laws that have been forged by experience to keep insurance pools stable.

Today, I will discuss ways in which the Affordable Care Act (ACA) is not working as planned, undermining its original goals of providing universal coverage through stable, affordable health insurance. I will focus on five problems and proposed legislation designed to address them: flawed age rating bands, a lack of verification of qualifications for special enrollment periods, abuse of the grace period for health insurance premium payment, waste of taxpayer dollars on failed state exchanges, and the need for a technical correction involving pediatric dental care.

AGE RATING

Avik S.A. Roy testified before your hearing on May 11, 2016, and explained why the 3:1 age band rating in the Affordable Care Act is backfiring:

Forcing the young to pay more drives costs up for everyone. The average 64-year-old consumes six times as much health care, in dollar value, as the average 21-year-old. Hence, in an underwritten (i.e., actuarially priced) insurance market, insurance premiums for 64-year-olds are roughly six times as costly as those for 21-year-olds.

Under the ACA, policies are age-rated; i.e., insurers cannot charge their oldest policyholders more than three times what they charge their youngest customers. If every customer remains in the insurance market, this has the net effect of increasing premiums for 21-year-olds by 75 percent, and reducing them for 64-year-olds by 13 percent.

However, if half of the 21-year-olds recognize this development as a bad deal for them, and drop out of the market, adverse selection ensues, driving up the average health care consumption per policyholder, thereby driving premiums up for everyone, including the 64-year-olds who were supposed to benefit from 3:1 age rating.

In an attempt to mitigate this problem, the ACA includes an individual mandate... In theory, the individual mandate's fine should force these younger individuals to purchase health coverage, even if that coverage is far more expensive than their actual health care consumption. In reality, however, the ACA's individual mandate is too weak, representing a fraction of the cost of ACA-based coverage. As a result, younger and healthier individuals have disproportionately avoided the exchanges.¹

Before passage of the ACA, 42 states allowed health insurance rates to vary by age by a ratio of 5:1 or more. In a state with a 5:1 age band, the ratio limits the amount an older individual will pay to no more than five times what a younger individual pays in premium dollars. This 5:1 ratio was based upon vast experiential data that shows utilization of health care services is broadly correlated with age. These higher age ratios strike a careful balance: they provide protection to older consumers without making it impractical for younger consumers to purchase insurance. Making health insurance too expensive for the healthier young people we want in the insurance pools drives them away, increasing the cost of insurance for everyone who remains.

The ACA restricts age bands in all states to a ratio no greater than 3:1. The result was predictable. The Congressional Budget Office reported this year that enrollment in ACA exchanges was far below projections.² Healthy young people have been the hardest to attract. Fewer than 40% of enrollees are younger than 35, though 50% of the potential exchange population is in this age bracket, reflecting a missed opportunity to enroll young, healthy consumers.³

One of the top experts on the workings of the ACA is Timothy Jost. He noted early on that age rating compression "is going to force younger people to pay more in the individual market as older individuals pay less."⁴ As younger, healthier individuals are discouraged from buying insurance because of the the high cost, an adverse market spiral happens in which costs rise for those who keep coverage, thereby serving to further discourage younger, healthier individuals from keeping or obtaining coverage. The premium increases we are seeing for next year are at least partly attributable to the ACA's restricted age rating bands.

Because affordability is such a high priority in stabilizing the health insurance system in the United States, action must be taken to bring young people back into insurance pools rather than drive them away. Rep. Susan Brooks is the lead sponsor on legislation to address the ACA's age-rating bands. Her bill would defer to the states to decide rating bands, starting in January 1, 2018. If a state does not have a law addressing the issue, the 5:1 ratio would prevail.

This is an important step toward the goal of making health insurance more affordable by attracting the larger number of the healthy young people needed to stabilize health insurance pools.

SPECIAL ENROLLMENT VERIFICATION

In testimony before this committee in May, American Enterprise Institute Scholar Scott Gottlieb said he believes that “some of our current cost challenges show the shortcomings that come from not having defined enrollment periods as a way to also help maintain a stable risk pool.”

He explained that: “One recent analysis, undertaken to evaluate the impact that special enrollment periods have on the non-group market, confirmed that these constructs skew the overall risk pool, ultimately leading to a higher cost and a less stable market.”⁵

Special Enrollment Periods are designed to help people obtain and maintain health insurance coverage through important life events, such as job changes, moving to another state, marriage, birth of a baby, etc. The Obama administration has created more than 30 special enrollment categories and sent emails to millions of Americans last year urging them to see if they might be eligible to sign up after the annual open enrollment deadline. But the administration has done little to verify whether late arrivals were in fact eligible under the special enrollment criteria.

Evidence shows that many Americans have figured out how to game the system by taking advantage of generous special enrollment period rules. A growing number of individuals are purchasing health insurance only when they need medical care and then are dropping it after they receive the medical services they need. This undermines the concept of insurance, drives up costs, increases premiums, and discourages healthy people from purchasing continuous health coverage.

An analysis compiled by the actuarial consulting firm Oliver Wyman found that:⁶

- The average per member per month (PMPM) claim costs for special enrollment period (SEP) enrollees in 2014 was 24% higher on average during the first three months of enrollment than for open enrollment period (OEP) enrollees
- In 2015, the difference in PMPM claims costs increased to 41% for the first three months of enrollment
- SEP enrollees that chose plans with the highest actuarial values showed especially high costs during the first month of enrollment.

At the end of 2014, SEP enrollees represented nearly 20% of total enrollees in the non-group, ACA-compliant market. Data from one plan show that individuals enrolling through a special enrollment period are more than twice as likely to drop their coverage after a short period of time as those who enroll during the annual open enrollment period.⁷

A recent Covered California report also found that “there are credible indications that the risk mix of special enrollment period enrollment is higher cost than those of Open Enrollment and that some of that difference is likely attributed to individuals inappropriately claiming special enrollment period events.”⁸ California found that the cost differential between special

enrollment period enrollees and open enrollment period enrollees ranged from 15% to 50% higher, based upon data from the state's largest four health plans.

The administration has taken preliminary steps to verify eligibility, but much more needs to be done. I commend Rep. Marsha Blackburn for taking the lead on legislation to verify eligibility before allowing an individual to enroll in an exchange via special enrollment period rules.

The goal should be not only for people to get covered, but for people to stay covered. This not only will contribute to stabilizing insurance pools and thereby controlling costs but also to providing incentives for people to maintain continuous coverage so they can benefit from preventive care and coordinated services to help manage their health and medical conditions.

THE GRACE PERIOD

People have learned they can game the system through another ACA rule. The law allows people to stop paying premiums and still obtain medical services for another 90 days. This “grace period” allows someone to stop paying premiums on October 1 and still maintain coverage through the end of the year. The individual can sign up for new coverage during the open-enrollment period for a policy that begins on January 1. That means a person can have a full year of coverage and pay only nine months of premiums.

There is no obligation for people to pay their unpaid premiums from the prior year before re-enrolling in coverage the next year—even if they are enrolling in the same plan. The incentives here are basically *designed* to undermine the concept of real insurance.

The Centers for Medicare & Medicaid Services (CMS) regulations and guidance about the grace period work this way:

- In the first month an enrollee fails to pay premiums, insurers must pay qualifying claims for medical services rendered to the enrollee
- In the second and third months of the grace period, insurers may withhold payment for claims, but the patient is still “insured” and cannot be billed by providers
- If the enrollee fails to pay all of the required premiums by the end of 90 days, the enrollee's coverage can be terminated. Insurers may then reject claims from the second and third months of the grace period, and providers may then try to collect payment from the enrollee for medical services they received during this time.

Independent studies show people have figured out how to use the grace period to their advantage, but to the disadvantage of a stable health insurance system:

- A national consumer survey by McKinsey and Company⁹ found that nearly a quarter of consumers stopped payment on their premiums in 2015, yet most repurchased an

exchange plan in 2016, and many repurchased coverage from the same health plan

- 18% of consumers stopped paying their premium in 2015 and then reenrolled again in 2016. Half of these consumers returned to the same plan they stopped payment for in 2015. Forty-five percent said they had stopped making payments in 2014, too.

Abuse of the grace period is undermining the concept of insurance and driving up the cost of coverage for others. Insurers must build the cost of non-payment of premiums into their premiums for the following year, increasing costs for those enrollees who play by the rules.

Doctors and hospitals are on the hook to continue treatment, even if the patient has stopped paying insurance premiums and the coverage has stopped. Many say they cannot continue to provide care to the growing number of exchange enrollees who are using the grace period to get “free” care.

Rep. Bill Flores is sponsoring legislation to end abuse of this provision of the Affordable Care Act by aligning the grace period for non-payment of premiums before coverage ends with grace periods under state laws. A 30-day rule would provide a greater incentive for people to keep and maintain coverage, and that was basically the standard in state law before passage of the ACA.

FAILED HEALTH EXCHANGES

States that decided to set up their own ACA exchanges were awarded more than \$5.5 billion in federal money to create them. Some states succeeded in creating functional exchanges, but the majority failed—from Massachusetts to Maryland, New Mexico to Nevada, and Oregon to Hawaii.

Oregon, which received approximately \$305 million to establish its exchange, terminated it entirely and opted to use the healthcare.gov federal exchange instead. Massachusetts was given more than \$200 to create an ACA exchange after successfully developing an exchange for its previously-created state health reform program. But the federal exchange failed miserably in the Bay State, with serious problems in determining eligibility and illegally enrolling hundreds of thousands of residents in Medicaid.

Several states, including Oregon, have filed lawsuits against the information technology contractors that helped build their exchange web sites. State officials also have indicated that if they collect any money from the lawsuit, the states want to keep the money instead of sending it back to the federal taxpayers who provided the funds in the first place. This clearly is an abuse and misuse of federal tax dollars.

Your committee released a report, “Misleading Congress: CMS Acting Administrator Offers False Testimony to Congress on State Exchanges,”¹⁰ that documented how CMS Acting Administrator Andy Slavitt gave misleading testimony to Congress on this issue. He testified under oath that state based exchanges returned more than \$200 million in grant funds to the

federal government. However, CMS documents do not support his claim, showing that the federal government has reclaimed only \$21.5 million from 17 exchanges.

Congressman Rick Allen is sponsoring legislation, the “Transparency and Accountability of Failed Exchanges Act,” that would require an audit of a state exchange when it fails and establish a procedure to require states to return any unspent funds to the federal treasury. The federal government also would be able to dispose of real property or repurpose it and deposit the funds in the federal treasury.

It is clear that Congress needs to continue to provide oversight and hold the Obama administration and the states accountable for what is likely to be hundreds of millions of dollars in lost and misspent federal funds on failed state exchanges.

FREE-STANDING DENTAL PLANS

Finally, Reps. Morgan Griffith and Diana DeGette are sponsoring bi-partisan legislation that would expand consumer choice in pediatric dental coverage. This clarifying legislation would allow individuals and families to purchase dental coverage, including pediatric benefits, through a stand-alone dental plan offered outside an ACA exchange. Currently, these stand-alone plans are allowed only for coverage offered inside an exchange. The Griffith-DeGette bill would level the playing field by applying the same rules to exchange plans and off-exchange plans.

“We hear from our members that their clients continue to express confusion regarding dental benefits,” the National Association of Health Underwriters wrote in a letter endorsing the bill. “This legislation would give consumers more choices when shopping for dental coverage and eliminate confusion in the marketplaces outside the public exchanges.”

This clarification is needed to establish that the offer of stand-alone pediatric dental coverage for policies offered outside an exchange is treated the same as coverage inside the exchange.

IN CONCLUSION

For health insurance to attract customers, the policies must be affordable, and everyone in the pool must pay their premiums over time so their insurance coverage is there to pay their bills if they need expensive medical services. If people only purchase health insurance when they need expensive care, the pools break down. It would be like allowing a family to purchase homeowners insurance only when their house is on fire. If the current trajectory with these ACA rules continues, costs will soar, more and more healthy young people will drop out, and the Affordable Care Act will fail in its goal of providing stable, affordable health coverage.

The Galen Institute is not officially endorsing these bills because we are prohibited from doing so by our 501c3 tax status. However, we believe the concepts behind them are sound and that they would begin the process of undoing some of the damage that the ACA has done to the

private health insurance market and that the bills would advance patient solutions for lower costs and better care.

Thank you for the opportunity to offer this testimony today, and I look forward to your questions.

ENDNOTES

¹ Avik S.A. Roy, “Transcending ObamaCare. Achieving Truly Affordable, Patient-Centered, Near-Universal Coverage.” Testimony before the United States Congress House Committee on Energy & Commerce Subcommittee on Health, May 11, 2016.

² Elmendorf D et al., Letter to the Hon. Nancy Pelosi. 2010 Mar 20; <https://www.cbo.gov/publication/21351>

³ Joel White, “Exchange Enrollment: An Opportunity for Reform,” Council for Affordable Health Coverage, June 7, 2016. <http://tinyurl.com/hrmukey>

⁴ <https://www.politicopro.com/tipsheet/healthcare/?id=324>

⁵ Scott Gottlieb, “Health Care Solutions: Increasing Patient Choice and Plan Innovation.” Testimony before the United States Congress House Committee on Energy & Commerce Subcommittee on Health, May 11, 2016.

⁶ Chris Carlson & Kurt Giesa of Oliver Wyman, “Special Enrollment Periods and the Non-Group, ACA-Compliant Market,” February 24, 2016.

⁷ Robert Pear, “Insurers say costs are climbing as more enroll past health act deadline,” The New York Times, Jan 9, 2016. http://www.nytimes.com/2016/01/10/us/politics/insurers-say-costs-are-climbing-as-more-enroll-past-health-act-deadline.html?_r=2

⁸ Peter V. Lee, Covered California, “Promoting Special Enrollment Periods,” Feb. 18, 2016.

<http://board.coveredca.com/meetings/2016/2-18/PPT-Covered%20California%20SEP%20Policy.pdf>

⁹ McKinsey & Company, Center for U.S. Health System Reform, “2016 OEP: Reflection on enrollment,” May 2016.

http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf

¹⁰ House Energy & Commerce Committee, “Misleading Congress: CMS Acting Administrator Offers False Testimony to Congress on State Exchanges, May 9, 2016. <https://morningconsult.com/wp-content/uploads/2016/05/051016-Slavitt-Report.pdf>