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HEALTH INSURANCE PREMIUMS UNDER THE PATIENT
PROTECTION AND AFFORDABLE CARE ACT

MONDAY, MAY 20, 2013

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

The subcommittee met, pursuant to call, at 4:02 p.m., in Room 2123, Rayburn House Office Building, Hon. Tim Murphy [chairman of the subcommittee] presiding.

Present: Representatives Murphy, Burgess, Scalise, Harper, Olson, Griffith, Johnson, Long, Ellmers, Barton, DeGette, Schakowsky, Butterfield, Castor, Green, and Waxman (ex officio).

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Staff Present: Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Karen Christian, Chief Counsel, Oversight; Andy Duberstein, Deputy Press Secretary; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Brad Grantz, Policy Coordinator, O&I; Debbie Hancock, Press Secretary; Sydne Harwick, Staff Assistant; Brittany Havens, Staff Assistant; Sean Hayes, Counsel, O&I; Andrew Powaleny, Deputy Press Secretary; Tom Wilbur, Digital Media Advisor; Phil Barnett, Minority Staff Director; Stacia Cardille, Minority Deputy Chief Counsel; Elizabeth Letter, Minority Assistant Press Secretary; Stephen Salsbury, Minority Special Assistant; Roger Sherman, Minority Chief Counsel; and Matt Siegler, Minority Counsel.

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Mr. Murphy. Good afternoon. I convene this hearing of the Subcommittee on Oversight and Investigation to examine the impact the Patient Protection and Affordable Care Act will have on the premiums of every American.

Today we are joined by several witnesses. Cori Uccello. Did I say it correctly?

Ms. Uccello. Uccello.

Mr. Murphy. Uccello? I see. Uccello like -- yes, we are good -- is a senior health fellow at the American Academy of Actuaries. Chris Carlson -- I think I got that right -- is an actuarial principal with the Oliver Wyman Group. Daniel Durham is executive vice president for Policy and Regulatory Affairs with America's Health Insurance Plans. And Topher Spiro is the vice president for Health Policy at the Center for American Progress. I thank the witnesses for joining us today.

Today's hearing will focus on a question that many Americans are concerned about: Will the Affordable Healthcare Act increase the cost of my health insurance? Based on information provided by some of the Nation's largest insurance companies and by outside analysts, the answer to that question is yes.

Two months ago the Subcommittee on Oversight and Investigation sent a letter to 17 insurance companies, including 15 of the Nation's largest insurers. We asked them for very basic information. What do

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you expect the Affordable Care Act will do to the premiums of Americans? Will they, in fact, be more affordable? We didn't ask them to create new material and we did not ask them to exclude or to focus on certain information or certain States. Instead, we simply asked them for the material they already had created to estimate the impact of the health care law on their consumers.

Nearly all the material the insurers submitted showed that Americans can expect massive premium increases. As one insurer told the committee, consumers in 90 percent of all States would likely face significant premium increases. Another wrote to the committee, "The bottom line is that the PPACA does not contain many provisions that will reduce costs and improve affordability, especially in the short term."

Now, to be clear, some individuals in a few States may see premium decreases. As identified by the insurers, these States are typically the ones that are already highly regulated, such as New York, Massachusetts, Maine, Vermont and others, but some of the materials submitted by the insurance industry show that even individuals in those States may still get a premium increase. And this still only represents five States. The other 45 can expect, as the insurers told us, significant premium increases. Forty-five States get premium increases and five may see a slight decrease.

On the day this law was signed, the President said it would, "lower

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costs for families and businesses." It seems remarkable that a law that was passed on the basis of affordability will instead bring Boston prices to a small town of Pennsylvania that it would have -- that otherwise would have been successful.

So why are costs going up? According to the materials provided by the companies, the Affordable Care Act mandates insurers provide a number of services regardless of consumer want or need, and then limits the ability for insurers to charge more or less depending on the likelihood of an individual using that insurance. We can easily predict those individuals who will be the hardest hit by these coming premium increases: young and healthy adults and some other age groups as well.

Furthermore, based on the materials provided by the insurers, the provisions in the Affordable Care Act that were supposed to mitigate the premium price increases are not going to be enough. For example, we have heard that those who can afford it the least will get subsidies if they earn less than 400 percent of the Federal poverty line, which is nearly \$46,000 for an individual. Yet one insurer told this committee that the subsidies would cover only 40 percent of the premiums. So after doubling your premiums, the Affordable Care Act pays for less than half of it.

And what if you aren't eligible for a subsidy? If you are individual making more than \$46,000 or a family of four making more

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than \$94,000, you won't be getting any help from the Federal Government. This health care plan was passed on the promise of lowering costs for everybody.

Supporters of the law often point out that women can no longer be charged a different amount because of their gender, but this benefit actually stops as women get closer to retirement. Several insurers told the committee these women will actually face higher premium increases than older men because of the end of gender rating. So as women get older and will inherently need more health care coverage, this health care bill makes it even more expensive.

We have also heard about the free services people get under the law, but these services are not free. Many insurers provide us -- provided us with material showing that these free services were simply added to the premiums. So instead of paying for these services as they actually use them, everyone gets to pay for this in their premium regardless of whether you benefit from it.

Now, our investigation has heard from the insurers, so today we hope to hear from those before us. We will hopefully be able to get the perspective of the actuaries before us as well as the industry representatives. Thank you again for joining us today.

I now recognize Ranking Member DeGette for her opening statement.

Ms. DeGette. Thank you so much, Mr. Chairman. Mr. Chairman, last week for the 37th time the House voted to repeal the Affordable

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Care Act. And I suppose someone -- I think you told me that we are all going to get little diamonds on our member pins when we hit 40 votes to repeal, but I am really mystified at the zeal to repeal the law, because I think we have made a lot of progress in the last 3 years, and as the law continues to be implemented, I think we will make a lot more progress.

Some of the worst abuses of the insurance industry, like rescissions of coverage for those who became ill, and the refusal to provide care for children with pre-existing conditions are no longer allowed. Tens of millions of Americans are already receiving better health insurance coverage, benefiting from free preventative care, and the elimination of lifetime coverage limits. States are taking advantage of new rate review tools, helping to slow the outlandish rates at which insurance premiums were increasing before the Affordable Care Act. And I would point out those who are complaining that insurance rates are still rising in some areas need to look at how much they have been rising in the last 10 or 15 years in this country.

Other things in the Affordable Care Act that are helping, over 3 million young adults under the age of 26 have been able to retain health insurance coverage on their parents' plan. Medicare coverage has gotten even better. Over 6 million seniors are benefiting from the Affordable Care Act closure of the part D doughnut hole. They have saved over \$6 billion in prescription drug costs. Tens of millions

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of seniors have received free preventative care under the Affordable Care Act.

And, Mr. Chairman, the early results seem to indicate that the Affordable Care Act's provisions design to reduce overall health care costs, which is what this hearing is about, are encouraging more coordinated care, moving away from payment systems that discourage unnecessary care, and paying more for quality than for quantity are working.

The National Health Expenditure Survey released in January found that health expenditures are increasing at their slowest rate in 50 years. The Congressional Budget Office reported what one analyst called "a sharp and surprisingly persistent downward slow" -- let me try that again -- "a sharp and surprisingly persistent slowdown in health care costs" since passage of the Affordable Care Act.

And last week, largely because of these changes, CBO reported a drop in deficit productions of hundreds of billions of dollars. And I think, Mr. Chairman, that these success stories are only the beginning.

In January 2014, the ACA will be fully in effect. When that happens, all Americans will, for the first time, have access to affordable health coverage regardless of age, gender or whether they have a pre-existing health condition. Millions of low income Americans will be able to sign up for Medicaid. Others, who do not

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receive coverage from their employer, will be able to shop for insurance on the competitive and transparent environment of health care exchanges, and most will qualify for tax credits to help pay for this coverage. According to the CBO, 86 percent of individuals who receive coverage through the ACA exchanges will receive tax credits, with the average credit reducing costs by over \$5,000 a year.

So, Mr. Chairman, I think the ACA represents a real and enduring improvement in quality of life. We have a lot of work to do, and that's why I am really glad that we are having this second hearing on implementation of the ACA. And I would urge the entire Energy and Commerce Committee to spend less time fighting about whether we should have this important legislation and more time talking about how we can make it work better.

We have heard people complaining that there are going to be massive premium increases, but the Affordable Care Act's tools to help cut costs, from rate review, to tax credits, to the availability of lower cost catastrophic plans for young people will ensure that health insurance is affordable.

Now, later this week, we are going to learn about the ACA premiums in my State in Colorado, but we already had more insurers than we expected, 19 of them, line up for enrollment in the exchange, so we think this should only benefit competition in Colorado. In States like Rhode Island, Washington State, and Vermont, they show no evidence that

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the worst-case scenario of rate increases, the rate shock that we hear so much about, will happen.

And so I hope that we can really take it -- take time in this hearing and as we go forward in this subcommittee, look at the good things the law is doing for the American people and figuring out how we can make health care even more available for all Americans and more cost-effective.

With that, Mr. Chairman, I yield back.

Mr. Murphy. Thank the gentlelady.

Now turn to Dr. Burgess for his opening statement, 5 minutes.

Dr. Burgess. Well, thank you, Mr. Chairman. And I appreciate the fact that we are having this hearing today. It's important, and I think we need to have this discussion.

You know, the summer of 2009 is a time that I will never forget. The town halls that summer, my little town of Denton, Texas, which normally if I could get 2 dozen people to show up, I thought I was doing a good job, we had 2,000 people show up for the town hall. And why? Because they were concerned about what they saw just over the horizon with the President's effort to take over the administration of health care in the entire country.

They weren't asking us to do that. They were saying, be careful. Do not disrupt the system that is arguably working well for 60 to 65 percent of the people in this country, but if you are going to do

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anything at all, could you please help us with costs?

Now, I think January 1st of 2014, we will begin to see how disruptive this law has been to the system in the country. We will -- we will have to wait on that day and see if I am right on that premise, but we do know today about the effects on cost, and they have not been good.

The President, in the heady days leading up to the passage and the signing of the Affordable Care Act, said 2,500 bucks is what you are going to save once this law comes into effect and online. Today, nobody's talking about saving \$2,500. In fact, most people are worried that they are going to spend that amount more. Now, it's all well and good to say that, hey, that costs would have gone up even more without the Affordable Care Act, but that's a pretty difficult premise to prove, but what people are -- do know, that they see when they open their cost of their insurance for the coming year is that it's going up significantly.

I had a youngster in my district over the weekend, mid 30s, single, he teaches school, his premiums have doubled this year. And, like many young men, he is questioning whether or not he even should continue the insurance, because after all, there is no real penalty, and if he gets sick, don't they have to take care of him anyway? That is a problem that is on the horizon that really has been poorly addressed, but this committee, in doing its work, sent out a number of letters to 17 of

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the Nation's largest health insurance companies requesting analysis of the effect of the Affordable Care Act's policies, the mandates, the taxes and fees on health insurance premiums.

The results demonstrate exactly what some of us have felt all along, that the Affordable Care Act fails to lower costs, and instead exacerbates the very problems it was sent to correct.

The greatest effects of the increase in costs from the Affordable Care Act will be felt by the very individuals that the President claimed it would help the most, that is, people in the small group market, people in the individual market, and people who lack health insurance.

Insurers in our survey reported that not only would premiums increase across almost all 50 States, but they also reported that these premiums will increase between 1 and 400 percent. Even more troubling is that the premium increases are not just contained to the individual market, but will also be felt by consumers in the small group market and the large group market. Small businesses purchasing these plans can expect premiums to go up by 50 percent on average.

Many employers in the large group markets choose to self-insure, and even these plans reported that the taxes and fees embedded in the Affordable Care Act could increase premiums from 15 to 20 percent on average.

Now, there has always been this notion that we will tax an insurance policy and that money will somehow come out of the salaries

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of the executives in the insurance company. Well, I tell you, that's a fantasy. Those charges do not come out the salaries of the executives. They are passed on to the rate payer, they are passed on to the premium payer of those insurance policies, and that effect is going to be felt in a very profound way beginning next year.

The central promise of the Affordable Care Act is the component of the law that was supposed to hold costs down is in fact going to be very detrimental to consumers, to job creators, and to health care providers.

One of the most offensive things that I hear people -- when I hear people talk about the Affordable Care Act is things are going to be free. Let me just tell you, practicing medicine for 25 years, there is nothing free that happens in a doctor's office or a hospital. You are either stealing something, even if it's just the intellectual property of the doctor or nurse who provides that care, it's paid for somewhere by someone. Unfortunately, those people aren't represented today.

I will yield back the balance of the time.

Mr. Murphy. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Waxman, for an opening statement.

Mr. Waxman. Thank you, Mr. Chairman. Our hearing today is supposed to discuss insurance coverage and insurance premiums under

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the Affordable Care Act. This is a -- not a new topic. When the Democrats, and I chaired this committee, adopted this legislation, we looked at that issue very, very carefully. We did numerous investigations of the health insurance market, and we found that premiums were rising very fast and in an incomprehensible way. Millions of Americans who had pre-existing conditions either couldn't get insurance at all or they were charged a very high extraordinary price for insurance coverage. And we also found out that even conditions where a woman might get pregnant or was the victim of domestic abuse wouldn't qualify for insurance or would have to pay more for her insurance.

Americans were paying for inadequate insurance. People were buying insurance that didn't really cover their health care needs, but it wasn't very expensive, so they thought they were covered. We learned Americans were paying very high amounts for deductibles and they had stringent annual and lifetime limits on the coverage. People didn't realize this, but a lot of the policies the insurance companies were selling were very, very limited.

So what we learned was that the market was broken. A lot of people who needed insurance badly couldn't afford it or couldn't even get it. If people had insurance, they lived with a great deal of insecurity about whether they would be able to continue to afford it.

And the Act, the Affordable Care Act, requires insurers to provide

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quality, secure coverage that is there for people when they need it. That's why the law contains numerous tools to make coverage affordable. So I was surprised last week when the Republicans on this committee ignored these provisions when they released an analysis warning of high premiums under the Affordable Care Act. This is what they are warning about. I think this is what they are hoping for, but they are going to be wrong.

The Republicans' report presented large premium increases as a certainty, but it only reached this faulty conclusion by cherry-picking data, ignoring the cost saving programs in the Affordable Care Act, ignoring the value of improved coverage available under the law.

The report, Mr. Chairman, ignored the fact that under Obamacare, the 85 percent of Americans with employer or public coverage will see little change in premiums or coverage because of this law. They will be able to keep that coverage. The report also ignored the impact of the Affordable Care Act's tax credits to help cover the cost of insurance premiums. And according to the CBO, 86 percent of the people that go to the marketplace for these individual policies will be getting tax credits, reducing the cost by an average of \$5,000 per year. These tax credits will help make insurance coverage affordable for millions.

The report, of course, ignored the impact of the small business tax credits that can cut the cost of insurance by 50 percent. It ignored the impact of competition, because when you go into that

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marketplace, you will have a number of insurance policies competing for your business. When there is competition, it will lower the cost, and CBO says in this case, by as much as 10 percent.

The Republican report ignored the fact that because of this Act, many women, older Americans and those with pre-existing conditions are likely to see their premium costs fall, because if they have insurance coverage and they are paying for it, they are paying a lot more for that coverage and they are no longer going to be required to pay more for that coverage in the future, starting in January.

The report the Republicans put out ignored the fact that many Americans pay higher premiums, but they will also be paying higher premiums because they are going to actually get better coverage.

In recent weeks, we have received some actual premium data that we can use to protest the Republicans' prediction of doom, and today my staff released an analysis of the States where insurers have submitted their premiums for 2014, five States, Vermont, Oregon, Washington, Rhode Island and Maryland, and there is little evidence in those States of a rate shock that Republicans have been predicting. In many cases, Americans will actually pay less for comparable coverage.

I would like to ask that this staff memo and a memo released last week be made part of the record, Mr. Chairman.

Mr. Murphy. Without objection.

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[The memo follows:]

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Mr. Waxman. This is going to be the true story of premiums under the ACA: better coverage, affordable rates, and protection from insurance company abuse. We need to begin to focus on the facts so we can stop misleading the American people. Thank you, Mr. Chairman.

Mr. Murphy. The gentleman's time has expired and now we will be continuing on with our other comments here. Now, we are going to talk about our witnesses here. Let me introduce each one. Our first witness is Ms. Cori Uccello. Got it right this time. She is a senior health fellow at the American Academy of Actuaries. She is the actuarial profession's chief policy liaison on health care issues. Ms. Uccello has prepared testimony and has authored, co-authored and contributed to several academy publications on various health-related issues. She was appointed to the Medicare Payment Advisory Commission, otherwise known as MedPAC, in May of 2010.

Our second witness is Chris Carlson. He is an actuary in the health care field working at Oliver Wyman. He provides consulting services to help insurers, health providers employers and State regulators. Previously, Chris worked in the industry as a pricing actuary at a Blue Cross/Blue Shield. Lately, Mr. Carlson has been assisting health care plans in developing premium rates in preparation of the market changes in 2014. He has written several reports that quantify the impact of the health insurance fees that have been widely accepted by the actuarial profession, and recently published an article

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describing the effect of age ratings compression in the American Academy of Actuaries magazine.

Our third witness, again, is Daniel Durham. He is currently the executive vice president for Policy and Regulatory Affairs for America's Health Insurance Plans, where he leads health care reform implementation efforts and policy activities. He has served in high level policy positions in the private sector as well as in the Federal Government at the U.S. Department of Health and Human Services, the Social Security Administration and the Office of Management and Budget.

And our final witness is Topher Spiro. He is the vice president for Health Policy at American Progress. Prior to joining American Progress, Spiro worked on health care reform at both the Federal and State levels. He served as deputy staff director for health policy for the U.S. Senate Committee on Health, Education, Labor and Pensions under Senator Edward M. Kennedy and Senator Tom Harkin.

I will now swear in the witnesses.

You are aware that the committee is holding an investigative hearing, and when doing so has a practice of taking testimony under oath. Do any of you have any objections to giving testimony under oath? All the witnesses responded no.

So the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony

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today? And all the witnesses have said no.

In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. Murphy. You are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. Each of you may now give a 5-minute opening statement.

Ms. Uccello, you are first.

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STATEMENTS OF CORI E. UCCELLO, SENIOR HEALTH FELLOW, AMERICAN ACADEMY OF ACTUARIES; CHRIS CARLSON, ACTUARIAL PRINCIPAL, OLIVER WYMAN GROUP; DANIEL T. DURHAM, EXECUTIVE VICE PRESIDENT, POLICY AND REGULATORY AFFAIRS, AMERICA'S HEALTH INSURANCE PLANS; AND TOPHER SPIRO, VICE PRESIDENT, HEALTH POLICY, CENTER FOR AMERICAN PROGRESS

STATEMENT OF CORI E. UCCELLO

Ms. Uccello. Good afternoon, Chairman Murphy, Ranking Member DeGette and members of the subcommittee. I am Cori Uccello, senior health fellow at the American Academy of Actuaries, which is the nonpartisan association for actuaries in the U.S. We provide objective information as policymakers and regulators work to formulate public policy. Thank you for inviting me to speak today.

New health insurance rules that apply to the individual and small group markets will go into effect in 2014. The new rules will affect average premiums, but premium changes will differ across States and individuals. The academy has not done a projection of premiums in 2014, either on a national basis or for any subgroups of the population; rather, my goal today is to provide a framework for understanding premium changes by discussing the factors that will affect premiums. I will focus most of my remarks on changes in the individual market.

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First I will discuss the factors that affect average premiums. As a reminder, premiums are set to cover the medical claims and administrative costs of the pool of individuals with insurance. In other words, premiums reflect the underlying demographics and health status of the insured population. The underlying composition of the insured population could change in 2014, due to several factors. One is the guaranteed issue provision that will prohibit insurers from denying coverage based on pre-existing conditions. Increasing the ability of high cost people to purchase coverage could put upward pressure on premiums. The individual mandate and premium subsidies will mitigate this effect by providing incentives for younger and healthier people to obtain coverage.

It's also important to consider whether individuals will shift between different types of coverage. If employers drop coverage and workers shift to the individual market, the impact on individual market premiums will depend on the demographics and health status of those shifting.

Individuals moving out of high risk pools and into the individual market will put upward pressure on premiums. Offsetting this effect in the near term will be the temporary re-insurance program.

Premiums also reflect a plan's benefit design, with more generous plans coming with higher premiums. New essential health benefit and actuarial value requirements could mean that plans will be more

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generous. While this could put upward pressure on premiums, it will also lower out-of-pocket cost sharing.

Premium changes will vary across individuals based on age, gender and health status. In most States, the compression of premiums due to the new age rating restrictions will increase the relative premiums for younger adults and reduce them for older adults. Prohibiting different premiums by gender will shift costs between men and women depending on age, and prohibiting health status rating will increase the relative premiums for healthy individuals and reduce them for those in poor health.

Although young adults not eligible for premium subsidies may be most at risk for premium increases, they will have access to catastrophic plans. The premiums for these plans can be set lower to reflect a younger enrollee population.

Premium changes will also vary by State. In States that already limit the extent to which premiums can vary across individuals, especially among those with guaranteed issue requirements, average premiums could decline as lower-cost individuals obtain coverage due to the individual mandate and the premium subsidies. In States with no or few rate restrictions, premiums are more likely to go up to reflect an influx of higher-cost individuals.

My remarks have focused primarily on the individual market. There will be premium changes in the small group market as well, but

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likely to a lesser extent. Insurers are already prohibited from denying coverage to small groups and small group plans are already more likely to meet most of the plan generosity requirements.

Most States, however, currently allow insurers to vary premiums across groups. The new rate restrictions will cause different premium changes across -- across groups. In general, the groups with the greatest increases will be the low cost groups, while those with the greatest decreases will be the high cost groups. And premium changes across groups will vary by State.

In closing, I want to, again, highlight that when examining how premiums will change beginning in 2014, it's important to understand the various factors underlying these changes. These include the effectiveness of the individual mandate and premium subsidies, the new benefit requirements, employer decisions to offer coverage, each State's current market rules, and each individual's characteristics.

Thank you, and I look forward to your questions.

Mr. Murphy. Thank you.

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[The prepared statement of Ms. Uccello follows:]

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Mr. Murphy. Mr. Carlson, you are recognized for 5 minutes.

STATEMENT OF CHRIS CARLSON

Mr. Carlson. Thank you. Mr. Chairman and members of the subcommittee, thank you for this opportunity to testify on premium rates under the ACA. My testimony will focus on factors that are affecting premium rates that have been filed for 2014, and have been made available for public review. I will also discuss the professional responsibility of actuaries that are involved in preparing and certifying these rates.

There are three specific actuarial factors of the rate filings that I would like to address, which are, the impact of changes in the population on morbidity, changes in the value of benefits, and the impact of the transitional re-insurance program.

Recall that the CBO estimated the change in premium rates in their November 2009 letter to Senator Evan Bayh. Overall, the CBO expected premium rates to increase between 10 and 13 percent. Now that filings are available, we can discuss what is actually happening to premium rates.

I reviewed the 2014 rate filings in three States: Oregon, Maryland and Vermont. In each State, I identified the top health insurers and pulled from their filings the factors described above.

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First, in Oregon, we reviewed the filings for the top three health insurers. We found that the expected change in morbidity due to new enrollees in the non-group market is between 27 percent and 46 percent. Although we note that Oregon -- the Oregon market also includes a merger with the high risk pool, which constitutes a very costly population. We also found the change in premiums due to average value of benefits ranged from an increase of 2 percent to a decrease of 17 percent.

Finally, the re-insurance program is expected to decrease rates by 10 to 12 percent. Overall, the average premium rate in these filings represents an increase of 36 to 53 percent over current premium rates.

The publication of these rates and the transparency of the process have had an immediate effect. One carrier has already expressed interest in revision to their rate filings due to concern about their rates relative to their competition and has produced reducing their rates by 15 percent.

The second State we reviewed is Maryland. We looked at the rate filings for two companies in the State and found the results to be quite divergent. One company has proposed rates that include 25 percent increase for morbidity for new enrollees, a 2 percent increase for benefits and a 4 percent reduction for re-insurance. Overall, they proposed a rate increase of 25 percent relative to current rates. The second company proposed an increase of 65 percent due to morbidity,

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a 6 percent increase for benefits and an 8 percent decrease for re-insurance. Overall, they proposed rates that are 120 percent higher than the current rates.

The final State we reviewed is Vermont, where there are only two health insurers that filed rates. Overall, the rates are expected to be consistent with the current premium rates in the market; however, it is worth noting that Vermont is already a community-rated State with guarantee issue, thus we would not have expected an increase, and in fact, some may have expected lower premiums -- premiums in the State.

The factors I discuss in each of these filings do not include the impact of age rating, therefore, for younger individuals that are affected by the age rating compression, the increases would be higher.

It is important to understand that these rates are before any consideration of the premium subsidies available in the exchanges. For the individuals that are expected to be eligible to receive premium subsidies, the amount they pay will be less, and sometimes substantially less.

Finally, I would like to add a few comments about the actuaries that have developed the rates described herein. The actuarial profession has a strong reputation of professionalism and independence. While many actuaries work and consult with insurance companies, we also work with regulators and consumer advocacy groups, and our high standards of professionalism always come first. This is

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illustrated in our code of professional conduct which, among other things, requires actuaries to act honestly, with integrity and competence, not be influenced by conflicts of interest, and only perform work where we are properly qualified.

The rates that actuaries are proposing require certification, which has components that are relevant in this discussion. The rates must be reasonable in relation to the benefits to be provided and must be neither excessive nor unfairly discriminatory. These provisions, in addition to minimum loss ratio requirements, protect consumers to ensure that they are receiving fair value and benefits for the premiums they pay.

The purpose in mentioning these issues is to help the public understand that the rate proposals that have been prepared in support of premium rates beginning in 2014 are done with the utmost of care. As actuaries, we do not take lightly the responsibility that has given us, and strive to maintain a high level of integrity and professionalism.

Mr. Chairman, again, I thank you for the opportunity to speak and look forward to answering any questions.

Mr. Murphy. Thank you.

[The prepared statement of Mr. Carlson follows:]

***** INSERT 1-2 *****

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Mr. Murphy. Now to Mr. Durham. You are recognized for 5 minutes.

STATEMENT OF DANIEL T. DURHAM

Mr. Durham. Good afternoon, Chairman Murphy, Ranking Member DeGette and members of this committee. I am Dan Durham, executive vice president for Policy and Regulatory Affairs at AHIP. I appreciate this opportunity to testify regarding the Affordable Care Act's impact on health insurance premiums.

Our members are focused on implementing all the new changes required by the ACA in 2014 in a manner that will be least disruptive and least costly to consumers and employers, and we have been working closely with Federal regulators and State regulators to identify challenges and offer constructive solutions. Health plans are committed to ensuring implementation is as smooth and possible, and are doing their part to be ready to go when open enrollment begins.

Our written testimony focuses on factors that are driving health insurance premiums, including specific provisions in the ACA, and strategies that we support for bringing down health care costs. A broad range of studies, including several commissioned by AHIP, provide insights into the likely impact the ACA will have on premiums beginning in 2014.

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An April of 2013 report by Milliman provides a comprehensive overview of ACA provisions that will impact individual market premiums next year. This report explains that covering pre-existing conditions, requiring a broader benefit package, and covering more uninsured Americans will have -- who have gone without medical costs will benefit millions of people while increasing the cost of coverage. It further emphasizes that the new health insurance tax and other fees will also increase premiums.

At the same time, Milliman indicates that other ACA provisions will make coverage more affordable, including premium and cost-sharing subsidies and the transitional re-insurance program, which will help offset the impact of high cost enrollees in the individual market.

Premiums for specific individuals will vary significantly depending on their age, gender, location, health status, income level, and what coverage they have today.

Additional studies estimate the impact on several specific ACA provisions. The new health insurance tax, the age rating restrictions, and the minimum benefit requirements that will directly impact premiums.

The ACA insurance tax begins in 2014 and will exceed \$100 billion over 10 years. While the tax is assessed on health plans, it will increase costs for individuals and small businesses, Medicare Advantage beneficiaries, and State Medicaid programs. CBO has stated

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that this tax will largely be passed through to consumers in the form of higher premiums. An Oliver Wyman analysis estimates that the tax will increase the cost of family coverage in the individual market by \$270 in 2014, and by an average of \$5,080 over 10 years.

We strongly support bipartisan legislation to repeal this tax introduced by Congressmen Boustany and Matheson.

Regarding the age band compression, beginning in 2014, the ACA will allow health insurance rates to vary based on an enrollee's age by a ratio of no more than three-to-one. This is a dramatic change from the age bands of five-to-one or more currently effective in 42 States. We are deeply concerned that the ACA's restrictive age band will cause premiums to increase dramatically for younger people.

An Oliver Wyman study concludes that young single adults age 21 to 29 with incomes beginning at about 225 percent of the Federal poverty level can expect to see higher premiums than would be the case absent the ACA, even after accounting for the presence of premium assistance. We thank Congressmen Gingrey and Matheson for introducing bipartisan legislation to address this concern.

Beginning in 2014, the ACA will require health plans to offer essential health benefits package covering a broad range of mandated benefits, some of which typically are not included in current individual and small group policies. This will require consumers to buy up coverage beyond what they have today. A variety of studies

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commissioned by State departments of insurance and State exchange boards have found that the EHB requirements will result in higher premiums.

In conclusion, additional challenges are raised by the underlying cost of medical care. Recognizing the need to reduce costs, our members have been very proactive in advocating solutions to this problem. AHIP's board of directors recently approved a series of strategies to bring down costs and to make coverage more affordable by tackling barriers to transparency, facilitating benefit modernization, and advancing bold structural reforms.

Thank you again for this opportunity to testify.

Mr. Murphy. Thank you, Mr. Durham.

[The prepared statement of Mr. Durham follows:]

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Mr. Murphy. Mr. Spiro, you are recognized for 5 minutes for your opening statement.

STATEMENT OF TOPHER SPIRO

Mr. Spiro. Mr. Chairman, Ranking Member DeGette, thank you for the opportunity to testify today about the premium impact of the Affordable Care Act.

When thinking about this issue, it is important to be clear about who will be affected by reforms and how. Nearly 90 percent of insured Americans are covered by employer plans, Medicare, Medicaid or other government programs. These Americans will not be affected by reforms to non-employer coverage under the ACA.

Now consider the remaining 10 percent of the population. Concern is focused on the premium impact for young adults with higher incomes who will not be eligible for full subsidies, but the fraction of the population that now has non-employer coverage is between the ages of 19 and 29 and has income above 250 percent of the Federal poverty level is 0.5 percent.

By contrast, the Affordable Care Act will benefit tens of millions of Americans, who have been offered Swiss cheese insurance, who were priced out of the market or who were denied insurance all together. All Americans will benefit from the security and peace of mind of

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knowing that if misfortune strikes, they will not suffer financial catastrophe.

Studies on this topic always omit key factors that greatly influence the costs people would pay out of pocket. While some of the studies take into account some of the factors, none of them take into account all, or even most of the following factors.

First, of course, most important, premium tax credits. According to the Urban Institute, 70 percent of young adults who now have non-employer coverage will be eligible for Medicaid or exchange subsidies; the availability of parents' coverage for young adults up to age 26; the availability of catastrophic plans for young adults up to age 30; insurance for insurers that incur high costs, known as re-insurance. For example, in California, re-insurance is projected to lower premiums by 9 percent. Administrative savings. For example, in California, administrative savings are projected to lower premiums by 4.5 percent. Finally, the medical cost trend that would occur anyway in the absence of the Affordable Care Act. For example, in California, the projected premium increase in the absence of the ACA is 9 percent.

Because these studies are not reliable, it is instructive to compare some of them with actual rate filings and analyses by independent experts. A recent report by the Lewin Group and Optum projects that the pool of insured people will become less healthy

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overall, increasing average costs by 32 percent, but the independent Congressional Budget Office came to a different conclusion on this point, finding that the influx of new enrollees will actually lower premiums by 7 to 10 percent on average. This huge discrepancy seems to be driven by the Lewin report's assumption that there will be an influx of unhealthy people from large employers.

To illustrate how the Lewin report is speculative and incomplete, consider actual rate filings in Washington. The Lewin report projected an average cost increase of 14 percent, but we now know that many Washingtonians will actually see lower premium rates. The average proposed premium increase is 7 percent, less than the projected medical cost trend that would occur anyway in many States.

The experience in Washington is noteworthy, because just last year the executive vice-president of the Blue Cross insurer warned that premiums would increase by 50 to 70 percent. In other words, the hysteria did not match up with the reality.

One recent development that is encouraging is that competition is already lowering premiums, because consumers can more easily shop for and compare plans. In Oregon, when premium proposals were posted publicly online, two insurers immediately lowered their proposed rates by 15 percent and more to remain competitive. Clearly these insurers had been inflating their projected costs. One insurer said its actuarial projections had been too pessimistic.

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Finally, it is important not to lose sight of the benefits of insurance market protections and improved coverage. Exchanges will offer brand-new, modernized products. Comparing their prices to the prices of old, Swiss cheese insurance products is like comparing the price of an iPhone to the price of a Sony Walkman. It is not a meaningful comparison.

Nor should we focus exclusively on premiums, which are not consumers' only costs. While providing more coverage increases premiums, it lowers out-of-pocket costs. A narrow focus on premiums also ignores the millions of Americans who have been shut out of a dysfunctional market.

Furthermore, premiums reflect a snapshot in time. Just because you are young and healthy now does not mean you will always be.

In the current dysfunctional market, premiums can spike for both individuals and small businesses --

Mr. Murphy. The gentleman's time has expired. Can you just summarize the rest of your --

Mr. Spiro. I am almost done.

Mr. Murphy. Okay.

Mr. Spiro. -- as a result of many factors that are totally beyond their control. In the modernized market when people get sick or are diagnosed with a medical condition or just grow older, they will not experience rate shock.

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Mr. Chairman, this concludes my testimony. I am happy to answer questions.

[The prepared statement of Mr. Spiro follows:]

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Mr. Murphy. I appreciate all of -- the testimony from all of the witnesses today. We will go on to some questions here, and I will start off with 5 minutes for myself here. Although I am reminded sometimes, like when we have economists in front of us, they all talk about you don't see a one-handed economist because they always say, "On the other hand." So this will be important to get some information from you all.

Mr. Carlson, today Mr. Waxman released a staff memo we had put in the record saying that the customers in Rhode Island, Vermont, Maryland, Oregon and Washington can expect large rate decreases. In your testimony, however, you note that you reviewed the actual rate filings in some of these States, Oregon, Maryland and Vermont. Am I correct?

Mr. Carlson. Yes, that's correct.

Mr. Murphy. And your testimony States an average premium rate in these files represents an increase of 36 to 53 percent over current premium rates. Can you elaborate on this?

Mr. Carlson. Well, that information was from the -- several -- I believe that was the Oregon rate filings that I was mentioning there. And based on all the factors that they have in their filing, including trend rates, all of the assumptions due to the changes in the market, market rules, all those factors combined resulted in rates for a similar benefit package of 36 to 53 percent increases. So having not --

Mr. Murphy. That's for Oregon? That's for Oregon, you are

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saying?

Mr. Carlson. I believe that was Oregon, yes.

Mr. Murphy. Okay.

Mr. Carlson. Having not seen the report that was put out today, I can't -- I can't comment on -- on how those numbers relate.

Mr. Murphy. I see. But I just want to make sure I understand. In Oregon, you said there's probably going to be a premium increase?

Mr. Carlson. Yes. That's correct.

Mr. Murphy. Right. Now, in Maryland you note that one insurance proposed an overall rate increase of 25 percent. Am I correct?

Mr. Carlson. That's correct, yes.

Mr. Murphy. And another insurance proposed rates that are 120 percent higher than the current rates in the market?

Mr. Carlson. Yes.

Mr. Murphy. Correct, too? Can you elaborate on these findings? Basically you said Maryland's going to see a premium increase, but can you elaborate on --

Mr. Carlson. Well, you know, I think the important point to take from there is that the rate increases are going to differ substantially based on what State you are in, what kind of market you are in, the level of benefits that you currently have, and, you know, other factors as far as, you know, the insurer that is showing a very high rate increase, they may have been able to enroll a much healthier population

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in the past, therefore, when they get a normal mix of membership, they end up with a much higher rate increase than if they had started with an average population.

So, you know, no individual is going to get the same rate increase. It's going to differ greatly from one -- one individual to the next.

Mr. Murphy. I see. All right. Mr. Durham, last week the committee released its findings on the investigation we conducted in the internal analysis of how premiums will be impacted by the Affordable Care Act, and after reviewing the internal analysis of the nation's largest insurers, we saw that massive premium increases are likely. Can you provide your view on the likelihood of this?

Mr. Durham. Well, I read the report from the committee and looked at the great degree of variability in premiums depending on the individual's age, their location, their health status, and it's similar to what we find in our Milliman report that I described in my testimony. again, a great degree of variability here in terms of how plans are building their premiums in 2014. There are certain things that are sure to include increases in premium costs, and those include the health insurance premium tax, other fees and assessments, the benefit buy-up, since many, particularly in the individual market, have coverage that is less generous than coverage that's required under the ACA, and also the age band compression, where younger individuals are likely to face much higher --

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Mr. Murphy. So it's safe to say in States that already have a number of these restrictions, they -- they will not see a lot of movement, in the States that do not have those, they will see a lot of upward movement --

Mr. Durham. That's correct.

Mr. Murphy. -- in general? Thank you.

Mr. Durham. And on -- on the other side of the coin, the Milliman report also goes into detail about the premium tax subsidies that will help lower income individuals, which -- which are very important, and also other things that will lower premium costs, such as competition in the marketplace that was mentioned earlier.

Mr. Murphy. Sure. Competition helped lower things in the Medicare Part D plan, which is often bashed, which -- by 41 percent below, I think it is.

But let me ask this real quickly, Ms. Uccello and Mr. Durham, because you both stated in your testimony about -- you talked about the individual mandate effect on this, Ms. Uccello, and Mr. Durham, you made a reference to people between 21 and 29.

Are a lot of these estimates based upon the assumption that all those people will sign up or do they also take into account if people see rates go very high for themselves, regardless of subsidies, they may not show up, may not sign up, and then that will affect rates as well?

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Ms. Uccello, can you comment on that?

Ms. Uccello. I can't comment directly on -- on the different projections, but I assume that each of those projections makes assumptions regarding participation in the -- in the market. And as you were alluding to, key to the viability of this program is attracting the lower cost people into the pool to help offset the higher costs of the -- of those other people.

Mr. Murphy. Thank you. I am out of time, but if I could ask, Ms. Uccello, if you could provide a little more information to this committee on what means, and Mr. Durham, elaborate on those two points, that's very important to us, in terms of the assumptions with regard to people signing up by the mandate.

I now recognize -- I am out of time -- Ms. DeGette for 5 minutes.

Ms. DeGette. Thank you very much, Mr. Chairman.

Ms. Uccello, just like Mr. Carlson, you are also an actuary. Is that correct?

Ms. Uccello. That is correct.

Ms. DeGette. And you -- you testify -- it sounds to me like the gist of your testimony is we are going to have sort of a rebalancing of rates, because in the exchanges at least and in these -- in these plans, we are going to be covering everybody. Is that right?

Ms. Uccello. Yes.

Ms. DeGette. So right now what happens is if an individual with

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a pre-existing condition, or a woman, or -- or somebody -- somebody who's older, people like that, if they choose to get insurance, their insurance will be more expensive, because the pool is smaller. Is that right? So -- so cheaper people aren't in those pools right now. I think you said that, too, Mr. Durham, as a matter of fact.

Mr. Durham. Right. I think the concern is --

Ms. DeGette. For some people, for some people, insurance is much more expensive now because health care costs more for them, right?

Ms. Uccello. There are some people -- depending on State, what State and the rules that apply in that State, some people with pre-existing conditions may not have access to coverage at all --

Ms. DeGette. Right. But what I am saying is --

Ms. Uccello. -- they may be paying more.

Ms. DeGette. What I am saying is so when you put everybody into the pool, some people will pay higher insurance rates, some people -- like young people.

Ms. Uccello. Yes.

Ms. DeGette. -- and some people will pay lower insurance rates. Is that right?

Ms. Uccello. Yes.

Ms. DeGette. And that's because the pool is bigger, right?

Ms. Uccello. It's -- it's part -- it's more about the distribution of who's in the --

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Ms. DeGette. Okay. Right. And so there are going to be a lot of people who are paying lower insurance rates under the Affordable Care Act, correct?

Ms. Uccello. Depending on the certain -- the particular circumstance, premiums go down for some people --

Ms. DeGette. For some people.

Ms. Uccello. -- and for others go up.

Ms. DeGette. And in addition, other people, in fact, the majority of people who will now be going into these exchanges will be subsidized, will be eligible for the tax credits, correct?

Ms. Uccello. I don't know the specific share, but the people who are eligible will -- will indeed see downward pressure on their -- their net premium.

Ms. DeGette. Spoken like a true actuary.

Mr. Durham, I wanted to ask you, because I think you would agree, since you have been looking at these issues, health insurance premiums have increased about 10 percent a year on average for the last 10 years from 1999 to 2009, correct?

Mr. Durham. Yeah. Premiums reflect the average cost of care, and so if --

Ms. DeGette. Right. They have been going up on an average of about 10 percent per year for the last 10 years or so. Is that right?

Mr. Durham. Right.

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Ms. DeGette. Correct?

Mr. Durham. Reflecting the average cost --

Ms. DeGette. Yes or no.

Mr. Durham. Yes.

Ms. DeGette. Thank you. And so you wouldn't expect to see a dramatic reversal of this trend right now, would you?

Mr. Durham. Oh, we have seen some reversal because of reduced utilization due to the downturn in the economy.

Ms. DeGette. Oh, okay. Okay. So -- so that's because people aren't buying insurance, right?

Mr. Durham. Or they are not using insurance as much. But we have seen --

Ms. DeGette. Yeah. So they are -- they are not -- so -- so for once, and don't hold me to this, I actually agree with Mr. Burgess, which is, you -- nothing is ever totally free, so if somebody doesn't get insurance and they get sick, somebody is still paying for their care. Is that correct?

Mr. Durham. There is some payment through uncompensated care, yes.

Ms. DeGette. Yes. Yes. Someone's still paying for it. And that's often the taxpayers, right?

Mr. Durham. Right. And it often gets shifted to private plans as well, which increases premium costs.

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Ms. DeGette. It -- so if it gets shifted to private plans, that increases the premium costs for those people, right?

Mr. Durham. Correct.

Ms. DeGette. Yeah. So I wanted to ask you a question, Mr. Spiro. Have you looked at -- have you looked at the memo that the Democratic staff released this morning about the results from Oregon, Washington, Maryland, Vermont and Rhode Island?

Mr. Spiro. I have not, but I am broadly familiar with the rate filings in those States.

Ms. DeGette. So what they found out was in Oregon, rates for people who stay in comparable plans offered by their current insurance are expected to fall by about 7 percent, and in Washington, consumers will see average reductions by 25 percent, and -- and in Vermont, a similar result. What is your reaction to this kind of a finding?

Mr. Spiro. I think, number one, it shows that some of the concerns have been inflated, in that in some of these States, the insurance executives, as I mentioned, were projecting increases of 50 to 70 percent, and it turned out not to be the case, so their concerns were overblown.

Second, I think it shows that there is -- you know, despite actuaries making it seem like a science, there is a lot of flexibility and fudge room in what they do, and that projected costs based on, you know, very minor changes in assumptions can vary wildly.

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RPTS KERR

DCMN SECKMAN

[5:00 p.m.]

Ms. DeGette. Just one last question. You would expect competition to -- you would expect competition to give a more apt competitive insurance price, right.

Mr. Spiro. Yeah. I think the interesting thing in Oregon, as I mentioned is, immediately after the rates were posted online, and not every State is as transparent as Oregon but -- so that is something to be encouraged, but once the competitors saw those rates being posted, they immediately requested to the insurance commissioner that they be able to propose lower rates.

Ms. DeGette. Thank you.

Mr. Spiro. And those are just the proposed rates, so they haven't even been reviewed by the insurance commissioner yet.

Mr. Murphy. Thank you. Time has expired.

Now recognize Dr. Burgess for 5 minutes.

Dr. Burgess. Thank you, Mr. Chairman. Mr. Durham, I wasn't going to go here, but since I was provoked by the ranking member, let's go here for just a moment. Cost of people who show up with no insurance does cost those who have insurance something, doesn't it?

Mr. Durham. Yes, sir.

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Dr. Burgess. But the greater amount of cross-subsidization that occurs is between the public plans, Medicare, Medicaid, and what they don't pay in covering the cost of the care rendered. Is that a fair statement?

Mr. Durham. Correct. And that is often again passed through to practice.

Dr. Burgess. And what is -- what is the larger group? People who show up in the emergency room without an insurance policy or Medicare and Medicaid that show up in the emergency room of the hospital?

Mr. Durham. Medicare and Medicaid.

Dr. Burgess. Yes, absolutely. That is the 9 percent cross-subsidization. We like to push that off onto the uninsured, but in fact, it is the Federal Government not paying their fair share of the note; is that not correct?

Mr. Durham. Correct.

Dr. Burgess. Well, look, Mr. Spiro, let me just ask you, I have got a -- your biography, I guess, in front of me. You are not a physician; is that correct?

Mr. Spiro. That is correct.

Dr. Burgess. But you did serve some time in the Senate Health, Education, Labor and Pensions Committee?

Mr. Spiro. Correct.

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Dr. Burgess. Was that time that you served there while a law that is now known as Affordable Care Act was under consideration?

Mr. Spiro. Yes.

Dr. Burgess. This is a good day for me because you may recall that the House had hearings and marked up a bill called H.R. 3200, and do you recall what happened to H.R. 3200?

Mr. Spiro. I was on the -- I was a staffer on the Senate side.

Dr. Burgess. Well, the correct answer is it vaporized. It went off into the ether. No one has seen it since November of 2009 because the law that we are talking about, the Affordable Care Act, was actually a Senate bill; is that not correct?

Mr. Spiro. It was a Senate bill, but it was very much informed by --

Dr. Burgess. Okay. Yes or no. It was a Senate -- it was a Senate bill.

Mr. Spiro. But to finish my answer, there was --

Dr. Burgess. The point I -- I control the time.

Mr. Spiro. May I finish?

Dr. Burgess. The point I need to make here is that there are some things that many of us have wondered about over here on the House side. Now, we have just been told that the House has voted to repeal all or a part of the Affordable Care Act some 37 times, but there was one part of the Affordable Care Act that everybody agreed with, the 1099

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provision. Do you remember the 1099 provision, the business-to-business transaction greater than \$600 that was going to generate the issuance of a 1099 form?

Mr. Spiro. Yes.

Dr. Burgess. Was that part of the work you did in your Senate committee?

Mr. Spiro. No. Part the work I personally did, I was not a tax counsel, but I am familiar with the provision.

Dr. Burgess. So that is a portion of the Affordable Care Act that again there was broad bipartisan agreement that this was an onerous burden on -- as a paperwork requirement on the businesses of this country, correct? And the President signed it into law. The President agreed with the Congress when that repeal portion came through

Now, there is another bill that was voted on January 1st of this year called the -- we called it a fiscal cliff bill. I actually voted against it, but one of the parts of it that I actually liked was the repeal of something known as the Class Act.

Now, that was one of Senator Kennedy's projects. Did you work on the Class Act when you were on the Committee of the Health, Education, Labor and Pensions?

Mr. Spiro. I did not, but I am familiar with it.

Dr. Burgess. Well, the Class Act was again one of those aspects

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of the Affordable Care Act where there was broad agreement between Republicans and Democrats that this was something that would be better off repealed. And again, I guess the President agreed because the President signed that, did he not?

Mr. Spiro. I think there was an acknowledgment that as structured, the Class Act, because it did not have an individual mandate, that it would spiral out of control, so --

Dr. Burgess. Well, I think the language that the chief actuary used, because we heard him here in this very committee, that it was the classic insurance death spiral that the Class Act was -- was fixing to inaugurate.

Well, what about the pre- -- we have talked a lot today about pre-existing conditions. Were you part of the committee that worked on the pre-existing conditions --

Mr. Spiro. Yes.

Dr. Burgess. -- program? Well, do you know what has happened to the Federal pre-existing conditions program since January or February of this year?

Mr. Spiro. A lot of things have happened with --

Dr. Burgess. Well, they are out of money, and so people who were hoping to age into that system, and we have heard from them in this -- already in the health subcommittee, they are now frozen out. There is no -- they cannot be taken into that system, so they are

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basically on their own between February 1st and January 1st of 2014.

Were you aware of that?

Mr. Spino. Do you want to provide more appropriations for that program?

Dr. Burgess. Well, I was hoping to move all of the money from the prevention fund into the pre-existing plan, but I haven't quite been able to do that, and therein is the problem. You knew, when this part of the law was drafted in committee, you knew that it was woefully underfunded. There is no one in the world who thought \$5 billion was going to be enough to do what you said it was going to do.

Mr. Murphy. Gentleman's time has expired.

Dr. Burgess. Do you have a thought on that?

Mr. Spiro. The bill was designed in such a way so that it would reduce the deficit, and it met that test. Now, could it have provided more funding for the PCIP program? Yes. Would you have supported the program and the bill if it had done so?

Dr. Burgess. Sir, with all due respect --

Mr. Murphy. Time has expired.

Dr. Burgess. I didn't support a single part of this, but I will save my followup questions for a second round.

Mr. Murphy. Time has expired.

Mr. Waxman is recognized for 5 minutes.

Mr. Waxman. Thank you, Mr. Chairman.

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It is interesting that my colleague talked about the things for there was a bipartisan consensus like to take away the burden on businesses to file 1099s, but where was the bipartisan consensus to protect people from being charged more money or denied insurance because of pre-existing conditions?

Dr. Burgess. Waiting on you --

Mr. Waxman. Mr. Chairman, it is my time. There was no bipartisan consensus for that. All they wanted was to protect the industry, the businesses. Fine. We all agreed to do that, and we are going to make other changes in this law.

Mr. Carlson, I want to ask you about your testimony. We looked it over, and I think that you -- you got this to us very late. We just got it today. The rules require you to put it in earlier, but -- so we are at somewhat of a disadvantage, but your testimony contains a review of premiums in three States recently released filings of proposed premiums, and you state that the average premium rates of the top three insurers in Oregon represent an increase of 36 to 53 percent over current premium rates. I would like to ask you a few questions about that.

Did you separate out the bronze, silver, and other levels of plans from your calculations of the average premium and changes in premiums?

Mr. Carlson. What I looked at was kind of the base rate. So as --

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Mr. Waxman. In other words, you didn't. You looked at a base rate, but there are several different kinds of plans under the Affordable Care Act. Did you do any comparison of the current rates of plan with comparable actuarial value to silver and bronze plans to the proposed rates of silver and bronze plans that will be available in the marketplace?

Mr. Carlson. I relied upon what was in the filings.

Mr. Waxman. But the law requires that there be several plans, a silver and a gold plan and a bronze plan, and they all have to provide basic services but they relate to how much are the out-of-pocket costs. Did you look at those different plans in a different way or you treat them all the same?

Mr. Carlson. Well, I looked at the average plan, so, you know, obviously, each of those plans are --

Mr. Waxman. You didn't look at an analysis then if people switched to the lowest cost silver and bronze plans offered in the marketplace; is that right?

Mr. Carlson. Well, if they were to do so, they would also, you know, their benefits would be reduced as well as their premium.

Mr. Waxman. Yes, but you didn't look at that. Some people would choose to do that. They want a lower premium, so they are willing to take a lower plan. That is a reasonable thing to do, isn't it, have a choice?

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Did you make any attempt to calculate the savings individuals might see because their improved coverage would lead to a reduction in out-of-pocket spending?

Mr. Carlson. No, I didn't consider the out-of-pocket spending.

Mr. Waxman. Did you estimate the impact of premium tax credits available in the marketplace on effective premiums in Oregon?

Mr. Carlson. Well, I mean, I am just looking at what the premium rate the insurance company is going to charge, not what the consumer is going to actually pay.

Mr. Waxman. Well, I think what this hearing is supposed to be all about is what consumers might expect. So you didn't look at what a lot of consumers will appreciate, which is a lower cost to them because of the premium tax credit.

Your testimony also differs in many important ways from the supplemental report that we put out. I know you haven't had a chance to do it, but our memo found that the average consumer currently enrolled in a bronze comparable plan would see a rate decrease of 11 percent and save \$470 annually if they stay with the same insurer. If they switch to a lower cost bronze plan, consumers would save an average of 32 percent or over \$1,300 annually. I want to just bring this to your attention because there is a more complete analysis.

Mr. Durham, you represent the insurance industry. Does the insurance industry support the full repeal of healthcare reform that

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the Republicans have voted on 37 times?

Mr. Durham. We are focused like a laser on implementation. This is the law of the land, and our plans are working around the clock to --

Mr. Waxman. Does your industry support repeal of the law?

Mr. Durham. We haven't taken a position on repeal. We are focused on implementation.

Mr. Waxman. What you don't like is the tax on insurance companies.

Mr. Durham. We would like to see --

Mr. Waxman. You would like to see that changed.

Mr. Durham. Yes, because --

Mr. Waxman. You don't want the whole law thrown out.

Mr. Durham. -- adds to the cost of premiums and makes premiums less affordable.

Mr. Waxman. I think your position shows how out of the mainstream my Republican colleagues are with their continuing push for full repeal of healthcare reform. I don't understand why Republicans would continue to vote for healthcare repeal that would cost 25 million Americans to lose health insurance coverage, increase the cost for millions of Medicare beneficiaries and increase the Federal deficit. My time is expired. I yield back.

Mr. Murphy. Gentleman's time is expired.

Now recognize Mr. Harper for 5 minutes.

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Mr. Harper. Thank you, Mr. Chairman.

And thank each of you for taking your time to be here. This is something we are dealing with in every State, in every district. And for me, the calls began even before Obamacare was passed back in 2010 because people were worried about what was going to happen with the -- their premiums, how they were going to be able to pay either the fine or provide health insurance when some of their businesses were on a very marginal rate.

And Mr. Spiro, listening to some of the information brings back a lot of memories, but when we were calculating the price on this, the plan did not include SGR, did it? That was the cost to fix the doc fix, that was not a part of the plan, was it? That was not included in the calculation for the price.

Mr. Spiro. The SGR is still part of current law.

Mr. Harper. Okay. My point is we didn't solve that because it would have driven up the cost, the price tag. I mean, it wasn't -- it wasn't included in the law that came out, was it?

Mr. Spiro. No, it was not.

Mr. Harper. Okay. You know, we are -- you know, when you talked and you said something about additional money to fund preexisting, how do you feel about doing away with the preventive care slush fund that Sebelius has and using that money to help with preexisting?

Mr. Spiro. How do I feel about that?

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Mr. Harper. Yeah. I mean, you are sitting there talking about it. Do you support doing away with the preventive care fund and moving that money over to help those that need it most in preexisting?

Mr. Spiro. As you may know, I worked for Chairman Harkin, so I support the prevention public health fund.

Mr. Harper. Okay. Even though that is being used for things that truly are not for preventive care. You have seen some of that already.

Mr. Spiro. Being used for evidence-based practices to lower the cost of healthcare and improve --

Mr. Harper. Okay.

Mr. Spiro. -- qualify of healthcare.

Mr. Harper. So the money used for lobbying for soda tax that came out of preventive care fund or that that was used for pet neutering programs, those are not -- you consider that part of importance for preventive care?

Mr. Spiro. I don't know what you are referring to.

Mr. Harper. Okay. Well, it is there.

And if I may, Mr. Chairman, I am going to yield to Dr. Burgess.

Dr. Burgess. I thank the gentleman for yielding.

Mr. Durham, let me -- let me ask you a question on preexisting conditions. Because we were told in the run up to pass the Affordable Care Act that there were 8 to 12, 15 million people who had preexisting

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conditions and as a consequence could not get insurance. As of January 1st or January 30th when the program closed to new folks, do you know how many people were in -- receiving insurance through the preexisting pool?

Mr. Durham. I believe it was around 135,000.

Dr. Burgess. So how do you explain the discrepancy between 8 to 12 to 15 million people who we were told in the run up to this law, and 100,000, 150,000 that are actually -- were actually in the pool when the doors closed?

Mr. Durham. I don't have an explanation for that?

Dr. Burgess. Well, wouldn't part of the explanation be in the large group market, under ERISA regulations, there are periods called open enrollment periods, where people who are hired onto say a large telecommunications company, they are hired on, they get on the insurance, if they have a preexisting condition, are they what, are they fired, are they turned down or what, what happens to them? They get insurance, don't they?

Mr. Durham. Yes, through their employer.

Dr. Burgess. And that is one of the issues. All of the debate leading up to the passage of the Affordable Care Act conveniently ignored that, yeah, here is a group of people who have a problem, people in the individual market. They have a preexisting condition, they get frozen out of market, but people in the large group market, because

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of some existing Federal regulations, some of which I have a problem with, to be perfectly honest, but nevertheless, they get coverage when they get hired onto one of the multi-State corporations; is that not correct?

Mr. Durham. That is correct.

Dr. Burgess. So, the problem with preexisting conditions was actually one that perhaps was quite manageable, I would submit. It never required a new Federal agency to be stood up, and that is where most of the dollars in the PCIP program were wasted setting up a new Federal agency. It would have been far better served to help those States that already had risk pools of reinsurance or some other novel approach to help someone in the individual market who didn't have coverage, but for whatever reason, we decided that we needed a new Federal agency because I guess we didn't have enough already; is that right?

Mr. Durham. I can't comment on the specific administrative side of the PCIP program.

Dr. Burgess. Well, Mr. Spiro may have some recollection about that from his time on the committee, but we have already visited about that, so I will yield back. I did want to make that point, though. There is -- the folks who have preexisting conditions are rarely in the large group market. They tend to be in the small group market and the individual market, and that was is a fixable problem --

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Mr. Murphy. Time expired.

Dr. Burgess. -- had the Congress had the will to do that.

Mr. Murphy. Okay. Gentleman's time expired.

I recognize Mr. Butterfield for 5 minutes.

Mr. Butterfield. Thank you very much, Mr. Chairman.

Thank all of you for your testimony today. We have heard a lot today about premiums under ACA may actually increase, and a lot of these claims aren't accurate, in my opinion, because they don't take into account factors like the tax credits that will be available to many enrollees to reduce the cost of coverage. But some of this discussion simply misses the point.

Under ACA, millions of Americans will have access to much better coverage, so even if they pay higher premiums, they will get a lot more for their money. Let me start off with Mr. Durham, if I can.

Your testimony puts this in what I call clinical terms. It refers to the Affordable Care Act's minimal actuarial value requirements. In plain English, what does this mean?

Mr. Durham. That is the percent of total healthcare cost that is paid by the plan versus the insured, so a minimum of 60 percent actuarial value means the plan picks up 60 percent of the total cost. The beneficiary pays the other 40 percent.

Mr. Butterfield. Has your industry projected with any certainty about how many more people will have insurance as a result of the

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Affordable Care Act?

Mr. Durham. We have seen CBO projections in terms of --

Mr. Butterfield. Do you accept that projection as valid for planning purposes within your industry?

Mr. Durham. Generally, yes.

Mr. Butterfield. And how many people do you project will get insurance?

Mr. Durham. Well, let me see. I have got the latest CBO projections here with me. They estimate that -- it looks like, in 2014, there will be 9 million additional Medicaid and SCHIP; 2 million will lose nongroup coverage; 7 million will gain coverage through the exchange.

Mr. Butterfield. But the industry is preparing for a large influx of new enrollees in the -- in the exchange.

Mr. Durham. Well, that is our hope. And our main concern is that if premiums are not affordable, then those younger and healthier will opt not to purchase coverage, stay out, and that will deteriorate the risk pool.

Mr. Butterfield. And that is why you focused on implementation. You want this thing to work, don't you?

Mr. Durham. Yes. Our plans are competing in this new marketplace and have been working on implementation round the clock to get ready for the October 1 open enrollment.

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Mr. Butterfield. And the tax credits that you will be getting to assist with these premiums, that is money. That is real money that your companies will spend and use to -- for your overhead and for other things that you do.

Mr. Durham. Those tax credits will not reduce the premium cost, but they will help lower-income individuals pay for premiums, that is correct. But they do -- they do phase out rapidly, so by the time you get up to around, according to CBO, about 250, 300 percent of Federal poverty level, those premium tax cuts are only paying for 40 percent of the premium, and so that is worth to note as well.

Mr. Butterfield. Do you have any idea what the average premium will be, let's say for a 35-year-old single healthy adult in the average State?

Mr. Durham. The average premium, I don't have that in front of me. I think for CBO's estimate, it is \$5,200.

Mr. Butterfield. And Ms. Ucello, do you have any projection on the average premium cost for a single adult?

Ms. Ucello. No, and I would argue that there is no such thing as average.

Mr. Butterfield. I think Kaiser comes out with like \$330 a month, which is \$4,000 a year or something. You are saying --

Ms. Ucello. We have not done any projections.

Mr. Butterfield. Because of the variations between the States

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and the different --

Ms. Ucello. Across individuals and States, exactly.

Mr. Butterfield. All right. So back to you, Mr. Durham. So, under the Affordable Care Act, plans on the exchange must offer policies that cover at least 60 percent of healthcare costs; is that correct?

Mr. Durham. That is correct. That is the minimum actuarial value.

Mr. Butterfield. But it can go up from there to 90 percent of the cost.

Mr. Durham. That is correct.

Mr. Butterfield. We have heard a lot of furor from my friends on the other side in this hearing and in previous hearings about potential large increases in premiums, but Mr. Spiro, your testimony walks through why some of these concerns seem to be overblown. For starters, people who currently have employer coverage, like Medicare and Medicare and other public coverage, are unlikely to be affected by premium changes; is that correct?

Mr. Spiro. That is correct. It is almost 90 percent of the American population.

Mr. Butterfield. And much of the remaining population, women and older people and people with preexisting conditions are likely to see lower premiums and not higher premiums. Would that be correct?

Mr. Spiro. Correct. It depends, as Cori has mentioned, it

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depends on a lot of different factors. The group of concern would be young adults with higher incomes who don't qualify for full subsidies, and in my testimony, I said that the estimated fraction of the population that that is 0.5 percent.

Mr. Butterfield. Mr. Spiro, if this act was completely repealed, what would happen to the number of uninsured people in our country?

Mr. Spiro. Relative to the act being in place, I believe CBO's latest estimate, if I can borrow this --

Mr. Durham. Sure.

Mr. Spiro. Is that, you know, within 10 years, the Affordable Care Act will reduce the number of uninsured by 25 million. Now, it would be much higher if all States expanded their Medicaid programs, so --

Mr. Butterfield. That was going to be my final question.

Mr. Spiro. And I expect that to be the case. Over time, States will realize what a good deal it is, how good it is for their economies, so I expect every State will eventually take up the expansion. And when CBO estimated on that basis, you know, the reduction in the number of uninsured was over 30 million.

Mr. Butterfield. When you served on the Senate committee that helped put the finishing touches on this thing, did you ever imagine that States would decline to expand their Medicaid program to cover poor people within their States?

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Mr. Spiro. Well, first, I never imagined that the Supreme Court would make that expansion a voluntary option. Now, I -- I don't think it is wise for States not to expand. One reason, since we are talking about premium impact, is that actually, in States that do not expand their Medicaid programs, premiums will rise in the exchanges.

Now, why is that -- why is that connected? It is because on average people who are lower income are sicker, it is a less healthy population, so if they are being covered under the exchanges, rather than under Medicaid, premiums are going to rise slightly in the exchanges, so I think it is an unwise policy --

Mr. Murphy. Gentleman's times has expired.

Mr. Spiro. -- not to extend Medicaid program.

Mr. Murphy. Mr. Long is recognized for 5 minutes.

Mr. Long. Thank you, Mr. Chairman.

Mr. Spiro, you worked on the Hill up here and were a staffer. If you were a staffer today and wanted to get information on what your healthcare was going to cost you January 1st of next year, were would you suggest I go?

Mr. Spiro. I am sorry, can you repeat the question?

Mr. Long. If you -- my 5 minutes will be up. If you were working on the Hill today and you go to the Member of Congress -- you worked for Senator Kennedy; is that right?

Mr. Spiro. Right.

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Mr. Long. And you go to Senator Kennedy and you say, what is my health insurance? They have got this new Affordable Care Act coming in and Members of Congress and their staff are going to be under the exchanges, how much is my healthcare?

Mr. Spiro. Uh-huh.

Mr. Long. Where would you go to get that information? Where can I -- because these are the questions my staff has asked for.

Mr. Spiro. Yeah.

Mr. Long. We are talking about the increased healthcare cost, so where can I get that information? I have been trying since January and I haven't been able to get it from anybody. Where would you suggest I go with your experience up here?

Mr. Spiro. This is the beauty, Congressman, of the exchanges. Each State is going to have its own exchange, whether it chooses to establish its own exchange. If it doesn't --

Mr. Long. Missouri is not going to -- I mean, Missouri is not going --

Mr. Spiro. If it does not, then the Federal Government will facilitate an exchange in that state and consumers can go online.

Mr. Long. Today?

Mr. Spiro. When the exchanges are functioning.

Mr. Long. May 20th?

Mr. Spiro. October 1st.

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Mr. Long. They go -- okay, October 1st.

Mr. Spiro. Yes. They can go online and see the rates and compare them, apples-to-apples comparison, makes it much easier to shop for and compare plans and that you will be able to see what your premium tax credit would be.

So, we won't be talking about all these studies that don't take into account your premium tax credits. Consumers will actually be able to see how much they will actually have to pay out of pocket.

Mr. Long. So that is October 1. So if you are a young -- how old are you?

Mr. Spiro. I am 38.

Mr. Long. 38. Okay. You look younger than that. If you -- but if you are a young staffer up here living three and four deep in an department like, as you know they do, trying to make a living and staffers back home that have one or two children, young family starting out, they are going to need to wait till October the 1st before they can then find out what their insurance is going to cost January 1st, so they are going to have October, November, December to make a decision on whether they want to stay employed here in public service or whether they need to find another job where they will have better coverage, correct? About three months.

Mr. Spiro. The open enrollment on period 6 months, and it starts on October 1st, so it is -- it is a long period of time for people to

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enroll.

Mr. Long. What was -- when you were talking to Mr. Butterfield there about the -- repeat that about the 90 percent; 90 percent of the people will not see premium increases? Was that a category or something, or did I -- surely that is not 90 percent of the public.

Mr. Spiro. What Mr. Butterfield was pointing out was that the vast majority of Americans who have health insurance today, they either have it through their employers or through Medicare or Medicaid or the Veterans Health Administration, other government programs, and when you add up all those people, that's 90 percent.

Mr. Long. And you are saying that their premiums are not going to rise.

Mr. Spiro. I am saying that because we are focussing today on the impact of reforms to the non-employer market, the nongroup market, that those -- we are not talking about that 90 percent of the population.

Mr. Long. I thought we were talking about the health insurance premiums under the Patient Protection and Affordable Care Act.

Mr. Spiro. Correct. And the reform --

Mr. Long. Let me -- Okay. Let me move on to another question. I had a CEO come to me, and he said, I am coming to you, I am coming to Senator McCaskill, Senator Blunt because I want you to realize how devastating this Affordable Care Act is to our company. We provided

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great healthcare.

This is a local company in my town.

Mr. Spiro. Uh-huh.

Mr. Long. They have 53,000 employees. To quote him, he said, we had great health insurance for our people. They loved it. It was affordable for us.

Mr. Spiro. Uh-huh.

Mr. Long. If we comply with Affordable Care Act, it is not affordable. We cannot do it. The only thing we can rationalize is cut everybody back to under 29 hours a week, which that is not feasible. So what would you suggest to someone like that?

I am talking to you and not them. What do you -- what do you suggest to somebody like that? What do I tell a CEO that comes to me, 53,000 employees, started out with one store in Springfield, Missouri, now, obviously, they have stores around the country, has built this company up and not able to keep the insurance they were promised, that they were promised, what do you tell somebody like that?

Mr. Spiro. The first point I would make is that it was an option to grandfather their plan, so it was an option for them to keep their --

Mr. Long. Are they past that deadline now?

Mr. Spiro. Now, the second thing is that a lot of --

Mr. Long. They don't think they can keep their plan, sir. If they can, I need to -- I need information out so I can get to them quick.

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Mr. Spiro. They had the option to keep their plan.

Mr. Long. They can keep what they had exactly.

Mr. Spiro. When the Affordable Care Act was enacted, they had the option to keep their plan, and they would be grandfathered or exempt from these reforms.

Now, a lot of employers were finding, are talking about cost increases and blaming the Affordable Care Act. Well, as we discussed earlier, there has been a trend for 10 years of premiums increasing.

Mr. Murphy. Gentleman's time has expired.

Mr. Long. Is that clock not working or what?

Mr. Murphy. Well, we gave you extra time on that.

Mr. Long. Very well. Yield back.

Mr. Spiro. Their policies not necessarily --

Mr. Murphy. Mr. Spiro, we are going into the next -- I would appreciate it if you could try to keep your comments under time.

Mr. Green recognized for 5 minutes.

Mr. Green. Thank you. Thank you, Mr. Chairman, and I guess I have had a whole line of questions, but in an earlier life, I actually managed a business and part of our employees were under a union bargaining agreement and part of the office personnel were not, but -- and one of my jobs was negotiate for a small firm for their insurance premiums. In the years that I did that, I never had my insurance company come in and say, we are not going to increase your

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premiums 10 percent, sometimes even 25 and 30 percent.

So, for us to say that we cannot guaranty insurance premium increases, didn't happen in the real world for the last 30 years because I know they went up. I know they went up on my business. I know they went up on even large businesses. And so that is what boggles my mind because, frankly, we have this huge pool of people who are not paying into anything right now. And so my hospitals have to cover them by Federal law, and we are not going to change that. Why shouldn't we have some type of mandate to go in there?

And frankly, I am familiar with my colleague from Missouri's company because I am a customer of that company, and it is a retail operation, and I think they would qualify. But in all honesty, I want to compliment you, Mr. Spiro, my colleague from Missouri has never told me I look younger than I am.

But let me talk about some of things, though, that were in the bill that, for example, the preexisting conditions. My colleague from Texas, Dr. Burgess talked about it, that it is mainly in the smaller groups, and it is right. Under ERISA, you have certain rules that once you are an employee -- and mostly yours only covers very large employers, you got that coverage. But I can tell you in the smaller group, in State government policies, which were individual and smaller group, they weren't coming under multi-State requirements. They did not have that, and so they could actually write people out for

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preexisting, and I will give you my example.

When I was negotiating with a company, for an insurance company for our 13 employees, they came to me after 3 years and said, you know, we can reduce -- we can lower the increase in your premiums if you would exclude this person in there and later go to the individual market because she just happened to have a double mastectomy, and it was only my job to negotiate. I wasn't the owner of the company. And I said, well, you know, I appreciate that, but that lady had a double mastectomy, she works here and she is the wife of the owner. I will share that information with them because that is what happens in the real world and that is why the preexisting condition is so important in the Affordable Care Act.

And by the way, that is not the only thing. A lot of my colleagues -- I know I didn't like the Senate bill. I am a House Member. I know what the Senate did. They took our House number and amended it. In our House bill, we fixed the SGR. In our House bill, we did not have an iPad in there. In our House bill, we did not include Senator Kennedy's long-term care because we couldn't afford and -- but we did include preexisting conditions. And yet, to a person, on the Republican side, they all voted against those things even though they were in the House bill, and they were added in the Senate bill, and they didn't vote for it either then.

So, you know, to sit here and say we didn't fix SGR, we did, and

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to my -- I still cannot imagine why the United States Senate didn't fix that because I don't think we can find any one of the Senators over there to support the SGR anymore than we can find a House Member to do it.

But Mr. Spiro, I appreciate your -- and I know my colleague talked about the 90 percent of the Americans -- insured Americans have employer covered insurance, and I regret the Supreme Court's decision on Medicaid. I also served as a State legislator, and in Texas, State legislators are not full-time. You get \$600 a month, whether you earn it or not. So all of us had other income, and that was part of my management of that printing company that I learned about insurance from a buyer's point of view in small group insurance. But, and again, coming from Texas, we have a huge number of people who are uninsured.

I have one of the largest districts in the country with people who work and yet their employer doesn't provide insurance for them. So, the Affordable Care Act, one of the benefits was the Medicaid -- we have a lot of working poor because you have to be pretty destitute and poor to get Medicaid in Texas to begin with, but if you are a working poor, you still don't get it now under the Affordable Care Act. So, and I know that has been discussed, and a lot of legislators all over the country, and I wish we would change that because that was one of the goals is to make sure these folks, if you are making \$15 an hour and have three or four children, there is no way you can afford insurance

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premiums and still be -- and still pay for rent and everything else.

Mr. Chairman, I know a lot of the questions have been requested I already have, but I appreciate my colleagues, and I appreciate your patience today.

Mr. Murphy. Thank you. Now we will recognize Mr. Olson for 5 minutes.

Mr. Olson. I thank the Chair, and welcome to our witnesses.

I am a congressman for Texas 22, which is a suburban district right outside of Houston. I go home every week and try to go out to eat a meal with my family at a restaurant one day when I am home because there is no better place in Texas, none, to get the feel of Texans when you are at a restaurant.

They are scared of Obamacare and what it is going to do to the healthcare of their family. Every time I go to eat at a restaurant, whether it is breakfast, lunch or dinner, they tell me stories about the broken promises that have been made by Obamacare. If they provide their own health insurance, it is going to go up somewhere between 5 and 43 percent. That is a study this committee determined, 5 to 43 percent. That is a broken promise. If their employer provides it, up to 23 percent increase of their cost, or they lose it. That is a broken promise.

These people have been hurt by this weak economy. They don't have money to spend more money on healthcare. They are tapped out. They

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are not just afraid of Obamacare. They are terrified of it.

I represent the most diverse district in America, and they express these same fears regardless of ethnicity, religion, gender, age. It happens all the time back home. At Bob's Taco Station in Rosenberg or barbecue lunch at the Swing Door in Richmond, Texas, or a steak dinner at Killen's in Pearland, Texas. These good scared Texans agree with Senator Baucus, Obamacare is a train wreck coming down the tracks.

I want to focus on one of these broken promises, is that young American will purchase their healthcare. They won't. They will get it when they need it, as they are driving to the hospital to get their healthcare. I am a former naval aviator. There is a thing in aviation called a death spiral and that is a situation where the aircraft, it starts out benignly enough, but then it starts spinning, spinning spinning and eventually you can't regain control and you can't eject out of the airplane, hence the term death spiral. My questions to you, Mr. Durham, if young Americans don't purchase healthcare, they forego that, does that put Obamacare into a death spiral?

Mr. Durham. It could if young Americans, young healthy individuals do not purchase coverage, that could increase cost for everyone who remains in the risk pool and that could have an adverse effect. That compounds over time, so depending on how many younger and healthier individuals opt out and pay the penalty, it could certainly compromise the risk pool, which could lead to that type of

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situation down the road.

Mr. Olson. So another broken promise. And we have got some actuarials here. I mean, Ms. Ucello, Mr. Carlson, how about the death spiral? If young people do not get involved in this healthcare bill, like I think is going to happen, is that going to start a death spiral with Obamacare getting more and more people coming into the exchanges because their employers get rid of healthcare insurance, all these things are happening on January 1st. I mean, that sounds to me like a death spiral.

Ms. Ucello. As I mentioned earlier, the viability of the market does rely on bringing in lower-cost people to offset the cost of the higher-cost people, and the guaranteed issue provision will, you know, provide more incentives to bring in the high-cost people. But the individual mandate and the premium subsidies will help to mitigate that effect by providing incentives to bring in lower-cost people. So it depends on how effective those provisions are at mitigating the other upward pressures on premiums.

Mr. Olson. Mr. Carlson, you care to elaborate, sir?

Mr. Carlson. Well, I think I agree with what Ms. Ucello said, and you know, because of the premium tax credits there, there is kind of a floor, but it doesn't minimize the importance of bringing young healthy individuals into the pool.

Mr. Olson. Okay. It is about time.

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I yield back the rest of my time, sir. Thank you all.

Mr. Murphy. Gentleman yields back.

I now recognize Ms. Schakowsky for 5 minutes.

Ms. Schakowsky. Thank you, Mr. Chairman.

Mr. Carlson, in reading your testimony, you said, for the individuals that are expected to be eligible to receive premium subsidies in the exchanges, the amount they actually pay may be less and sometimes substantially less. So, your analysis did not take into account the out-of-pocket cost that people are going to pay, given the premium subsidies, right?

Mr. Carlson. Correct. My report looked at what the insurance company would change in premium rate.

Ms. Schakowsky. And following up on the -- oh, did Mr. Olson leave? He was talking about young people and getting them in the plans.

Mr. Spiro, isn't it true that when young people have been surveyed, the main reason that they don't get health insurance, my understanding is, is the cost of health insurance, that they would, and isn't it also true that young -- young Americans tend to have lower incomes and could be the -- some of biggest beneficiaries of the premium subsidies. I wondered if you would reflect on younger people getting in the plan.

Mr. Spiro. Right. So, as I said, 70 percent of young adults with non-employer coverage would be eligible for Medicaid or the

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exchange subsidies, and in many cases, those subsidies would be very generous and lower the cost that they see.

I do want to mention that there are three things that this committee could do constructively to mitigate any premium increases. One is, don't scare away young Americans by talking about rate shock all the time. Second is encourage Medicaid expansion, because as I mentioned before, in States that don't expand their Medicaid programs, premiums will be slightly higher in exchanges as a result. And third, fund consumer assistance and education. The exchanges are there to lower barriers to young Americans, to make it easier to shop for and compare plans. But one thing that you can really do, if you are concerned about rate shock, is to provide more funding for consumer outreach and assistance.

Ms. Schakowsky. The other thing I was interested in.

Mr. Olson was talking about how fearful people were because of the rate increases that they are experiencing, but only five States have said what the rates are going to be.

Mr. Durham, do -- does anybody know right now what kind of increases -- I mean, we know that they have been going up every year as Mr. Green pointed out, but when you -- they talk about, oh, my rates are going to go up this, my rates are going to go up that, do we really know that already?

Mr. Durham. We don't yet. We won't know for sure until the rates

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are actually approved and individuals can start shopping on the exchange Web sites and the like come October 1st, so there is still a long way between now and then. A number of States are still --

Ms. Schakowsky. So blaming Obamacare for increases in rates before -- at this point is not really accurate, is it?

Mr. Durham. Well, I think what we are conveying through the studies that have been talked about this morning is a number of actuarial firms have indicated that there are provisions in the Affordable Care Act that put upward pressure on premiums. It is variable, depending on the age, health status, location and the current coverage the individual has, and so it is more shaping the environment than the --

Ms. Schakowsky. Well, let me ask -- anybody can answer this. But seems to me, for example, that competition is not really taken into account. In Maryland, Blue Cross, the largest carrier in Maryland, and we do have it, proposed a 25 percent average increase for its 2014 individual market. Other plans saw smaller increases, in some cases, below annual trends in years prior to health reform. For example, Kaiser Permanente's average rate increased only by 4.3 percent.

So, wouldn't it make sense, Mr. Spiro, that in a marketplace, that if you could compare rates and go online and find that, that you would take a Kaiser Permanente over a Blue Cross/Blue Shield then?

Mr. Spiro. Yeah. I think the exchanges are working as intended,

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and there is intense competition among insurers because the premium subsidies are linked to the second lowest cost plan, so they want to be close to that plan.

In Maryland, as it turns out, the original proposal from CareFirst was for a 50 percent increase, and then they lowered it to 25 percent, and that is proposed. So, after the Maryland insurance commissioner reviews that rate, it is probably going to come down even more. And as you said, there are other plans available that will be cheaper and consumers can vote with their feet, with their pocketbooks and choose those plans.

Ms. Schakowsky. Thank you.

Thank you, Mr. Chairman.

Mr. Murphy. Thank the gentlelady whose time has expired.

Now recognize the gentlelady from North Carolina, Ms. Ellmers for 5 minutes.

Mrs. Ellmers. Thank you, Mr. Chairman.

Thank you to our panel for being here today. Ms. Ucello, there has been discussion today about decreases in premium costs, and one of those discussions focuses around reinsurance. Can you very quickly give a description of what reinsurance is?

Ms. Ucello. Sure. Reinsurance is that plans who have a high-cost person who spends, you know, has a catastrophic accident or something, that plan is going to be reimbursed for the spending on that

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person, and so by reimbursing that spending, their costs are, in effect, subsidized so they can lower their premium.

Mrs. Ellmers. And who pays that subsidy or that reimbursement?

Ms. Ucello. So, in this particular reinsurance program, it is for the individual market and it is funded by assessments on all plans.

Mrs. Ellmers. So all plans will pay an increased cost.

Ms. Ucello. It is a --

Mrs. Ellmers. To pay for the subsidy?

Ms. Ucello. Yes, but it's a -- Chris, I don't know if you know. It is like it is \$5.

Mr. Carlson. \$5.25.

Ms. Ucello. \$5.25 per member.

Mr. Carlson. And it includes self-insured plans have to pay it, too.

Mrs. Ellmers. And I am sorry, \$5.25. What -- can you --

Mr. Carlson. Per individual per month. So every member that's enrolled in the plan, whether it is insured or self-insured, they're responsible for paying \$5.25 per month for that individual.

Mrs. Ellmers. \$525?

Mr. Carlson. No, \$5.25.

Mrs. Ellmers. \$5.25. Kind of -- okay. So it is kind of an insurance on the insurance.

Ms. Ucello. Exactly.

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Mrs. Ellmers. And the individual pays that for that premium, the individual pays that.

Ms. Ucello. It is incorporated into that --

Mrs. Ellmers. The cost.

Ms. Ucello. -- premium for --

Mrs. Ellmers. Okay.

Mr. Carlson, the subsidies. As far as -- I keep hearing about the, you know, the tax subsidies and subsidies. Who pays the subsidies and who benefits from that? What group? Is it income-based, I am assuming.

Mr. Carlson. It is income based. You know, where those funds come from, you know, is, you know, the general Treasury basically.

Mrs. Ellmers. So basically the American -- hardworking taxpayers of America are paying for that.

Mr. Carlson. Yes.

Mrs. Ellmers. And -- but we don't really know what that cost is. I mean, overall, do we know what that cost is, how we are going --

Mr. Carlson. No, I think CBO has made assumptions. I don't know them offhand.

Mrs. Ellmers. And who would benefit? I mean, is there -- when I say income-based, I mean, which individuals will be able to benefit from these subsidies?

Mr. Carlson. Well, it is everybody up to 400 percent of the

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federal poverty line, which I believe was \$40,000-some for an individual and \$80,000, \$88,000, I think, for a family of four.

Mrs. Ellmers. Okay. Mr. Durham, part of the discussion today is based on the numbers as they are today and implementation, and you identified that your organization that you are with is headed with this being fully implemented; is that correct?

Mr. Durham. That is correct.

Mrs. Ellmers. Okay. Now, has that been -- the thought that there are employers who currently cover their employees with healthcare plans, is that being taken into consideration, because many have said that they will not be able to afford this and will have to drop the coverage that they now have on their employees. Has that been taken into consideration?

Mr. Durham. In terms of the implementation work that our plans are doing, it is focused on applying to be a qualified health plan through the federally facilitated exchange. So that window just closed and CMS is now reviewing those plans. We are also applying --

Mrs. Ellmers. But the point is, is that you really haven't projected, yes or no, you have not projected how many plans -- how many healthcare plans will be dropped and forced onto exchanges or --

Mr. Durham. CBO has projected that. I believe their projections are 6 million in 2016, and that goes up to 7 million, and that in later years.

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Mrs. Ellmers. Okay. Mr. Spiro, I have one question for you. You had cited CBO saying that there will be a decrease of 25 million with implementation of Obamacare, that 25 million people who are now uninsured will be insured. Well, I also have a CBO number, and I am wondering if you can explain this to me. May 13th, the CBO came out and said that by 2023, with implementation of Obamacare, there will still be 30 million people left uninsured. Can you describe or explain that discrepancy in about 10 seconds?

Mr. Spiro. Well, for some people, the cost of insurance will still be too high. For some people, some people are undocumented immigrants.

Mrs. Ellmers. Would they -- oh, so this is in accordance with undocumented immigrants; is that how you describe it?

Mr. Spiro. Undocumented immigrants make up a big chunk of the remaining uninsured, yes.

Mrs. Ellmers. All right. Thank you, sir. I see my time has expired.

Mr. Murphy. Thank you.

I recognize the gentlelady from Florida, Ms. Castor 5 minutes.

Ms. Castor. Thank, Mr. Chairman, and thank you for calling this hearing because it is -- I appreciate the panel because it is important for all of us to try to cut through some of the political rhetoric right now. I know that is difficult here in the Congress, but you know, when

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you -- when you cut through some of that, that rhetoric, there are some very important reforms and opportunities for small businesses across America and individuals, and you just have to look at my State of Florida, where about 20 percent -- it is actually a little more than that -- of individuals in the State of Florida do not have access to health insurance. Over time, it has just been -- it has been warped because we kind of kept sick people out, took care of people who were healthy. The large group plans are functioning fairly well, except for these big insurance -- these big premium increases over time, but part of the problem is this huge chunk of the uninsured.

So, what the Affordable Care Act does is it gives these folks some important insurance market reforms. It gives them an opportunity to take personal responsibility and come into the market. In Florida, you know, many people in the tourism industry, in retail, the mom and pop restaurant down the street that just didn't have the wherewithal to go out into the individual or small business market and afford insurance. So the Affordable Care Act improves the insurance market in two important ways for these folks.

One, it requires that insurers offer high quality coverage to all without discriminating against people who have preexisting conditions, like cancer, diabetes or asthma. And another way of saying that is that people cannot be denied any longer just because they were sick or had a preexisting condition.

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Second, the Affordable Care Act provides some very important tools to make it affordable for small businesses and individuals. Specifically, for small businesses, one of the great secrets that this committee could really to help the spread word on is the fact that we have very substantial tax credits available for our small business owners now. Over 360,000 small businesses across America have already taken advantage of them, and there are millions and millions more small businesses that will be available -- that can take advantage of the tax credits.

We also help small businesses by creating this new online marketplace, because what we -- what we do, we empower those small businesses now, give them the same negotiating power that the large -- the larger employers had in the marketplace by pooling everyone together. So, for small business owners, this is going to be a very positive sea change where they will be able to have that kind of health security and economic security for the owners and their employees.

Now, for individuals, the Affordable Care Act provides very substantial tax credits to families, up to about 400 percent of the poverty level, and people just don't know, that is a good middle class family all the way up to maybe \$80,000, \$90,000, folks can get some type of tax credit. The medium income in my hardworking district in the Tampa Bay area is about \$35,000 per year. A great majority of these

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folks are going to be able to tap these very robust tax credits.

What I would suggest for people that want to cut through the political rhetoric is they go to the independent Web site of the Kaiser Family Foundation. They set up a calculator to estimate the value of these tax credits for families. It shows that a family of four making the medium household income of \$50,000 will receive tax credits worth up to \$6,500.

Mr. Spiro, I wondered, talk to us about how these tax credits will help families afford health insurance coverage. What has been happening in the market prior to this time as these reforms roll in?

Mr. Spiro. I think one important thing to note about the tax credits is they are advance-able. You can get them right away. You don't have to wait till you file your taxes at the end of the tax year. So it really is an immediate reduction in the costs you would pay out of pocket. You can see it online when you go to the exchanges, what costs you would have to pay. The exchange will automatically determine how much you are eligible for.

And so, for young Americans, this is going to be very important because they disproportionately have lower incomes, and they are the key population, as Cori and others, really the whole panel, I think, agrees, they are the key population that we want to enroll because they are young and healthy and they will keep premiums low, average premiums low for the whole exchange population.

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Ms. Castor of Florida. Thank you.

Mr. Murphy. Gentlelady's time has expired.

Now recognize the gentleman from Ohio, Mr. Johnson, for 5 minutes.

Mr. Johnson. Than you, Mr. Chairman.

For -- I appreciate the witnesses being here today, by the way.

Thank you for taking the time.

For Ms. Ucello and Mr. Carlson, could you identify, please, the aspects of the law that may lead to premium decreases?

Ms. Ucello. Did you say decreases?

Mr. Johnson. Yes.

Ms. Ucello. So the factors that will put downward pressure on premiums, again, include the individual mandate and the premium subsidies, which will help bring in the young and healthy into the insurance market and put, like I said, downward pressure on premiums. In addition, the premium subsidies themselves will directly lower net premiums.

There is also the reinsurance program, which by, again, reimbursing plans for their high-cost enrollees will act as a subsidy to the plan, so that will lower premiums.

There is also the availability of the catastrophic plans for the adults up to age 30 and to those exempt from the mandate, those plans are going to be able to have adjustments to their premiums to reflect the lower expected costs of that -- of that population. So those are

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some of the things that will help put downward pressure on premiums.

Mr. Johnson. Any addition to that, Mr. Carlson?

Mr. Carlson. Well, you know, there were two things I would mention. One, certainly, you know, I would agree that the open competition on the exchanges will, you know, force plans to be careful about their pricing and make sure they have competitive rates. However, on the other hand, you know, they still have a financial responsibility to make sure that they have a premium that is sufficient to cover the claim. So, you know, I think that competition will help there, but on the other hand, you still have to fund the benefits.

And I think the other item that has been discussed is the question of uncompensated care, and the more young individuals and the more enrollment you can get into the program and minimize the uninsured population as much as you can, that will allow plans to get rid of that cost shifting from the uninsured to the -- you know, the commercial market.

The problem is that that will take time for those things to work out and in the system, so that is kind of a longer term goal.

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DCMN ROSEN

[5:56 p.m.]

Mr. Johnson. Well, these things that decrease a premium, and obviously you've identified some things that would or could, do these items that lower premiums outweigh the items that will increase premiums under the law?

Mr. Carlson. Certainly not in the short term. I mean, they're --

Ms. Uccello. And I think it also depends on for whom you're talking. In certain States, it's possible that there could be premium decreases if they already have market rules that are similar to those that will go into effect in 2014.

Mr. Johnson. Okay. Mr. Durham, are you -- as you are aware, the IRS will be responsible for implementing a great deal of the health care law, mainly enforcement. Have you or your association had any discussions with the IRS about what that role will be, and what the industry can expect from the IRS?

Mr. Durham. I have not personally had discussions with the IRS, but other members of my team have had discussions with the IRS. They play a very significant role in implementation, clearly, with regard to the advanced premium tax credits and the system build to ensure that

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the right information is available to help plans for enrollment.

Mr. Johnson. Okay. You know, as -- as costs continue to rise, health care -- the health care law defenders now say that even though they promised lower costs, that it really doesn't matter if premiums go up, because as Ms. Uccello just pointed out, the subsidies will help. Well, these subsidies phase out after 400 percent of Federal poverty level, which is about \$44,000 for an individual, \$94,000 for a family of four.

Have you conducted any analysis that has analyzed the impact of the subsidies nationwide, how many individuals will receive them and at what level?

Mr. Durham. We have not, but I could look into that for you.

Mr. Johnson. Okay. My time is almost ready to expire, and I just wanted to end with this comment, Mr. Chairman. You know, the President promised a lot of things in the Affordable Care Act, two very striking things. He said costs will go down, and he said if you want to keep your current health coverage, that you can do so.

I have heard it repeated on -- by my colleagues on the other side several times today that in order to get your premium to go down, you're going to have to take less benefit. That doesn't sound like the promise that the President made to the American people, in my view. And with that, I yield back.

Mr. Murphy. The gentleman yields back.

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I ask unanimous consent for the majority report of March 14th be included in the record. And so ruled.

[The report follows:]

***** COMMITTEE INSERT *****

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Mr. Murphy. Ms. DeGette, you have --

Ms. DeGette. Yes. I ask unanimous -- it cut me off.

I ask unanimous consent for the May 13th Democratic memo, the May 20th Democratic memo, a letter to this committee dated May 20th from Families USA, and a letter dated May 20th to this committee from AARP. And you have all of those, Mr. Chairman.

Mr. Murphy. Yes. Without objection, they'll also be included in the record.

[The letters and memos follow:]

***** COMMITTEE INSERT *****

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Mr. Murphy. In conclusion, I'd like to thank our witnesses. Thank you very much. You've given us a lot to think about today and we deeply appreciate your candor and your data. Other questions will be following up.

And I remind members they have 10 business days to submit further questions for the record. And I ask all the witnesses please respond promptly to the questions, because we do appreciate your information on that.

With that, this subcommittee is adjourned.

[Whereupon, at 6:01 p.m., the subcommittee was adjourned.]