STATEMENT OF

GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE AFFORDABLE CARE ACT IN 2014

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

JANUARY 16, 2014

U.S. House Committee on Energy & Commerce,
Subcommittee on Oversight & Investigations
The Affordable Care Act in 2014
January 16, 2014

Good morning, Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee. Thank you for the opportunity to speak about our work implementing the Affordable Care Act to put in place strong consumer protections, provide new coverage options, and give Americans additional tools to make informed choices about their health insurance. Thanks to the consumer protections and insurance market reforms in the Affordable Care Act, millions of people have already obtained coverage, and millions more will have the peace of mind that the coverage they have cannot easily be taken away.

In March 2010, President Obama signed the Affordable Care Act into law, putting in place comprehensive reforms to improve access to affordable, quality health insurance for all Americans and protect consumers from abusive insurance company practices. Over the past three years, Americans have benefitted from insurance reforms that have already gone into effect, such as allowing adult children up to age 26 to stay on their parent's insurance, eliminating lifetime dollar limits on essential health benefits, and prohibiting rescissions of insurance when someone gets sick. Now, in 2014, discrimination by insurance companies against individuals with pre-existing conditions is banned for nearly all individuals of all ages, and consumers have better access to comprehensive, affordable coverage.

What We Have Already Achieved: Better Access to High Quality Coverage

The Centers for Medicare & Medicaid Services (CMS) has implemented strong consumer protections that hold insurance companies more accountable, give consumers more coverage options, and improve the value of that coverage. While the initial consumer experience on HealthCare.gov did not live up to our expectations or the expectations of the American people, those technical issues have now largely been addressed. Since the beginning of open enrollment

in October 2013, over 6 million individuals[1] have enrolled in private health insurance, Medicaid, or the Children's Health Insurance Program (CHIP)—many for the very first time—thanks to the Affordable Care Act. Both state and Federal Marketplaces saw a surge in the number of Americans enrolling in health plans in December, and enrollment in December was five times that of October and November combined. Halfway through a six-month open enrollment period, it is evident that there is strong demand for health coverage and millions of Americans will now have access to quality, affordable health coverage.

Shopping in the Health Insurance Marketplace

Already, millions of individuals have experienced a new way to shop for health coverage through the Marketplace created by the Affordable Care Act. By enrolling in private health insurance through the Marketplace, consumers effectively become part of a statewide group that spreads risk between sick people and healthy people so the costs of care are more equitably distributed. Because of enhanced competition, insurers are now eager for new business, and have created new health care plans with more choices.

The Marketplace makes it possible for eligible consumers to use a streamlined application to apply for coverage through a qualified health plan, to qualify for a premium tax credit and reduced cost sharing, or to determine eligibility for coverage through Medicaid or CHIP.[2] The Marketplace makes it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality. In addition to the Marketplace website, HealthCare.gov, which is the site for most states, consumers can also apply by phone through a toll-free call center, by mail with a paper application, or in person with a trained counselor in their community, to choose health coverage that best fits their needs. Additionally, where permitted by the state,[3] licensed agents and brokers, as well as online brokers, may help consumers and employers enroll in a qualified health plan through the Marketplace.

[1] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html
[2] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html
[3] Per 45 CFR 155.220

Consumer interest in gaining health coverage is strong among Americans who currently lack insurance—63 percent say they are likely to get health insurance in 2014.[4] Additionally, interest in the Marketplace is strong and growing. A majority of adults (63 percent) who are potentially eligible to enroll in coverage through a qualified health plan or Medicaid said they were aware of the Marketplace as a place where they might shop for coverage.[5] Twenty-four percent of those potentially eligible reported that they had visited the Marketplace to shop for a plan by December, whether online, by phone, in person, or by mail, up from 17 percent in October.[6]

By pooling consumers, reducing transaction costs, and increasing transparency and competition, Marketplace plans tend to be more efficient and competitive than consumers' previous options. Further, enrollment data shows that despite initial technical challenges, the Marketplace is enabling individuals to successfully enroll in health insurance coverage. Nearly 2.2 million people have enrolled in a private health insurance plan through the Federal and State-based Marketplaces since October 1st,[7] and in October and November, 3.9 million individuals learned they are eligible for coverage through Medicaid and CHIP.[8,9] We expect these numbers to continue to grow through the end of March, when open enrollment ends.

Guaranteed Core Benefits and Comparison Shopping

One reason consumers can be confident about the quality of the plans offered in the Marketplace is that the Affordable Care Act standardizes certain benefits most insurers must offer. Most non-grandfathered plans in the individual and small group markets now cover essential health benefits,[10] which include items and services in ten statutory categories, such as ambulatory patient services (including doctors' visits), hospitalization, prescription drugs, and maternity and newborn care. These benefits must be equal in scope to a typical employer health plan. To this end, the essential health benefits are defined in each state by reference to a benchmark plan. As

[4] Gallup daily polling results, December 3, 2013.
[5] Sara R. Collins et. al., *The Commonwealth Fund*, Americans' Experiences in the Health Insurance Marketplaces: Results from the First Three Months, January 2014.
[6] Sara R. Collins et. al., *The Commonwealth Fund*, Americans' Experiences in the Health Insurance Marketplaces: Results from the First Three Months, January 2014.
[7] http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Jan2014/ib_2014jan_enrollment.pdf
[8] These numbers include new eligibility determinations and some Medicaid and CHIP renewals.
[9] http://www.hhs.gov/healthcare/facts/blog/2013/12/nationwide-enrollment-surges.html
[10] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

a result, consumers are now able to select an insurance plan with confidence that it will cover key health care services when they need them.

Beginning this year, most non-grandfathered health plans in the individual and small group markets also must meet certain actuarial values: 60 percent for a bronze plan, 70 percent for a silver plan, 80 percent for a gold plan, and 90 percent for a platinum plan. Actuarial value means the percentage of the total allowed costs of benefits paid by a health plan on average. For example, if a plan has an actuarial value of 70 percent, the average consumer would be responsible for 30 percent of the costs of the essential health benefits the plan covers. These tiers allow consumers to compare plans with similar levels of coverage, which, along with comparing premiums, cost-sharing provisions, provider participation, and other factors, will help consumers make more informed decisions.

More Affordable Coverage

The market reforms of the Affordable Care Act are also working to make health insurance pricing more fair and to provide tax credits and cost-sharing reductions for eligible individuals, resulting in coverage that is more affordable. New rules prohibit most health insurance companies from charging higher premiums to certain enrollees because of their current or past health problems. Women can get a plan for the same price as men. Most plans are limited in how much more they can charge older individuals than younger individuals. These changes stand in stark contrast to health insurance pricing before the Affordable Care Act, when women could be charged more for individual insurance policies simply because of their gender, and when premium rates charged to older individuals could be five times or more the rate for younger individuals.

At the same time that insurance prices have become more fair, many individuals also have new help paying for their health care coverage through premium tax credits and cost sharing reductions. Many middle and low-income individuals are eligible for a new kind of tax credit that can be used right away to lower monthly premiums for coverage through the Marketplace. The tax credit is sent directly to the insurance company and applied to the premiums, so consumers pay less out of their own pockets. The amount of the tax credit for which an eligible

individual qualifies depends on the individual's household income. Individuals are eligible for premium tax credits if, among other things, they:

- Are not eligible for other affordable health insurance coverage designated as "minimum essential coverage" (*e.g.*, government-sponsored coverage or employer-sponsored coverage); and
- Have modified adjusted gross household incomes between 100 percent and 400 percent of the Federal poverty level (*e.g.*, $23,550 to $94,200 for a family of four in 2013).

Many people can now buy more comprehensive coverage often with lower out-of-pocket costs than they previously paid. Additionally, young adults and certain other people for whom coverage would otherwise be unaffordable or who are transitioning away from their old health insurance plan may enroll in catastrophic plans, which have lower premiums, protect against high out-of-pocket costs, and cover recommended preventive services without cost sharing—providing additional affordable coverage options.

Significant Steps to End to Pre-Existing Condition Discrimination and Limits on Care

The Affordable Care Act has provided consumers with more protections than ever before. As many as 129 million non-elderly Americans have some type of pre-existing health condition.[11] Pre-existing health conditions range from life-threatening illnesses such as cancer, to chronic conditions such as diabetes, asthma, or heart disease.

In the past, health insurers in most states could refuse to accept anyone for individual-market policies because of a pre-existing health condition, or in the group market they could limit benefits for that condition. Now, the Affordable Care Act provides consumers with the security that their coverage will be there for them when they need it. Non-grandfathered health insurers in the individual and small group markets will generally no longer be able to use health status to determine eligibility, benefits, or premiums. New plans in the individual market are required to enroll individuals, regardless of health status, age, gender, or other factors and will be prohibited from refusing to renew coverage because an individual becomes sick. Additionally, insurance

[11] ASPE Report: At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans http://aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml

companies cannot drop or rescind people's coverage because they made an unintentional mistake on their application.[12]

The Affordable Care Act's market reforms also make changes to insurance coverage so it is there when people need it most. Before the Affordable Care Act, some people with cancer or other chronic illnesses could run out of insurance coverage when their health care expenses reached a dollar limit imposed by their insurance policy or group health plan. Now, most group health insurance plans and non-grandfathered individual health insurance policies are prohibited from imposing annual or lifetime dollar limits on essential health benefits. This change will help ensure that consumers will no longer have to worry about hitting a dollar ceiling on their benefits, which could force them to pay out of pocket for health care costs above the dollar limit, forgo necessary care, or even declare bankruptcy – a potentially life-saving change made by the Affordable Care Act.

We have implemented additional consumer protections such as establishing a set of uniform standards for external review of individual health plan decisions restricting an enrollee's access to benefits. Now, consumers enrolled in most non-grandfathered group health plans and individual health insurance policies can ask for an independent third party review of decisions made by their plans and insurance companies to deny coverage of a service.

Easing the Transition to a New Health Insurance Market

CMS is working closely with insurers to ease consumers' transition to health plans with new protections, benefits, and coverage. In December, CMS announced additional steps to help ensure that consumers who are seeking health insurance through the Marketplace transition to coverage that best fits their needs. In the interim final rule (IFR) issued on December 12, 2013,[13] CMS finalized that insurers must accept payment through at least December 31, 2013 for coverage beginning January 1, 2014, and that individuals had until December 23, 2013 (an extra eight days) to sign up for Marketplace health insurance coverage beginning January 1, 2014. In addition, CMS separately urged several steps on the part of insurers to ease consumers' transition

[12] For an example see: http://www.healthcare.gov/law/features/rights/cancellations/index.html
[13] http://www.ofr.gov/OFRUpload/OFRData/2013-29918_PI.pdf

to new coverage, including giving consumers additional time to pay their first month's premium for coverage beginning January 1, 2014, treating out-of-network providers as in-network to ensure continuity of care for acute episodes or if the provider was listed in the plan's provider directory when the consumer enrolled, and covering prescriptions covered under previous plans during the month of January.

Many stakeholders have responded positively and are working together to smooth this transition and help ensure consumers have coverage and receive needed medical care. On December 18, 2013, America's Health Insurance Plans' Board of Directors announced that health plans would voluntarily extend the deadline for consumers to pay their first month's premium, accepting payment through January, 10, 2014 for coverage retroactive to January 1, 2014. In addition, several pharmacies, including CVS, Walgreens, Kroger, Rite Aid, and numerous community pharmacies, announced plans to furnish consumers with transitional supplies of prescriptions if needed.

CMS continues to work closely with consumers and other key stakeholders to ease the transition into 2014. For example, CMS is working with consumers to make sure that they know whether their doctor or prescriptions are covered before they choose a plan, and providing consumer tips on how to get care during the transition. Additionally, CMS continues to reach out to consumers who experienced technical difficulties when applying for coverage through the Marketplace to ensure their opportunity to enroll.

Conclusion

CMS has worked hard since the enactment of the Affordable Care Act to improve the health insurance market for all Americans. We are proud to see many of the Affordable Care Act's key market reforms now in place, and while more work remains, we are encouraged that those who already have health insurance will have better, more reliable coverage, that families will not be denied coverage because of a pre-existing condition, and that more than 6 million individuals have been enrolled in Marketplace, Medicaid, or CHIP coverage. We look forward to continuing our efforts to strengthen health coverage options with the help of our partners in Congress, state

leaders, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CMS has been doing to implement the Affordable Care Act.