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PPACA ENROLLMENT AND THE INSURANCE INDUSTRY

WEDNESDAY, MAY 7, 2014

House of Representatives,

Subcommittee on Oversight

and Investigations,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:18 a.m., in Room 2123, Rayburn House Office Building, Hon. Tim Murphy [chairman of the subcommittee] presiding.

Present: Representatives Murphy, Burgess, Blackburn, Olson, Gardner, Griffith, Johnson, Long, Ellmers, Barton, Upton (ex officio), DeGette, Braley, Lujan, Schakowsky, Castor, Tonko, Yarmuth, Green, Dingell, and Waxman (ex officio).

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Staff Present: Gary Andres, Staff Director; Karen Christian, Chief Counsel, Oversight; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, O&I; Brittany Havens, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, O&I; Alexa Marrero, Deputy Staff Director; Christopher Pope, Fellow, Health; Krista Rosenthall, Counsel to Chairman Emeritus; Tom Wilbur, Digital Media Advisor; Jessica Wilkerson, Legislative Clerk; Jean Woodrow, Director, Information Technology; Phil Barnett, Minority Staff Director; Stacia Cardille, Minority Chief Counsel; Brian Cohen, Minority Staff Director, Oversight & Investigations, Senior Policy Advisor; Hannah Green, Minority Staff Assistant; Karen Nelson, Minority Deputy Committee Staff Director For Health; Stephen Salsbury, Minority Investigator; and Matt Siegler, Minority Counsel.

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Mr. Murphy. Good morning. I now convene this hearing to examine the implementation of the Affordable Care Act and enrollment of the State and Federal exchanges here in the Oversight and Investigation Committee for the Committee on Energy and Commerce.

This subcommittee has a long history of trying to get straight answers from the administration on the status of the Affordable Care Act. Two weeks before the launch of HealthCare.Gov, the administration official responsible for the implementation of the ACA exchanges told this committee that the Web site would be ready, consumers would be able to go online, shop for a select plan and then enroll in coverage.

When the Federal exchange opened on October 1, consumers instead found a crashing Web site. The administration's excuse for why the Web site didn't work: Volume. Through this committee's investigation, we learned that the administration spent over $.5 billion on a Web site that they had been warned for several months would not be ready and would not work. Facts that administration officials did not disclose when questioned by this committee during oversight hearings through 2013.

Just after the failed launch, we asked the administration on October 8 to provide enrollment data for the first week of HealthCare.Gov debacle. The administration ignored us. Why? It wasn't because the data didn't exist; it was because the news wasn't

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good. When Secretary Sebelius testified before the full Energy and Commerce Committee on October 30 of last year, was asked about enrollment, she stated that she could not provide any data because the administration did not "have any reliable data around enrollment."

The very next day, it was reported that there were only six successful enrollments on October 1. We tried again during a hearing in January before this subcommittee when we asked the head of the office running the exchanges if the administration collected any data on who has paid their health coverage. This administration official told us that they did not collect this information "but we will be," as soon as it was finished building the Web site.

While the administration refused to provide straightforward answers to our questions on enrollment, it continues to tout enrollment figures that included individuals who had merely selected a plan online. When pressed by reporters for information on the number of enrollees who had paid their premiums, a White House spokesman said that questions about payment "can best be directed to those private insurance companies that are collecting those payments."

After months of an administration that refused to be transparent about enrollment, that's what we did; we did exactly what the administration suggested we do. On March 13, we sent a request to each insurance company in the Federal marketplace and asked them to submit basic information: Who selected a plan and who paid for it?

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The data submitted by the insurers paints an uneven picture about the status of enrollment and payment through April 15. As of that date, just two-thirds of enrollees through the Federally-facilitated marketplace paid their first month premium. Some States are doing better than others.

My home State of Pennsylvania, for example, has an 81 percent payment rate. Texas, on the other hand, is much lower at 42 percent. We recognize that many individuals still have time to pay their first month's premium, which is why we have asked the insurers to update this information on May 20. As with any criticism or questions of the Affordable Care Act, the administration predictably protested and attempted to misrepresent the purpose of our inquiry.

Let's be clear about why we had to engage in this exercise in the first place. The administration would not be transparent about enrollment and provide the underlying data. For the witnesses today, we ask you to be patient with our questions about enrollment and implementation. After months of promises about the status of HealthCare.Gov from HHS officials, we have learned to be skeptical about blanket statements that everything is well.

One purpose of today's hearing is to examine enrollment because it is a key factor in measuring whether these exchanges are viable. We have a number of other questions for the witnesses today about the status of implementation. The ACA is more than a payment rate. We

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need to know if Americans can expect the premium reductions they were promised, and we need to know if they can keep the plan they liked. We need to know if they can keep their doctor.

We cannot understand the status of the law in its implementation without hearing from you, the insurance companies, whose plans make up these exchanges. Under the President's health care law, these companies will receive taxpayer dollars in the form of premium subsidies and cost sharing. We expect the witnesses today to provide the committee with facts and information about the first year of coverage under the Affordable Care Act.

Thank you for the witnesses being here today, and I now would like to recognize the ranking member, Ms. DeGette, for 5 minutes.

Ms. DeGette. Thank you, Mr. Chairman. I just want to take a few minutes, since the chairman has walked through the greatest hits of the problems they have had with the ACA, of where we stand now and where we stand after the first enrollment period has just closed. So as we continue to get information about how the exchanges in the Affordable Care Act and the enrollment are performing, let's review what we already know.

The first thing is, despite the disastrous beginning of the Federal exchange, good news: The Web site was fixed. More than 8 million people signed up for insurance through the exchanges created through the Affordable Care Act which is more than 1 million more than

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were originally projected before the disastrous unveiling.

Now, of those 8 million people, 3 million of them waited until the last month of enrollment, and so their premiums are not due until April 30, or in some cases, later than April 30. Even so, my colleagues, in their quest for knowledge on the other side of the aisle, sent out a questionnaire to insurers that manipulated the payment deadlines to skew the understanding of how new insurance coverage is performing.

How does that happen? Because they cut off the responses April 15, at least 2 weeks before many of the premiums of these 3 million people were even due for payment. What this does is it skews the amount of people who were enrolled. Then, of course, they issued a press release posthaste.

Now, for years, my friends on the other side of the aisle have made a series of claims that really are unsubstantiated. First, they claimed that the bill contained death panels, then they claimed that the bill would eliminate private insurance within 3 years, then they claimed that the law would destroy millions of jobs. When the Web site was broken, they insisted the law would never meet enrollment goals.

Now, Mr. Chairman, today we finally have a chance to see in a snapshot what's happening with the Affordable Care Act, and the facts reveal that every single one of those claims were wrong. As of today, as I said, more than 8 million people enrolled in private plans through

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Federal and State marketplaces. Millions more have enrolled through Medicaid and in off-exchange plans.

Gallup just released a new poll finding that in the last 6 months, the percentage of adults without insurance has dropped about 20 percent, and what that means is there are more than 11 million Americans with insurance today than there were 6 months ago. Premiums are below the levels predicted by the Congressional Budget Office, and the agency has once again reiterated that the Affordable Care Act has slowed inflation and saved billions of dollars and will even reduce deficits. So by any rational, reasonable measure, we can call this law success, and that success will make a real difference in people's lives. That's what's important here.

Yesterday, researchers from the Harvard School of Public Health released a comprehensive study on the impacts of health insurance coverage. They were looking at mortality rates before and after the passage of RomneyCare, the landmark Massachusetts health insurance expansion that served as a model for the Affordable Care Act. They found that the mortality rate in Massachusetts fell by about 3 percent in the 4 years after passage of the State's health insurance law.

Mr. Chairman, I would like to ask unanimous consent to put a copy of that study into the record.

Mr. Murphy. Without objection.

Ms. DeGette. Thank you.

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[The information follows:]

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Ms. DeGette. So if we can achieve that same level of success nationwide with the Affordable Care Act, and there's no reason why we shouldn't be able to do so, that could result in 17,000 fewer deaths per year. That, Mr. Chairman, in a nutshell, is what the Affordable Care Act means for Americans.

Now, what I wish we could do in this subcommittee, and I've said this both publicly and privately many, many times, is sit down with the ACA, figure out what the flaws are and figure out how we can work in a bipartisan way to fix it. And that's what I think we should do. Instead, what we get is this misleading analysis last week which said that only 67 percent of enrollees had paid for the coverage they enrolled in on the exchanges.

And my chairman, Mr. Upton, said the administration's recent declarations of success may be unfounded. But again, I will say, the report was misleading because almost half of the enrollees in the health care exchanges, 40 percent of them, did not even have to make their initial premium payment until April 31. I'm glad we've got the insurers here today to clear up this record. I'm glad we have everybody here to see exactly what we're talking about here.

So my suggestion is, let's look at the successes, let's look where we need to make improvements, and let's work together to do just that. Thank you.

Mr. Murphy. Gentlelady's time has expired.

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Now recognize the chairman of the full committee, Mr. Upton for 5 minutes.

The Chairman. With a friendly pat on the back, I'll just say April 31 has yet to come. "30 days has September, April, June and November."

Thank you, Mr. Chairman. I thank the witnesses for being here today as well, for sure. At this subcommittee, our investigations are about getting the facts. A quest for transparency, the self-proclaimed most transparent administration in history has repeatedly dodged our simple questions about the health care law and refused even a semblance of transparency about how its signature legislative achievement is or is not working.

We wanted the basic data from the administration on enrollment 1 week after the launch of HealthCare.Gov, and the administration has rejected our request for more information each and every time. Members of the press have asked. The administration suggested the only way to get the facts was directly asking the insurance providers themselves. So we took their advice and we did just that, but the administration cried foul again.

We began asking about HealthCare.Gov months before October 1 of last year. Repeatedly, we are told things were on track and working the way it was supposed to. We learned that this was not the case and the administration officials did everything in their power, it seems,

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to hide the chaos behind the scenes.

The American public does deserve better. They deserve better than an administration that promised them $2,500 in savings on health care premiums only to see the cost rise sharply for many. They deserve better than an administration that repeated promises officials knew that would be impossible to keep, promises that Americans could keep their doctors and keep their health care plans, also.

Like it or not, millions of Americans have found themselves with the unwelcome reality of cancellations and lost access to their trusted doctor. And one Democratic colleague from Massachusetts said just 2 weeks ago, the worst is yet to come.

Today we are going to hear firsthand from insurance providers about how implementation is working from their perspective. While the administration has declared this conversation over, the fact is that serious questions remain unanswered, and it is our responsibility to continue seeking the facts.

How many people have completed the enrollment process? Are the risks presented by these pools sustainable? How much more will premiums rise this next year? Is the back end of the Web site on track to be working by the next enrollment period? Are there any other delays or changes ahead that will disrupt the ability of families and businesses to plan for their health care coverage and needs? Will more health care plans be canceled in the coming years?

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So what's wrong with seeking that information? Nothing that I know of. We released basic data points on enrollment as of April 15, and we'll do so again on the data that we collect through May 20. The facts are the facts, and while the administration and its allies furiously try to muddy reality, the public deserves transparency.

And while the administration toasts to the law's success with its Hollywood allies, declaring this conversation over, we will continue our pursuit for facts for the American people so that we can finally have a full, accurate picture of this health care law, and I yield the balance of my time to Dr. Burgess.

Dr. Burgess. I thank the chairman for yielding.

I thank our witnesses for being here today. I know it's not always easy or pleasant to come before this subcommittee. I, like the chairman, wish that the administration had been a little bit more forthcoming about information which would have obviated your need to be here today, but I do appreciate the fact that you responded to our requests and that you have provided the data.

The fact remains the administration has withheld facts or changed facts during the rollout of this law and that the Federal agencies responsible for the implementation currently excel only in opacity. So you are here today to provide that transparency that the American people were promised earlier in this administration, and I thank you for being here.

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I have particular concern over one aspect, and I will delve into it a little bit more during the questioning today, but that is the issue on the grace period, the 90-day period of time that is granted to people who are receiving the tax credits, the advance tax credits for the offset of the cost of their insurance. If they don't pay their premium in spite of the tax credit, they are given a grace period of 90 days.

My understanding is that the companies will be responsible for the first 30 days; beyond that, it will be the doctor or the hospital, the provider who submits the bill who may be on the hook for that. And I am very interested to know what you have in development to keep practices, to keep providers apprised of the fact that a patient's claim may be in a pending status when that claim is submitted.

I know from running a doctor's office, you always call and verify benefits, but now we have a new realm that we've entered into: Not only would you identify that someone has been enrolled, but that they've paid and that they're current on their payments so that the provider in question would not be at risk. So we will get into a little bit more on that in the question-and-answer period.

I thank the chairman for the time and yield back.

Mr. Murphy. Gentleman's time has expired.

Now recognize the ranking member of the full committee, Mr. Waxman, for 5 minutes.

Mr. Waxman. Thank you, Mr. Chairman.

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Last week the Republican whip, Representative Kevin McCarthy, wrote an op-ed opposing the Affordable Care Act. He wrote, "President Obama needs to learn a simple lesson: Saying something doesn't make it true." Well, psychologists call that projection, a defense mechanism that involves ascribing your own behavior to others.

In one phrase, Representative McCarthy summed up 5 years of Republican opposition to the Affordable Care Act. Over and over, Republican leaders have fabricated criticism of the Affordable Care Act and none of them have been true. Republican leaders said that the ACA would create death panels; well, there are none in the law.

Republican leaders said that the law was unconstitutional; the Supreme Court held exactly the opposite. Republican leaders said that the ACA would increase the deficit; well, the nonpartisan Congressional Budget Office found that the law will reduce deficits by over $1 trillion. Republican leaders said that the law would cause health care costs to skyrocket; in fact, in the 3 years after passage of the ACA, health care spending growth was at its lowest rate in 50 years.

Republican leaders said that the law would cause massive job losses; in reality, there have been 48 consecutive months of job creation since the ACA was passed with more than 9.2 million jobs created. Republican leaders said there would be a huge loss of coverage under the law, but every independent analysis shows that the number of Americans with health insurance is growing and the number

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of uninsured dropping rapidly. Republicans said enrollment would fall far short of CBO estimates because few Americans would sign up; at 8 million and growing, enrollment has exceeded everyone's expectations.

Mr. Chairman, I just summarized 5 years of relentless Republican opposition to the Affordable Care Act. It's a sad and, I believe, reprehensible record. The Republican Party is trying to scare families from getting the health insurance they need. We saw the same pattern just last week when this committee released another report claiming imminent failure. This time, the report said that one-third of enrollees had not paid for coverage. There was just one problem: The data was incomplete, out of date, and manipulated. Due to the late surge in enrollment, premiums were not even due for over 3 million Americans.

The testimony we're going to hear today from the insurers contradicts the Republican findings. That testimony says that 80 to 90 percent of enrollees have paid their premiums. Mr. Chairman, it was a mistake to release those inaccurate and misleading findings, and it's not the first time this has happened.

This morning, I released a memo describing the Republican record of distortion, exaggeration and misdirection. It's a sad record, and I'd like to make it part of this hearing record. The simple fact is, despite 5 years of ceaseless opposition, the Affordable Care Act is

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working. Over 8 million Americans have signed up for private health care coverage on the State and Federal exchanges. Millions more have signed up for Medicaid. Premiums are well below CBO expectations. No American ever has to fear being discriminated against or denied coverage based on a preexisting condition.

No amount of blatant falsehoods and cynical partisanship can obscure the facts. The Affordable Care Act is an enormous step forward in the health of our Nation. And I yield back the balance of my time, and I appreciate this opportunity to set the record straight.

Mr. Murphy. Thank you. The gentleman yields back.

We'll now move forward here with our witnesses. Just one moment, please. We're moving quicker and that's good. I just wasn't quite ready.

So I'd like to introduce the panel for today's hearing. We have Mr. Mark Pratt, who is a senior vice president of State Affairs for America's health insurance plans; Mr. Frank Coyne is the Vice President of Operations and Chief Transformation Officer of Blue Cross Blue Shield Association; Mr. Paul Wingle -- am I saying that correctly? -- is the Executive Director of Individual Businesses and Public Exchange Operations and Strategy for Aetna; Mr. Brian Evanko is the president of individual segment for Cigna Health and Life Insurance Company; Mr. J. Darren Rodgers is the senior vice president and chief marketing officer at the Health Care Services Corporations; and Mr. Dennis

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Matheis is the president of Central Region and Exchange Strategy at Well Point, Inc.

I will now swear the witnesses. You are aware that this committee is holding an investigative hearing and when doing so, we have the practice of taking testimony under oath. Do any of you have any objections to testifying under oath? All the witnesses have indicated no.

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 today?

Mr. Wingle is saying you would like to be advised by counsel. Well, if you are sitting behind him, that's fine.

Anybody else? You have counsel behind you. You are certainly are welcome at some point to ask clarification from them, that's fine.

In any case, would you all please rise and raise your right hand, and I'll swear you in.

[Witnesses sworn.]

Mr. Murphy. Thank you. You may be seated. All the witnesses have taken that oath, and you are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. We'll have you now each give a 5-minute opening statement. Please stick to the 5 minutes. You'll see a red light go on when you're at

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the end of your time.

Mr. Pratt, you may begin.

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TESTIMONIES OF MARK PRATT, SENIOR VICE PRESIDENT OF STATE AFFAIRS, AMERICA'S HEALTH INSURANCE PLANS; FRANK COYNE, VICE PRESIDENT OF OPERATIONS, CHIEF TRANSFORMATION OFFICER, BLUE CROSS AND BLUE SHIELD ASSOCIATION; PAUL WINGLE, EXECUTIVE DIRECTOR OF INDIVIDUAL BUSINESS AND PUBLIC EXCHANGE OPERATIONS AND STRATEGY, AETNA; BRIAN EVANKO, PRESIDENT, INDIVIDUAL SEGMENT, CIGNA; J. DARREN RODGERS, SENIOR VICE PRESIDENT AND CHIEF MARKETING OFFICER, HEALTH CARE SERVICE CORPORATION; AND DENNIS MATHEIS, PRESIDENT OF CENTRAL REGION AND EXCHANGE STRATEGY, WELLPOINT, INC.

TESTIMONY OF MARK PRATT

Mr. Pratt. Chairman Murphy, Ranking Member DeGette and members of the subcommittee, I am Mark Pratt, Senior Vice President of State Affairs in America's Health Insurance Plans. I lead AHIP's legislative and regulatory activities in the States, including implementation of the Affordable Care Act and our work with the National Association of Insurance Commissioners. We appreciate this opportunity to testify on enrollment in the new health insurance exchanges and implementation of the ACA.

Our written testimony focuses on two broad areas: One, our members' experience in the ACA's initial open enrollment period for 2014; and two, our members' priorities for improving access to

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high-quality affordable health coverage in 2015 and beyond. Since the enactment of the ACA, our members have been working the implement the law's many requirements with a strong focus on delivering high value coverage options for consumers. Helping them obtain the secure, affordable coverage they need has been our central goal throughout the implementation process.

While working on operational issues related to ACA implementation and providing recommendations to policymakers, our members have focused on several major goals. Among them: Minimizing disruptions for consumers, businesses and stakeholders; ensuring the workability of the exchanges and allowing State flexibility; maximizing choice and competition; and addressing specific ACA provisions to make health coverage more affordable.

On numerous issues, our members have provided technical assistance and expertise to assist Federal agencies in resolving the operational challenges that surrounded the launch of the new exchanges in the HealthCare.Gov Web site. They have devoted significant resources to performing manual processes and workarounds that were necessitated by the problems following the October 1 launch. Despite the challenges our members encountered, we are proud that they ultimately were successful in offering a broad range of high-valued coverage options to consumers who are enrolled in exchanges in 2014.

HHS has reported that approximately 8 million individuals signed

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up for exchange plans during the initial open enrollment period for 2014. While uncertainty remains with respect to how many people have paid their first month's premium, health insurers have been doing everything possible to encourage exchange enrollees to pay their premiums.

In the coming weeks, we anticipate that there will be greater clarity on the question of how many exchange enrollees have paid their premiums. A number of individual plans have publicly announced their preliminary data, and we anticipate that more announcements will be forthcoming; however, it may be a period of time before system-wide numbers on premiums payments are available. Our members will continue their ongoing outreach to encourage exchange enrollees to pay their premiums.

Looking forward, we continue to believe that affordability must be the central priority as we focus on further expanding access to high quality, affordable health insurance coverage in 2015 and beyond. One critically important step that Congress can take to make coverage more affordable is to delay the ACA health insurance tax and eventually repeal it.

We are deeply concerned that this tax is undermining efforts to control costs and provide affordable coverage options. We strongly support bipartisan legislation to fully repeal the tax introduced by Representatives Boustany and Matheson and cosponsored by 230 House

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members. We also support as a short-term solution separate bipartisan legislation that proposes a 2-year delay on the tax.

On another front and in closing, we have worked closely with our members to provide comments to Federal agencies on dozens of proposed rules and other regulatory documents. We consistently have emphasized the importance of creating a regulatory environment that promotes a wide range of affordable coverage options. Thank you again for this opportunity to testify. I look forward to your questions.

Mr. Murphy. Thank you, Mr. Pratt. I thank you for yielding back.

[The prepared statement of Mr. Pratt follows:]

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Mr. Murphy. Now, I recognize Mr. Coyne for his 5 minutes. Thank you.

TESTIMONY OF FRANK COYNE

Mr. Coyne. Good morning, Chairman Murphy, Ranking Member DeGette, and members of the subcommittee. Thank you for the invitation to testify here today. I am Frank Coyne, Vice President in the Office of the President for the Blue Cross Blue Shield Association, which represents the 37 independent community-based Blue Cross and Blue Shield companies that collectively provide health coverage for 100 million Americans.

Blue Cross and Blue Shield companies offer health care coverage in every ZIP Code in the country and have long been committed to offering consumers across the country a wide variety of insurance options. My remarks today focus on the Blue's participation in the Multi-State Plan Program administered by the Office of Personnel Management and enrollment in Blue Cross Blue Shield MSP plans.

The Affordable Care Act authorizes OPM to contract with at least two entities, at least one of which must be a not-for-profit to offer products on the State and Federal marketplaces. Under this Multi-State Plan Program, OPM certifies health plans in conjunction with States for placement on the exchanges.

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For 2014, OPM certified Blue Cross and Blue Shield companies to offer Multi-State Plan products in 30 States and the District of Columbia. Collectively, Blue Cross Blue Shield companies offered more than 150 Multi-State Plan products. OPM has developed a standard contract for OPM issuers that meets its requirements. The association is party to that contract with OPM and are Blue licensee plans have agreements with us to fulfill many aspects of that contract, such as customer enrollment, benefits and claims administration and customer service, among other activities.

In addition, the contract contains a requirement to report enrollment information to OPM. In order to fulfill this requirement, we ask Blue plans to report information on their Multi-State Plan enrollments to us, and we convey enrollment information to OPM. As of April 1, 2014, a total of 283,783 individuals have selected an MSP plan.

I appreciate the opportunity to discuss Blue participation and enrollment in the MSP plan, and I look forward to your questions.

Mr. Murphy. Thank you, Mr. Coyne.

[The prepared statement of Mr. Coyne follows:]

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Mr. Murphy. Now, Mr. Wingle, you're recognized for 5 minutes.

TESTIMONY OF PAUL WINGLE

Mr. Wingle. Good morning, Chairman Murphy, Ranking Member DeGette and distinguished members of the subcommittee. My name is Paul Wingle, and I am executive director of Individual Business and Public Exchange Operations and Strategy at Aetna. Thank you for inviting us to today's hearing. I have a brief opening statement and will then be happy to answer any questions you may have.

Aetna is currently participating in the individual market on the exchanges in 17 States. Over the course of approximately the last 2 months, Aetna has worked with the subcommittee to provide requested data and information related to enrollment in plans offered through federally-facilitated marketplaces.

As of the third week of April, Aetna had over 600,000 members who had enrolled, and roughly 500,000 members who had paid. For those who are reached their payment due date, the payment rate, though dynamic, has been in the low- to mid-80 percent range. As outlined in our prior submissions to the subcommittee, these are dynamic figures and do not reflect final enrollment numbers, as some enrollees have not yet reached their payment due dates.

An example would be a member with a June 1 policy effective date

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who has not yet paid but whose initial payment is not yet due. We are happy to continue to work with the subcommittee to provide updated information and data and note that, as the subcommittee has recognized, this might include material, nonpublic, confidential and proprietary information.

Thank you again for the opportunity to be here today, and I would be happy to answer any questions you may have.

[The prepared statement of Mr. Coyne follows:]

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Mr. Murphy. Thank you, Mr. Wingle, he yields back.

And now, Mr. Evanko, you're recognized for 5 minutes.

TESTIMONY OF BRIAN EVANKO

Mr. Evanko. Chairman Murphy, Ranking Member DeGette, members of the subcommittee, good morning and thank you for the opportunity to testify at this hearing on PPACA enrollment and the insurance industry. I'm Brian Evanko, and I currently serve as president of the U.S. Individual Segment at Cigna Corporation. I oversee the operation tasked with developing, promoting and maintaining the Cigna products that are offered in the individual health market, including those products that are offered on the exchanges set up pursuant to the patient protection and Affordable Care Act, or ACA.

Cigna is a global health services company dedicated to helping people improve their health, wellbeing, and sense of security. Through its subsidiaries, Cigna offers an integrated suite of health services, such as medical, dental, behavioral health, pharmacy and vision care benefits, along with other related products including group disability, life and accident coverage.

We employ more than 26,000 people and have sales capability in 30 countries and jurisdictions. We manage more than 80 million customer relationships throughout the world. Despite our large

footprint, 80 percent of Cigna's overall health care business consists of administrative services. This means that we help employers to administer their policies. We also administer claims processes which are not risk-based like traditional insurance. Many of the employers that we assist are self-insuring and the claim payments come out of the employer's own funds.

Cigna's traditional insurance business is concentrated in the large group market. We have a very limited presence in the individual market, including on the ACA exchanges. The individual market currently constitutes approximately 3 percent of Cigna's total revenue. We currently offer health insurance products on the exchanges in five States, four of which, Arizona, Florida, Tennessee and Texas, are Federally-facilitated marketplaces. The only State-run exchange in which Cigna is participating is in Colorado.

We have entered the exchanges on a focus basis in 2014 to gather deeper learning about consumer behaviors in the individual market, to understand the operational implications of how the exchanges function, and as a potential longer-term source of growth for Cigna. For 2014, we did not expect the exchanges to have a significant financial impact on our company. The health insurance marketplace is evolving rapidly, and Cigna, like other health insurance companies, is constantly challenged to maintain affordability, accessibility and consumer choice in its product offerings.

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Cigna has worked collaboratively with our clients and customers, health care professionals, State and Federal regulators as well as other stakeholders to maintain our heritage of providing high-quality health insurance products and services while adapting to the ACA and other statutory and regulatory changes.

We believe that health care is a shared responsibility of the individual, the private sector, the medical community and the government. Accordingly, we look forward to how we can all work together to improve the health and wellness of and the quality of care for all Americans. I'd welcome any questions that you may have.

[The prepared statement of Mr. Evanko follows:]

******** INSERT 1-4 ********

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Mr. Murphy. Mr. Evanko yields back, and now we go to Mr. Rodgers to be recognized for 5 minutes.

TESTIMONY OF J. DARREN RODGERS

Mr. Rodgers. Good morning, Chairman Murphy and members of the subcommittee. I'm Darren Rodgers --

Mr. Murphy. Bring the mic as close to you as possible because we can't hear up here. Speak right into it.

Mr. Rodgers. Good morning again, everyone. I'm Darren Rodgers. I'm senior vice president and chief marketing officer At Health Care Service Corporation or HCSC. HCSC is a mutual legal-reserve company which does business as Blue Cross Blue Shield of Illinois, Montana, New Mexico, Oklahoma and Texas. HCSC is the largest customer-owned nonprofit health insurance company in the Nation. We're headquartered in Chicago, Illinois, with a workforce of nearly 20,000 employees serving nearly 14 million members throughout our five State Blue Cross Blue Shield plans.

For over 80 years, HCSC has been committed to expanding access to cost-effective health care to as many people as possible in every part of each of our five States. Whether through employer-sponsored insurance, government programs or individual products, HCSC is committed to its purpose and to offering our customers a wide range

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of cost-effective and sustainable product choices to meet the needs of -- to meet their health and wellness needs.

As we transition to a new health care marketplace, HCSC remains committed to its individual and small employer markets and continuing to offering accessible products, particularly to those individuals who do not have access to employer-sponsored coverage.

We're proud of what our brand stands for: Security and peace of mind, and our commitment to our communities in which we operate, as well as our large and geographically-diverse network of health care providers in our operating States. This allows us to offer a variety of affordable product choices in every county of every State in which we operate.

To support our individual and small-employer market, HCSC participated in the health insurance exchanges. We offered a similar portfolio of products both on and off exchange with a variety of deductibles, copays, coverages and other options with the goal of meeting our members' diverse health care needs.

At the current time, enrollment and payment information can only be presented as of each day when the numbers are counted. As such, their natural lags between the effective date of coverage and the date on which the members' coverage payment may be due. For instance, applicants with policies with an effective date of May 1 still have time remaining in their payment deadline. In addition, adjustments

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and reconciliations to this data are ongoing. The data HCSC is providing represents our good-faith estimate based on our records to date.

With these caveats, HCSC received between October 1, 2013, and April 15, 2014, approximately 830,000 applications across our five States, comprised of approximately 600,000 on-exchange and 230,000 off-exchange applications. We estimate that these 830,000 applications represent coverage for just over 1.2 million applicants.

In the written copy of my opening statement, we provided a snapshot of our current first-month payment rates. As you can see, January through April looked fairly consistent and range from 83 to 93 percent. The payment rates for May are currently less because payments are still coming in and being posted.

HCSC is and always has been committed to improving access to quality of care for all Americans. I thank you on behalf of HCSC for the opportunity to be a part of this important discussion.

Mr. Murphy. I thank the gentleman.

[The prepared statement of Mr. Rodgers follows:]

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Mr. Murphy. Now, Mr. Matheis, you are recognized for 5 minutes.

TESTIMONY OF DENNIS MATHEIS

Mr. Matheis. Chairman Murphy, Ranking Member DeGette and members of the House Energy and Commerce Subcommittee on Oversight and Investigations, thank you for the opportunity to be here today on behalf of WellPoint. I am Dennis Matheis, President of the Central Region and Exchange Strategy. I am responsible for creating WellPoint's exchange strategy and overseeing its launch. Prior to my current role, I was President of Anthem Blue Cross Blue Shield in Missouri.

WellPoint is one of the Nation's leading health benefit companies. We believe that our health connects us all, so we focus on being a valued health partner in delivering quality products and services that give members access to the care they need. With nearly 67 million people served by our affiliated companies, including nearly 37 million enrolled in our family of health plans, we can make a real difference to meet the needs of our diverse constituents.

We are an independent licensee of the Blue Cross and Blue Shield Association. We serve members as the Blue Cross licensee for California, and as the Blue Cross and Blue Shield licensee for Colorado, Connecticut, Georgia, Indiana, Kentucky, Maine, Missouri, Nevada, New Hampshire, New York, Ohio, Virginia and Wisconsin. In most of

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these service areas, our plans do business as Anthem Blue Cross, Anthem Blue Cross and Blue Shield, Blue Cross Blue Shield of Georgia and Empire Blue Cross Blue Shield or Empire Blue Cross. We also serve customers in other States through our Amerigroup and CareMore subsidiaries.

WellPoint is currently operating in the federally-facilitated exchange, which includes Georgia, Indiana, Maine, Missouri, New Hampshire, Ohio, Virginia and Wisconsin. We also participate in several State-based exchanges, including California, Colorado, Connecticut, Kentucky, New York and Nevada.

While there is no doubt that implementation of the exchanges presents a complex and daunting undertaking, we believe we've been able to apply our knowledge and experience to make the system work better for our members. We are seeing strong membership growth and large percentages of our of newly-enrolled customers are successfully paying their premiums by the due date.

Our most important priority through all of the complexity of ACA implementation is to ensure that our members receive the best possible care. Working closely and collaboratively with the physician community, our innovative programs from new payment models to telehealth solutions to sophisticated data analytics that arm physicians with better information, we are creating value for our members, for our physicians and for the health care system. We are proud of the work we are doing to transform health care.

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WellPoint was pleased to provide the committee last month with enrollment data from October 1, 2013, through April 15, 2014, for States where we participate in the federally-facilitated exchange. As we stated to the committee at the time of submission, this data is not final and only represents a snapshot in time. The data included enrollees whose policies have effective dates of April 1, May 1 and June 1, which means that premiums for such policies would not be due until April 10, May 10 and June 10, respectively.

Also, the reported enrollment in premium payment data is subject to adjustments. For example, enrollees may elect to drop their coverage, elect to change the effective date of their coverage after submission of their application, or continue to enroll through special enrollment periods. In response to the committee's request, we submitted the total number of applications received for enrollment in the federally-facilitated exchange during the period of October 1, 2013, through April 15, 2014.

The percentage of applications that have paid a premium will differ depending on whether the percentage is calculated based on the total number of applications and premium payments received during this entire period, roughly 70 percent; or as calculated based on the total number of applications and premium payments received for policies whose premium deadline has passed, ranging up to 90 percent depending on the State.

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WellPoint feels privileged to be able to serve our growing community of members. We take great pride in transforming health care with trusting, caring, creative and innovative solutions. I thank the committee for the opportunity to testify today on behalf of WellPoint and look forward to your questions.

Mr. Murphy. Thank you.

[The prepared statement of Mr. Matheis follows:]

******** INSERT 1-6 ********

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Mr. Murphy. For the record, all the witnesses did not go over time, and we'll make sure we fill in the gaps here what has not been provided to us and see if we can get some information.

Do any of you, particularly from the insurance companies, do any of you have -- I'm recognizing myself for 5 minutes, by the way -- have any data among those people who have subscribed, if the costs their paying for their overall health insurance plan is more, less, or the same as they were paying in a previous year? Mr. Wingle, does your -- do you keep that data?

Mr. Wingle. I don't have that data available.

Mr. Murphy. Mr. Evanko, do you know if your plan has that?

Mr. Evanko. I don't have specific figures to share. I can try to provide some context.

Mr. Murphy. Would you submit it for the record.

Mr. Rodgers, Mr. Matheis, do your plans keep a record of what people paid in a previous year versus what they're paying now?

Mr. Rodgers. No, I haven't looked at that information.

Mr. Murphy. Thank you.

And of those who all have signed up for insurance, do any of your companies ask for or have any data if people were among those who had lost their insurance, that is their insurance was canceled because of change in the Affordable Care Act? Any of you from insurance companies, do any of you have that data?

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Mr. Matheis. We currently do not have that information available.

Mr. Murphy. Okay. All right. Thank you.

So we don't know if the people who were signing up with these health insurance plans are people who are renewing insurance, had lost insurance or never had insurance, am I correct? Mr. Wangle? Mr. Evanko? Mr. Rodgers? Matheis?

Mr. Matheis. That's correct.

Mr. Murphy. I know Secretary Sebelius said that she did not think we had that data either.

Mr. Wingle, your chief executive, Mark Bertolini, said that premium rates in 2015 will range from very low single digits to some that will be over double digits. Can consumers expect this for their 2015 premiums?

Mr. Wingle. It's important to recognize, first of all, that we're at the start of the rate filing and approval process, so we're very early in the process of establishing those rates and submitting them to State regulators for approval and review. Our rates, it's also important to understand, reflect a number of key factors, most importantly the benefits covered by the plans we're filing, the population covered by those plans and the underlying health care costs in the geographies where those plans are offered. There will be some variability across geography and depending on those circumstances.

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Mr. Murphy. Some might face double-digit increases? We don't know yet, you're saying?

Mr. Wingle. I can't say for certain whether some will pay double digits, single digits or no increase at all. It's too early to say.

Mr. Murphy. If there's no increase in insurance, we should all celebrate because I'm not sure that has existed in my lifetime.

Will there be decreases?

Mr. Wingle. It's hard to say. It will vary by geography and rating factors.

Mr. Murphy. All right. Mr. Matheis, you announced your quarterly earnings and noted that the ramp-up in the fee of government is charging insurers under the health care law would impact marketplace premiums next year. What can consumers expect?

Mr. Matheis. So similar to my colleague's comment, we are in the process of developing our rates now for the 138 rating regions in which we do business across the 14 States. So I don't have exact numbers yet, chairman, in terms of what our rate increases are going to be. Certainly, inputs into that are the experience that we're developing through the population that we're serving, the expected medical trend that's going to occur and then the fees and taxes that occur through the ACA and through State and other Federal constructs, that all goes into the rate construct process.

Mr. Murphy. I think I'm going down the same hole with each of

you, so let me cut to the chase. The bottom line here is, you do get for risk corridors, you do get some money back from the Federal Government to balance out some of your costs, am I correct, with each plan? Mr. Evanko, is that true?

Mr. Evanko. The risk corridors, as you know, sir, are part of the three Rs. We at Cigna Corporation are not expecting a material, receivable or payable, as it relates to risk corridors.

Mr. Murphy. My point is that, as we're looking at this data -- and we'll continue to monitor and we recognize some of this is still preliminary -- based upon who has signed up and what their health care costs are, for example, if we don't reach -- if you don't reach the 40-percent number that the President had hoped, people between 18 and 35, and mostly those who signed up have been the older and sicker, then that's going to have an impact upon your plan costs. Am I correct, Mr. Rodgers?

Mr. Rodgers. Could you restate that question?

Mr. Murphy. That if people who have signed up are not the young, healthy invincibles but are indeed the older folks who have preexisting conditions and other health care costs, that you're going to have to face some sort of increase in premiums. Am I correct?

Mr. Rodgers. Well, as two of my colleagues have said, the rates that we file for 2015 haven't been finalized yet, but those will reflect --

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Mr. Murphy. I understand. I am anticipating. You've been in the business for a while.

And the Federal Government does provide some funds for you to help balance these out. Am I correct? Federal money comes to you to help as the risk corridors, and you have other people there who, the increased -- costs go up. Am I correct?

Mr. Wingle. The three Rs program does exist to provide some guard rails. We have not --

Mr. Murphy. Right. And but over time, that amount of money from the Federal Government will decline. Am I correct?

Mr. Wingle. Some of those programs are transitional and one's permanent.

Mr. Murphy. I understand. But we'll get back to this. Thank you.

I yield and now recognize Ms. DeGette for 5 minutes.

Ms. DeGette. Thank you, Mr. Chairman. Last week, the majority Republicans on this committee put out a report stating that only 67 percent of the people who signed up for insurance through the State and Federal marketplaces had paid their first month's premiums and then had a big press blitz about that saying that Obamacare had once again failed. So I kind of want to walk some of you through that allegation and see how true it is.

I want to start with you, Mr. Matheis. I believe that the press

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reports I've seen, the reports from the administration show that through the end of March, which was the deadline, about 8.1 people enrolled through either the Federal or State exchanges. Is that correct, to your knowledge?

Mr. Matheis. Did you mean 8.1 million?

Ms. DeGette. Yes.

Mr. Matheis. Yes. I have the same source of data that you do on that point.

Ms. DeGette. That's fine.

Now, in your testimony, you said that the data used in that Republican analysis, quote, included enrollees whose policies have effective dates of April 1, May 1 and June 1. Is that correct?

Mr. Matheis. Yes.

Ms. DeGette. And that's about 3 million out of 8 million people, about 40 percent. Is that correct?

Mr. Matheis. Again, since we didn't enroll all 8 million people, I can't attest to that question or not.

Ms. DeGette. But, okay. Well, I will say what I've seen is it's about 3 million out of 8 million. Now, so the 3 million people who enrolled -- or let me just say, the people who enrolled in March, they had coverage, in general, that began no earlier than May 1. Is that right?

Mr. Matheis. If you enrolled in March, you would have

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potentially an effective date, depending on what day of the month you enrolled in, could be April 1, could have been May 1.

Ms. DeGette. May 1. And so those people premiums were not due until at the earliest, the end of April; is that correct? If you enrolled March 31, your premiums were due at the end of April or later, right?

Mr. Matheis. To help facilitate members enrolling, what we have done at WellPoint is actually extended the payment period 10 days beyond last day of the effective month.

Ms. DeGette. So it could be April 30, or it could be even later, correct?

Mr. Matheis. So an April 1 --

Ms. DeGette. Yes or no will work.

Mr. Matheis. An April 1 effective --

Ms. DeGette. Right.

Mr. Matheis. -- would actually have until May 10 to pay their premium.

Ms. DeGette. Okay. Now, Mr. Matheis, let me ask you, your testimony said, while WellPoint ACA's policies whose deadline for paying premiums has passed, about 90 percent have paid their premiums. Is that correct?

Mr. Matheis. So our data in our --

Ms. DeGette. You can say yes or no. That's what your testimony

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said.

Mr. Matheis. Yes. So it's --

Ms. DeGette. Okay. Now, that's more than 67 percent. Is that correct?

Mr. Matheis. Last time I looked, yeah. Greater than 67.

Ms. DeGette. Now, Mr. Wingle, let me -- let me take you off the hot seat, Mr. Matheis.

Mr. Wingle, I want to ask you, Aetna has shown of the 5- to 600 enrollees who have paid, about 85 percent up until March paid their premiums. Is that correct?

Mr. Wingle. Our range is in the low- to mid-80s, month to month.

Ms. DeGette. Okay. And that's also more than 67 percent, isn't it?

Mr. Wingle. Empirically, yes.

Ms. DeGette. Yes.

And Mr. Rodgers, let me ask you, for your company, the ACA payment policies whose premium payment deadlines have passed, about 83 to 85 percent of them have paid their premiums; is that correct?

Mr. Rodgers. Yes, except for the most recent month.

Ms. DeGette. Right. The ones whose payment deadlines have passed.

Mr. Rodgers. Yes, that is correct.

Ms. DeGette. Yes. And that's also more than 67 percent, isn't

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it?

Mr. Rodgers. That is more than 67 percent.

Ms. DeGette. Yes. So what I wanted to ask about is, do any of you expect to see substantially lower payment percentages than you saw historically before the latest enrollment? Mr. Matheis.

Mr. Matheis. So I will give a little context to my answer.

Ms. DeGette. Okay. I need a yes or no. I don't have much time. I'm sorry.

Mr. Matheis. Well --

Ms. DeGette. Do you expect to see it go down to 67 percent for April?

Mr. Matheis. I don't think we have enough information to know exactly where it's going to be.

Ms. DeGette. Okay. Well, Mr. Rodgers, let me ask you this question, then: Mr. Upton said that he thinks suddenly, maybe they won't pay for their enrollment in March. So I wanted to kind of go through, because you've got a nice chart in your testimony and it shows the payments month by month that people made when they enrolled. So for 1/1/2014 on the exchange, 85 percent of the people paid; is that correct?

Mr. Rodgers. That's correct.

Ms. DeGette. For 2/1/2014, 86 percent paid, correct?

Mr. Rodgers. That's correct.

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Ms. DeGette. For 3/1/2014, 88 percent paid; is that correct?

Mr. Rodgers. Yes.

Ms. DeGette. And for 4/1/2014, 83 percent paid; is that correct?

Mr. Rodgers. That is correct.

Ms. DeGette. And you're still waiting for everybody else to pay because their deadline has not passed yet; is that correct?

Mr. Rodgers. That's correct.

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

Mr. Murphy. Can I just follow up with a clarifying question: When she asked about historical data, were you referring to the last couple months or comparison with previous years under different plans?

Ms. DeGette. Well, we didn't have an exchange.

Mr. Murphy. No, no, I just --

Ms. DeGette. Chairman, we only just got the exchange.

Mr. Murphy. No, I wasn't sure if you meant under historical you mean previous years of plans versus just the exchange.

Ms. DeGette. Mr. Chairman, what I mean is since the ACA was implemented starting on October 1.

Mr. Murphy. Okay. Thank you. I just wanted clarification on that.

Now recognize Ms. Blackburn for 5 minutes.

Mrs. Blackburn. Thank you all so much for being with us. I want to say with this issue on the premiums because we get asked about this

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a lot.

So Mr. Wingle, Aetna, your CEO said that premium increases will vary over 17 States and encompass 132 rating areas, correct?

Mr. Wingle. That is correct.

Mrs. Blackburn. Okay. Can you identify where premiums will decrease in 2015? What identification can you place on that?

Mr. Wingle. At this point in the filing season, we can't offer any guidance on or speculate on where they're going to fall. We're still gathering the information for file.

Mrs. Blackburn. None?

Mr. Wingle. I can't say none. I can't say any.

Mrs. Blackburn. Okay. Mr. Matheis, can you tell me, identify any States where you are offering products in the exchanges where consumers can expect a premium decrease?

Mr. Matheis. At this juncture, we do not have the information.

Mrs. Blackburn. You don't have the information?

Mr. Matheis. No. The filing rates are due starting in late May into June, and so we have not computed yet with any certainty what the actual rates are going to look like in our 138 rating regions.

Mrs. Blackburn. Okay. A lot of uncertainty floating around out there.

Okay, Mr. Evanko.

Mr. Evanko. I would echo my colleague's comments. We're in the

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process making decisions. Some decisions on certain assumptions have been made, but most assumptions are still to be determined.

Mrs. Blackburn. So you don't know if your consumers are going to see any decreases. You know they were promised decreases through the Affordable Care Act, so.

Okay, Mr. Rodgers, to you.

Mr. Rodgers. As the company's marketing officer, I can tell you I'm not involved in rate setting, but I'm aware of some of the deadlines we're facing which are generally toward the end of June.

Mrs. Blackburn. Okay. Well, let me ask you all this, then: Have any of you conducted any internal analysis of what your organizations premiums are going to look in 2015? Do any of you have any internal analysis? Raise your hand for me. So you all have conducted no -- we've got some of our Nation's biggest insurers, and you have done no internal analysis on what the trend line is for these premiums? None?

Mr. Evanko. Ms. Blackburn --

Mrs. Blackburn. Oh, Mr. Evanko, have at it.

Mr. Evanko. So I'd like to clarify our comments here a little bit, or at least my comments as it relate to this issue. So the decisions related to this are very complicated and they impact each individual a little bit differently because of where someone's located, maybe what their APTC eligibility is, et cetera. So there's a long

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list of reasons there.

Mrs. Blackburn. Right. We understand that. You're talking about a 2,300 page law that became about over 20,000 pages of rules and regulations and we know this changes daily. We appreciate the predicament that you are in. We also appreciate the predicament that our constituents find themselves in.

And it is baffling that we can have some of our Nation's largest insurers and you all don't have any internal analysis as to what these rates are -- I thought that, reading your reports, you all did analysis in trend lines for the near-term, the midterm and the long-term and you looked at what the expectations were so that your stakeholders would all be aware of what was happening within that market. You know, has anybody done any kind of analysis?

Mr. Matheis. So can I answer your question?

Mrs. Blackburn. Yes, please. Have at it, Mr. Matheis. Your mic, please.

Mr. Matheis. So analysis is typically ongoing in organization. Rate development typically takes 3 to 6 months to occur once you have credible information. And so just for context purposes, we, as has been stated earlier in this meeting --

Mrs. Blackburn. Let me --

Mr. Matheis. Let me finish.

Mrs. Blackburn. Okay. Go ahead.

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Mr. Matheis. -- we are just now understanding what membership we have attracted and so the work is ongoing, but it has not been finalized. And that's the important point.

Mrs. Blackburn. Let me ask you this: What has been prepared for your CEO? Any of you?

Mr. Matheis. At this juncture, we do not have a compiled package to sit down and say, here is what we believe a rate is going to be in any of our 130 rate areas.

Mrs. Blackburn. When do you expect to have that?

Mr. Matheis. Typically, it will be towards the end of this month, as rates need to be filed in our States starting end of May through the June or July time period.

Mrs. Blackburn. Would you submit that to us for the record, each of you. Do you agree to submit this for the record so that we will have this?

Mr. Wingle. And representative, I want to concur with my colleague, we are constantly analyzing our exchange experience. This is a new population. We don't have the long claims record or history we have we had in the previous market, so the more data we get the better and more confident we feel as we propose rates. It's an ongoing analysis. It's a constant analysis.

Mrs. Blackburn. Okay. We appreciate that, and we would like to have that analysis and the information you have as you get it and ask

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that you please stay in touch with us and do those orderly insertions for the record.

I yield back, Mr. Chairman.

Mr. Murphy. Gentlewoman yields back, and now recognize Mr. Dingell for 5 minutes.

Mr. Dingell. Mr. Chairman, I thank you for your courtesy and I thank you for the hearing. I'm pleased the committee is examining the first open enrollment period under the Affordable Care Act. I would like to examine the staff report where it claims only 67 percent of Obamacare enrollees have paid their first month's premium. We want to find out whether that's so and what it means.

The bottom line, I think, is ACA is working. After a turbulent start we got the Web site up. It's running and HHS now reports that 8 million people have selected plans through the exchanges. Furthermore, some 4.8 million people are enrolled in Medicaid and CHIP, and that number would be much higher if all 50 States chose to expand Medicaid.

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RPTS HUMISTON

DCMN HOFSTAD

[11:18 a.m.]

Mr. Dingell. CBO estimates that another 5 million people purchased ACA-compliant plans outside the marketplaces. Finally, Gallup just found that the percentage of Americans who do not have health insurance fell to 13.4 percent, down from some 18 percent 1 year ago.

So let's examine and see what goes on.

This question to Mr. Matheis. And "yes" or "no," if you would, please. When WellPoint turned over enrollment figures to the majority, you did this under the caveat that the data was not final and only represented a snapshot in time. Is that correct?

Mr. Matheis. Yes, it is.

Mr. Dingell. Yes?

Mr. Matheis. Yes.

Mr. Dingell. Now, this question, again to you, Mr. Matheis. And that is because the committee only requested data through April 15, 2014; is that correct?

Mr. Matheis. Yes, it is.

Mr. Dingell. Now, Mr. Matheis, is it correct that the people who signed up after May 15 may not have to pay their premium until later

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in April, May, or even June, yes or no?

Mr. Matheis. Is there anybody after April 15th, would have -- would have a longer time --

Mr. Dingell. Those folks who signed up after March 15th.

Mr. Matheis. Yes.

Mr. Dingell. Now, Mr. Matheis, is it correct that nearly 90 percent of WellPoint's customers whose premium deadline has passed have already paid their first month's premium, yes or no?

Mr. Matheis. Yes, it is.

Mr. Dingell. Now, in your experience, have you found that people are more likely to make their premium payment right before the deadline?

Mr. Matheis. That is typically human nature, sir.

Mr. Dingell. And we know that from the behavior of Americans with regard to income tax and things like that.

Now, this question is for Mr. Wingle of Aetna. Is it correct that, according to your best estimate, roughly 80 percent of Aetna beneficiaries who have reached their payment due date have paid their first month's premium, yes or no?

Mr. Wingle. Month to month, it ranges from the low to mid 80s.

Mr. Dingell. Say that again?

Mr. Wingle. It ranges from the low to mid 80s, month by month.

Mr. Dingell. Thank you.

Now, this question to, Mr. Coyne of Blue Cross-Blue Shield. Is

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it correct that, according to your best estimate, 80 to 85 percent of the individuals buying Blue Cross-Blue Shield plans through the marketplace have paid their first month's premiums, yes or no?

Mr. Coyne. Yes, that is correct.

Mr. Dingell. I'm not hearing you, sir.

Mr. Coyne. Yes, that is correct, based on --

Mr. Dingell. That's correct.

Mr. Coyne. -- a report we --

Mr. Dingell. Now, gentlemen, it doesn't take, I think, a genius or an atomic physicist to figure out the numbers we just heard from the actual insurance companies greatly differ from the staff report. I hope everyone will take these companies at their word instead of falling for smoke and mirrors from my friends on the other side of the aisle.

I can understand why my friends on the other side of the aisle are not in attendance, because they would get a very unpleasant taste of fact which they might not like. My old daddy taught me, he used to say to me, "Son, figures don't lie, but liars can figure."

And I have always thought that it would be a good thing, when this committee does its business, that we know what we are doing, that we deal in hard facts, so that when the legislation that we work on, the laws that we are dealing with, the oversight in which we engage actually lead us to truth and correct response, so that public policies may be

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founded on fact rather than fiction and on staff reports that mislead all.

I would suggest that the staff report should be reviewed with the utmost of care and deposited then very carefully in the nearest large wastebasket.

Thank you, Mr. Chairman.

Mr. Murphy. The gentleman yields back.

I now recognize the vice chair of the committee, Mr. Burgess, or Dr. Burgess, for 5 minutes.

Dr. Burgess. Thank you, Mr. Chairman. I thank you for the recognition.

I would remind the chairman emeritus that we are friends.

Let me ask you a question. April 17th, the day the President came out with his "mission accomplished" speech at the White House in the press briefing, there was a briefing of executives of your companies; is that correct?

Anyone is free to answer.

Mr. Matheis. I believe that was correct, sir.

Mr. Rodgers. That is correct, yes.

Dr. Burgess. And was your company represented?

Mr. Rodgers. I'm not sure which particular meeting you're describing, but I know there have been some.

Dr. Burgess. Well, let me give you the particular meeting. It

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was on April the 17th at 1:35 p.m., the President and Vice President meet with insurance executives in the Roosevelt Room.

Did that meeting take place?

Mr. Matheis. WellPoint was present at that meeting, sir.

Dr. Burgess. WellPoint was present.

Was Cigna present?

Mr. Evanko. Our CEO was not present at that meeting.

Dr. Burgess. Your -- was not. Okay.

Mr. Wingle. I'm advised that our CEO was not present at that meeting.

Dr. Burgess. That was Blue Cross?

Mr. Wingle. That's Aetna for me.

Dr. Burgess. Was Blue Cross represented at the meeting?

Mr. Coyne. I don't have that information right now.

Dr. Burgess. Well, for those that were --

Mr. Pratt. And just for the record, I'm advised that AHIP's President was present at the meeting.

Mr. Rodgers. And I don't -- I can't remember the exact date of those meetings, but I can tell you that when we are called to the White House, generally we would attempt to be there.

Dr. Burgess. Well, it was April 17th. I mean, I would think you'd remember. It's a pretty big deal. I mean, I haven't had a meeting with the President or the Vice President.

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Ms. DeGette. Would the gentleman yield? Perhaps --

Dr. Burgess. No, I will not. No, I will not. My time is -- my time is limited.

What I would like, from those that answered affirmatively, Mr. Matheis and Mr. Pratt, can you provide us information as to what was covered in that meeting -- who made the presentation, how long it was? And was there, in fact, time for there to be question and answer, or was it simply a presentation to you from the President and Vice President?

Mr. Matheis. Mr. Congressman, I was not personally present at that meeting, our CEO was, and I do not know the facts of the meeting.

Dr. Burgess. Would you make an attempt to answer for me those questions? Was, in fact -- was this an interactive process, or was this a proclamation? Was it a monologue, or was it a dialogue?

And, Mr. Pratt, if you would provide us that information, as well.

And here is the deal. I mean, why am I making -- why am I making a big deal of this? You all are here today because the White House won't respond to us. And I would think, if it was possible for the White House to provide a briefing to your executives on April 17th, that same person could be made available to this committee and be prepared to answer our questions. I don't see what is so difficult about that. If the news is as great as everyone has said it is this morning, I think that they would welcome the opportunity to come to

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our committee and give us the information that we are asking for.

Look, one of the questions that I raised in the opening statement, and I do want your answers on this because it is important, this 90-day grace period and the coverage that can't be cancelled during that 90-day grace period because of nonpayment. Is there any way for any of your individual companies to keep up with that information on a rolling basis and keep your providers informed as to the status of a person's payment or nonpayment of their premium?

We'll start with you, Mr. Coyne, and let's just work down the table.

Mr. Coyne. We are working with Blue Plans to inform providers of the enrollee's status, as you indicated.

Dr. Burgess. Mr. Wingle?

Mr. Wingle. Yes. We do have a unique identifier for our exchange membership on the ID card, and we do provide updates on the member's payment status in our physician information centers. So when the physician offices call or the provider calls, they understand what the payment status is of the member.

Dr. Burgess. Mr. Evanko?

Mr. Evanko. Our doctors and our hospitals that are servicing our customers have the ability to either call or check online the status of the individual's payment grace-period situation.

Dr. Burgess. And, Mr. Rodgers, would that even pertain to you?

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Mr. Rodgers. Yes. Similarly, we have electronic means as well as telephone service, as well, for providers of various types to verify coverage.

Dr. Burgess. And Mr. Matheis?

Mr. Matheis. Yes, we provide the same service.

Dr. Burgess. And what I would ask of each of you is, will you make available to the committee the type of information and how it is transferred to your providers, your doctors and hospitals, when they call for that information?

And then, Mr. Chairman, further, I would like to ask unanimous consent -- the Secretary was here in December, the Secretary of Health and Human Services. After that hearing, I submitted a letter to the Secretary with several questions that I wanted answered. They have not been answered to date.

I am going to ask those same questions of our insurance representatives today. I am going to ask those in writing, and I would appreciate your response to those questions that the Secretary was unwilling to answer.

Ms. DeGette. Reserving the right to object. I would just point out that the Secretary was here in front of this committee testifying three times last year. And if there are questions she has not answered, we certainly will be happy to work with the majority and get those questions answered.

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Mr. Murphy. Well, the Members do have the right to --

Ms. DeGette. I will drop my reservation.

Mr. Murphy. -- submit questions for panelists.

Dr. Burgess. And I will be submitting those questions in writing for our panel.

[The information follows:]

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

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Dr. Burgess. Thank you, Mr. Chairman.

Mr. Murphy. Mr. Green, you are now recognized for 5 minutes.

Mr. Green. Thank you, Chairman Murphy and Ranking Member DeGette, for having this hearing today, and our witnesses for the testimony.

My district in Texas is a very urban district in Houston and has one of the highest rates of uninsured people who don't receive insurance through their employer in the country.

One of the other talking points that my Republican colleagues have seized upon last year, especially when the HealthCare.gov was encountering problems early in the enrollment period, was the idea that fewer people would have health insurance following the implementation of the Affordable Care Act than did beforehand.

Now, I know that all our representatives here today see that the information and how many people they have enrolled and their total number of customers are proprietary, and I understand that. But you are all also, I would hope, familiar with the general insurance landscape and how it has changed under the Affordable Care Act.

Earlier this week, the Gallup Poll released a survey examining the total number of Americans that have insurance.

Mr. Pratt, are you familiar with that survey?

Mr. Pratt. Generally, yes.

Mr. Green. The Gallup Poll conducted interviews with 14,000

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American adults. Gallup found that the number of adults without insurance had dropped to its lowest level since the beginning of 2008. A drop of this magnitude correlates to more than 11 million people gaining coverage.

Are you familiar enough with the poll to say that that sounds like a reasonable amount?

Mr. Pratt. Congressman, I think that's what they reported. I'm not in a position to say whether that's a reasonable amount or not.

Mr. Green. Okay.

Anyone else on the panel want to talk about that Gallup poll? Because, you know, again, these are what we are seeing since the enrollment period ended.

RAND and The Urban Institute released similar reports in March and April. Are any of you familiar with these reports?

Mr. Matheis. Just very generally, Congressman.

Mr. Evanko. I'm not familiar with the reports.

Mr. Green. Okay. Well, in early April, RAND Corporation released the results of their poll, which found the overall number of Americans with insurance had grown to 9.3 million as of mid-March, even before the late enrollment date surge. The Urban Institute also released a report in the past month suggesting that millions more people have coverage than before the ACA was implemented.

My question of any of our witnesses: Would you agree that the

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findings of these, whether it be RAND, Gallup, or The Urban Institute, are consistent with millions of Americans signing up for health insurance? Did you all experience that with your companies during the signup, that they selected your company as part of the -- if you happened to be part of the exchange, both national or the State exchanges?

Mr. Matheis. Congressman, we do not have -- at WellPoint, we do not have enough information at this point to know how many uninsured are actually among the enrollees, because that data is -- we just don't have access to that data at this point.

Mr. Green. Okay.

Well, generally, the ACA has led to a huge increase in coverage. Even without the polls, we have seen some of the numbers. And can you verify that with your companies, whether it would be WellPoint, Blue Cross? Have you seen that increase in the number of people who have signed up with your companies since the deadline?

Mr. Rodgers. Speaking for Healthcare Service Corporation, I provided in my written testimony as well as in my opening comments the number of people that we signed up on- and off-exchange through the open enrollment period. I can't tell you today how many of those came from the ranks of the uninsured or from our competitors or either from a prior policy with one of our five Blue Cross and Blue Shield plans, but we're certainly happy to have the numbers up.

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Mr. Green. Okay.

Well, and we understand there were people who were using the Web sites and the national exchange to shop. And I had some companies who said, I'm a small business, I encourage -- in fact, I have a number of them in my area. He said, we have actually helped our employees sign up individually, because, you know, you have 10 employees, they weren't required, but they actually used it. And I know that's an analogy, but I have heard that from a lot of my employers.

Now, I know my Republican colleagues, with the missed data from these polls, that anything that comes through the administration for the overall signup -- in March, Speaker Boehner said that there were less people today with health insurance than there were before this law went into effect.

I think, not even basing it on a poll, would you all agree that there are more people that have health insurance now, let's say since May 1st, than we had before the ACA?

Mr. Pratt. I can't speak to numbers on that enrollment.

Mr. Green. Okay.

I don't know how my colleagues continue to make unfounded claims in the face of the clear evidence that the Affordable Care Act is providing millions of Americans with healthcare coverage. It makes me wonder what would possibly convince them that millions of Americans have gained coverage under the law. I suspect that, ultimately, once

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the information becomes so indisputable, that it maybe will change the subject and, rather, concede that clearly more people have health insurance as a result of the ACA.

And having served many years in Congress and even before that in the State legislature in Texas, no law Congress ever passes is perfect. That's not how our forefathers created the system. So we do need to go back, like our ranking member said, and see what we can do to fix the ACA. And I appreciate you all's efforts to help us do that once we get to that point.

And I will yield back my time.

Mr. Murphy. The gentleman yields back.

I now recognize Mr. Griffith of Virginia for 5 minutes.

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

Thank you all for being here.

Ms. Blackburn asked you earlier for a show of hands, and I am going to do the same. If your company anticipates a reduction for the average family that you insure of $2,500 or more, would you raise your hand?

If your company anticipates a reduction in premium of $2,000 per average family for your subscribers, raise your hand.

Same for $1,500?

All right. I appreciate that.

When will your companies submit their rates to the administration for 2015? Do you all have a date that you're going to do that by? We'll

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start with --

Mr. Rodgers. I believe the --

Mr. Griffith. Yes?

Mr. Rodgers. -- rates are due toward the end of June. I believe it's June 27th. I think that some of the States are a little bit ahead of that.

Mr. Griffith. All right. And do you know when those will become public?

Mr. Matheis. Depending on the market, sir, that will vary, depending on the States.

Mr. Griffith. All right.

And when you submit those to the administration, will you commit today to submitting those rates to us, as well?

Mr. Rodgers. I'm not involved in the rate submission process, but to the extent that's possible -- I'll need to talk with our company representatives about that.

Mr. Griffith. Well, I certainly can't see how it would be illegal to share information with the United States Congress, but --

Mr. Rodgers. I didn't say "illegal."

Mr. Griffith. But if possible, you will do it, Mr. Rodgers?

Mr. Rodgers. I need to confirm with our actuaries who are involved in the rate-filing process, because I'm not.

Mr. Matheis. We are happy to work with this committee as long

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as the rates remain proprietary until they do become public and all of our competitors see them.

Mr. Griffith. All right. That's certainly fair.

Any others?

Mr. Wingle?

Mr. Wingle. I'd have to take that under advisement about how we share rates.

Mr. Griffith. Mr. Evanko?

Mr. Evanko. I'd just say that the rates are very competitively sensitive, for obvious reasons. So we want to make sure that it's a level playing field at the time any rates are disclosed.

Mr. Griffith. Have either you or anyone in your organizations -- and, again, it's for all of you all -- engaged in discussions with the administration already about the 2015 rates?

Mr. Rodgers. Not that I'm aware of.

Mr. Wingle. Not to my knowledge.

Mr. Griffith. Everyone is silent. Does that mean there have been none? Has anyone had any discussions with the administration about rates for 2015?

Mr. Matheis. None that I'm aware of.

Mr. Griffith. Okay.

Mr. Evanko. No.

Mr. Rodgers. No.

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Mr. Griffith. All right. Appreciate that. Thank you very much.

Mr. Pratt, the ACA includes a tax credit for small businesses to purchase health insurance coverage for employees. The law also levies a tax on health insurance purchased by small businesses.

On the one hand, we give employers a tax credit to make health insurance more affordable, and then we turn around with the other hand and we tax those policies. Does that not seem as an inherent conflict in policy to you?

Mr. Pratt. Congressman, we have expressed significant concerns with the new tax on small businesses and individuals that total some $100 billion that will largely be passed on to them in the form of higher premiums.

Mr. Griffith. And what we are trying to do, of course, is to see if we can't keep premiums down. And the ACA, Obamacare, has failed to meet its promise of a $2,500 reduction for the average family. That's pretty straightforward, isn't it?

Mr. Pratt. Congressman, we do believe that the health insurance tax runs counter to the goal of providing more affordable coverage.

Mr. Griffith. And as a part of this, we are actually taxing government itself. We've got Federal programs, including Medicare Advantage, Medicaid Managed Care. The Federal Government is, in fact, taxing itself with the tax that you spoke of earlier through its

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subsidization of Medicare and, in part, Medicaid. And then State governments are also having to pay the tax.

Do you have any idea how much that tax is on the American people? You said $100 billion in increase, but how much for the Federal and State governments?

Mr. Pratt. Congressman, I don't have that information handy. But we did commission a study by Oliver Wyman that does break out that information in more detail, including on a State-by-State basis, and we'd be happy to make that available.

Mr. Griffith. All right. I appreciate that, if you would.

Also, in your testimony, you write that insurers have many duplicate enrollments because of the problems with HealthCare.gov. And I can tell you that we had that in both -- I have heard it from constituents and in our family. Apparently, we didn't push the right button the first time around. I say "we"; my wife did it all. Don't want to take on any assumptions that it was us doing it; it was my wife working over the computer for hours and hours. But actually submitted several different applications, ended up with one.

How widespread is that problem for citizens out there? And is that part of the confusion between whether or not people have paid their premiums or not?

Mr. Pratt. Congressman, the challenge you referred to, I think, was presented as a result of the problems with the Web site and the

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technology. And, anecdotally, we have heard from our members about a number of duplicate enrollments. Don't have an order of magnitude on that other than to know that it has been a problem and an issue.

Mr. Griffith. All right. I appreciate that.

And, Mr. Chairman, I yield back.

Mr. Murphy. The gentleman yields back.

I now recognize Ms. Schakowsky for 5 minutes.

Ms. Schakowsky. Thank you, Mr. Chairman.

This morning, the Democratic committee staff released a memorandum on the amazing number of distortions and false claims that Republicans have made about the Affordable Care Act. It's a deplorable record. Virtually every major prediction or claim made by the Republicans about the ACA since 2009 turned out to be wrong.

Today, we have the benefit of hearing from some of the companies that are actually working on the Affordable Care Act in the real world. These companies were not the biggest supporters of the law, they still oppose many provisions, but they do not live in the Republican echo chamber, they live in the real world. And I hope they can provide some clarity on a few questions.

The first question I have for all of you is whether the ACA is a government takeover of health care.

Republicans have made that claim I don't know how many times. By one count, the phrase appeared on Speaker Boehner's Web site 90

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different places. It's mentioned on the RNC, Republican National Committee, Web site 200 times. Days before the Affordable Care Act's passage in 2010, then-House-Minority-Leader John Boehner's office wrote that, quote, "Democrats have opted for a government takeover of health care."

So, Mr. Wingle, the ACA is now in effect. Has the government nationalized Aetna, or is it still a for-profit corporation?

Mr. Wingle. We are a publically traded, for-profit corporation.

Ms. Schakowsky. And, Mr. Evanko, what about you? Has Cigna been taken over by the Federal Government?

Mr. Evanko. No. We're a for-profit organization.

Ms. Schakowsky. Mr. Rodgers, Mr. Matheis, have your companies been nationalized, or are they still nonprofits?

Mr. Rodgers. We are a not-for-profit, mutual legal reserve company.

Mr. Matheis. And we are actually a for-profit organization.

Ms. Schakowsky. Oh, you're a for-profit. Sorry.

Mr. Pratt, you work for the trade group that represents the private insurance industry. Is there still a private insurance industry, or has the industry been destroyed or taken over by the government, as Republicans predicted?

Mr. Pratt. There is still a private industry, and we represent many of those companies.

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Ms. Schakowsky. Thank you.

Republicans also questioned whether private health insurance would even exist in 2014. In 2010, Senator Coburn said, quote, "There will be no insurance industry left in 3 years," and that, quote, "Private health insurance will be dead in 3 years," unquote. I should note that nearly 4 years have passed since that statement was made.

Mr. Pratt, is the private health industry dead?

Mr. Pratt. Representative, no.

Ms. Schakowsky. Does anybody else on the panel believe the private industry has disappeared, private insurance industry?

Thank you.

Republicans have also claimed that Americans will no longer be able to see their doctors because of the ACA.

Mr. Wingle, does your company healthcare plan -- do the plans cover physician care?

Mr. Wingle. They do.

Ms. Schakowsky. And, Mr. Evanko, what about you? Does Cigna have doctors in its healthcare plans?

Mr. Evanko. Yes, we do.

Ms. Schakowsky. Mr. Rodgers, what about HCSC? Do you include doctors in your networks?

Mr. Rodgers. Certainly.

Ms. Schakowsky. And, Mr. Matheis, what about WellPoint?

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Mr. Matheis. Yes, we cover physician services.

Ms. Schakowsky. Thank you. Thank you very much.

Republicans have claimed that nobody would sign up for coverage. They've claimed that huge numbers have not paid for coverage. Eight million people have signed up for coverage on the exchanges. Millions more have coverage outside the exchanges. And each of the insurance companies here today have testified that people have signed up in droves and upwards of 80 or 90 percent have paid their premiums.

Mr. Chairman, I don't know if there will ever come a day when Republicans will admit their criticisms of the ACA have been unfounded. I think we may have reached a turning point last week when you released your misleading report on the Affordable Care Act enrollment. I think the American public finally realize that Republicans have absolutely no credibility on this issue. You cannot be this wrong this many times and still expect to be taken seriously.

One commentator, Ezra Klein, even gave the Republican behavior a name: Obamacare Derangement Syndrome. He defined it as, and I quote, "the acute inability to see Obamacare as anything but a catastrophic failure that the American people will soon reject. For those suffering from ODS, all bad Obamacare news is good news and all good Obamacare news is spin. In this world, delays of minor provisions in the law prove that the entire structure is collapsing, while surges of millions of people enrolling in insurance don't prove anything at

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all."

Mr. Chairman, perhaps we can ask our panel of insurers if their policies cover Obamacare Derangement Syndrome. But, really, that's rhetorical.

And I yield back. Thank you.

Mr. Murphy. But it would be important to know if that's a preexisting condition, and I think it's not coverable --

Ms. DeGette. It would be covered now. Good news, Mr. Chairman.

Mr. Murphy. It depends what the death panel says, I think.

Mr. Olson is now recognized for 5 minutes.

Mr. Olson. I thank the chair.

And welcome to our witnesses.

I wish you weren't here, but you are here. You're here because the administration will not give us the information we need to educate our constituents about Obamacare and the rollout of HealthCare.gov.

I want to talk about, all of you, a question about the back end and the money you're supposed to be getting from the exchange and the information. In your experiences, is it working?

Mr. Pratt, is the back end working? Are you getting what you need from HealthCare.gov?

Mr. Pratt. Representative, throughout the open enrollment period, we worked very closely to develop workarounds, manual processes, and other things that were necessary to make the system work

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better. It's my understanding that, while the back-end problems have improved, some remain.

Mr. Olson. Workarounds. You guys stepped up to the plate to work around the disaster of the healthcare exchange rollout? Is that what you're trying to say?

I mean, you guys took it upon yourself instead of depending on what -- they've got information. You depend upon them. And is sort of trickling down and just coming out slowly, slowly, slowly not what you need? Is that you're saying? You guys stepped around to make that happen?

Mr. Pratt. Representative, I think what I would say is that we kept the interests of our members squarely in mind, in terms of minimizing disruption for them. And our members did what was necessary to make sure that it was as smooth as it possibly could be.

Mr. Olson. Mr. Coyne?

Mr. Coyne. I would agree with Mr. Pratt. There are still back-end issues to be worked through but that we are working with CMS on those. CMS has called a meeting of health insurers in the Federal marketplace on May 20th to consider some of those back-end issues and try and find solutions to them.

Mr. Olson. And I hope you keep us advised of what that meeting puts forth, give us that information. Because we are not getting it from the Obama administration.

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Mr. Wingle?

Mr. Wingle. We've worked closely to share our concerns about technical needs and help work with the industry, through our trade association, with colleagues to recommend and -- recommend prioritization on fixes for back-end issues, whether they're data cleanup issues or other issues related to the back end of the exchange.

Mr. Olson. Mr. Evanko?

Mr. Evanko. There are certainly more manual processes than we anticipated prior to the exchanges launching. I'd say there have been improvements in some areas. The one back-end issue that we are most focused on is the APTC payments coming from CMS to us as a carrier. That's a manual process today. We have been getting the payments we've been requesting, though, as it relates to APTC.

Mr. Olson. Manual process. Twenty-first century, manual process.

Mr. Rodgers?

Mr. Rodgers. We're continuing to work with the enrollment process to make sure that any of the members that have selected one of our five Blue Cross and Blue Shield plans get the information they need from us and ultimately the care they need.

Mr. Olson. Mr. Matheis?

Mr. Matheis. Yes. We're -- we've seen significant improvement, but we still have a number of opportunities for

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improvement as we move through the remainder of this year.

Mr. Olson. And one final question for all the panelists. Is the Web site fixed?

Mr. Pratt?

If it's not fixed, when it will be fixed?

Mr. Pratt. Representative, I don't work in the operations area. I think if the back-end issues are considered part of the Web site, I would say --

Mr. Olson. They are.

Mr. Pratt. -- yes, that there are still issues outstanding that we're working on.

Mr. Olson. Not fixed.

Mr. Coyne?

Mr. Coyne. There are still issues on the back end.

Mr. Olson. Another one not fixed.

Mr. Wingle?

Mr. Wingle. There's still work to be done.

Mr. Olson. Not fixed.

Mr. Evanko?

Mr. Evanko. I can't comment on the end-to-end process. I can only comment on the component when CMS sends us enrollment transactions, and there is still work to do before that's 100 percent.

Mr. Olson. Not fixed.

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Mr. Rodgers?

Mr. Rodgers. Yes. We are still working with the files that we get, and I think there could be some improvement.

Mr. Olson. Still not fixed.

Mr. Matheis?

Mr. Matheis. Yes. I echo my colleagues' statements. We still have opportunities for improvement.

Mr. Olson. Six for six. All not fixed.

Mr. Chairman, I yield back the balance of my time.

Mr. Murphy. The gentleman yields back.

I now recognize Mr. Tonko for 5 minutes.

Mr. Tonko. Thank you, Mr. Chair.

So much of the debate we have with our Republican colleagues about the Affordable Care Act comes down to one simple question: Is it a good thing for Americans to have access to quality health insurance?

You would think this is a simple question. Every Republican member of the committee has health insurance. I bet that every pundit who makes a living attacking the ACA has health insurance. They all make certain their children have health insurance. I bet they wouldn't dream of going without it for an extended period of time.

Two big reasons these people make sure they have coverage is that it can help them stay healthy and it can prevent catastrophic medical bills that can lead to financial ruin. But, this week, we got clear

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evidence from Massachusetts that health insurance actually saves lives. Researchers at the Harvard School of Public Health looked at mortality rates in Massachusetts and in surrounding States.

My question, Mr. Pratt, is that, in 2006, Massachusetts passed major health reform legislation; is that not correct?

Mr. Pratt. Yes, that's correct.

Mr. Tonko. And did that coverage expansion bear some significant similarities to the Affordable Care Act, including an individual mandate, expanded Medicaid coverage, and insurance exchanges?

Mr. Pratt. Generally, I would say that's fair to say.

Mr. Tonko. Thank you.

The Harvard researchers found that, following healthcare reform in Massachusetts, mortality rates dropped significantly compared to surrounding States. The death rate from treatable illnesses like cancer and heart disease declined even faster.

These findings are truly remarkable. Nearly a 5 percent drop in mortality from preventable illnesses. They found that for every 830 individuals who gained coverage, 1 life was saved. Extrapolating that onto the national scene, if the trend holds, it means that ACA will save tens of thousands of lives.

I'm not going to ask the witnesses to comment on the specifics of that study, but these witnesses know the value that health insurance provides.

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Mr. Matheis, do you have any doubt that your health insurance plans cover lifesaving treatments?

Mr. Matheis. No, they do, sir.

Mr. Tonko. Mr. Evanko, what about you? Do you help members access lifesaving treatments?

Mr. Evanko. Absolutely.

Mr. Tonko. Thank you.

And, Mr. Rodgers, Mr. Wingle, what about your plans?

Mr. Wingle. As a healthcare company, we are proud of providing consumers with high-quality plans competitively priced. We are very proud of that.

Mr. Rodgers. Yes, sir, I agree.

Mr. Tonko. Thank you for your affirmative answers. Thank you.

I think Republicans are really outside of the mainstream when they try to argue that Americans aren't better off if they have health insurance coverage. Their tireless efforts to discourage people from getting covered are truly shameful.

Even more shameful is the refusal of Republican Governors and some legislatures to expand the Medicaid program. Doing that would provide millions of Americans with healthcare coverage, and the Harvard study indicates that doing so would save thousands of lives.

So we thank you for your affirmative answers.

I yield back.

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Mr. Murphy. The gentleman yields back.

I now recognize Mr. Gardner for 5 minutes.

Mr. Gardner. Thank you, Mr. Chairman.

And thank you to the witnesses for being here today and your time.

Last year, the President apologized for his broken promise, if you like your plan, you can keep your plan, after millions of Americans received plan cancellations.

I'd like each insurer to reply in turn, how many plans did you cancel or discontinue last year because of Obamacare?

Mr. Coyne?

Mr. Coyne. We don't have that information at the association. Individual health plans have that information.

Mr. Gardner. Mr. Wingle?

Mr. Wingle. We can provide that information to the committee.

Mr. Gardner. Could you submit that for the record, and by State, with the total for all of you?

[The information follows:]

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Mr. Gardner. Mr. Evanko?

Mr. Evanko. Sure. Yes.

Mr. Gardner. Do you have the number off the top of your head right now?

Mr. Evanko. I can give you approximations and --

Mr. Gardner. Sure. That would be great.

Mr. Evanko. We had approximately 2,000 customers, individual customers, in South Carolina and Connecticut.

Mr. Gardner. Mr. Wingle?

Mr. Wingle. Again, we'd want to get you the firm data.

Mr. Gardner. Okay.

Mr. Rodgers?

Mr. Rodgers. I don't have that data with me. I think we've provided it to other congressional committees, so we'd certainly be happy to --

Mr. Gardner. But that's not a number that you keep on the top of your head?

Mr. Rodgers. Not at all.

Mr. Gardner. Okay.

Mr. Matheis?

Mr. Matheis. I don't have the number of products off the top of my head, but we'd be happy to find that out.

Mr. Gardner. If you could submit for the record by State and what

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the total, I would appreciate it.

And then, to AHIP, does your organization know how many plan cancellations there were nationwide last year, or for your members?

Mr. Pratt. Congressman, we would not have that information.

Mr. Gardner. You don't ask that of your members, or they don't provide that to you?

Mr. Pratt. To my knowledge, we do not, no.

Mr. Gardner. Okay.

Mr. Coyne, does your organization know how many member plans were canceled? You don't?

Mr. Coyne. We haven't asked for that information either.

Mr. Gardner. In order to avoid these cancellations, some insurers offered early renewal plans so they could continue into 2014. If each of the insurers could reply in turn, how many plans did you offer early renewals to last year that would have been otherwise cancelled?

Mr. Matheis?

Mr. Matheis. We offered early renewals to all of our customers in all 14 States that was allowable. So California did not allow us to offer early renewal, but in the majority of every other market we offered it to every customer.

Mr. Gardner. Mr. Rodgers?

Mr. Rodgers. We offered early renewals in four of our five

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States. The Montana plan became part of our larger --

Mr. Gardner. And how were those offers? How many offers were there?

Mr. Rodgers. I don't have the number with me, but they're significant numbers, yes. And --

Mr. Gardner. Could all of you provide those for the record and by State, breaking it down, please?

[The information follows:]

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Mr. Gardner. Mr. Evanko?

Mr. Evanko. Yes. We offered early renewal to about 235,000 customers in all States except for Connecticut and South Carolina, as I testified earlier.

Mr. Gardner. Okay.

And Mr. Wingle?

Mr. Wingle. We offered early renewals as consistent with State laws and regulations.

Mr. Gardner. Okay.

Last year, President Obama apologized for these canceled plans and offered a 1-year delay of enforcing the Obamacare requirements that led to the cancellations. This delay has since been extended.

I'd like each insurer to answer: How many plans do you currently offer that do not meet the law's requirements but you are able to continue offering because of this delay?

Mr. Matheis?

Mr. Matheis. I would have to get you that number, sir. I don't know it off the top of my head.

Mr. Gardner. Mr. Rodgers?

Mr. Rodgers. Yeah, I don't know the number.

Mr. Gardner. Mr. Evanko?

Mr. Evanko. I don't know the exact figure either.

Mr. Gardner. Mr. Wingle?

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Mr. Wingle. I don't have the hard numbers on the pre-ACA plans.

Mr. Gardner. To AHIP, do you know how many plans your member organizations currently offer under this delay?

Mr. Pratt. Could you please repeat that question, Congressman?

Mr. Gardner. The question is the 1-year delay of enforcing Obamacare requirements that led to the cancellation, this delay has been extended. How many plans do you currently offer that do not meet the law's requirements but you're able to continue offering because of this delay?

Mr. Pratt. I don't have that information.

Mr. Gardner. You don't have that number.

Mr. Coyne?

Mr. Coyne. The only information we have has been informally reported to us, and it contains all non-ACA-compliant plans across the Blue system. And that number is 3.2 million.

Mr. Gardner. Yeah.

Mr. Matheis, what happens with those plans when the time runs out, when the delay expires?

Mr. Matheis. So, depending on how the State handles it, with the extension, in theory a customer could sign up for 2 more years --

Mr. Gardner. What happens after that time expires?

Mr. Matheis. Then they would be --

Mr. Gardner. Canceled?

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Mr. Matheis. -- moved to an ACA product.

Mr. Gardner. So that plan would be canceled?

Mr. Matheis. Yes, sir.

Mr. Gardner. Mr. Rodgers, would that plan be canceled at the end of the time period?

Mr. Rodgers. Mr. Matheis's characterization was correct, I believe.

Mr. Gardner. So, yes, that's a cancellation after the time expires.

Mr. Evanko, would those plans be canceled after the time expired?

Mr. Evanko. Based on the current guidance, yes.

Mr. Gardner. Mr. Wingle, would those plans be canceled after the time expires?

Mr. Wingle. Where feasible, we would offer the member an ACA-compliant alternative.

Mr. Gardner. Could you submit the total numbers for all of those plans that would be canceled when the time expires and break it down by State, please?

[The information follows:]

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Mr. Gardner. Thank you.

And one of the excuses that we've heard from the supporters of the healthcare bill is that the law didn't do this, didn't cause the cancellations, that you were the ones who planned the cancellations and planned all of the cancellations.

Were the massive cancellation notices sent last year, the ones the President apologized for, were these because of Obamacare or because of you?

Mr. Matheis?

Mr. Matheis. The law required us to send out those cancellations.

Mr. Gardner. So Obamacare required the cancellations.

Mr. Matheis. Yes.

Mr. Gardner. Mr. Rodgers?

Mr. Rodgers. The law required us to, in certain situations --

Mr. Gardner. So Obamacare caused and required the cancellations.

Mr. Evanko?

Mr. Evanko. We had such a small fraction of our book of business that was not offered early renewals. But that was --

Mr. Gardner. But Obamacare required the 2,000 cancellations that you said?

Mr. Evanko. In the two States where we did not offer early

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renewals.

Mr. Gardner. Mr. Wingle, did Obamacare cause the cancellations?

Mr. Wingle. Plans that weren't compliant with the benefit requirements of the law were canceled.

Mr. Gardner. So that's a yes?

Mr. Wingle. That is a yes.

Mr. Gardner. In attempting to pass this law, the President said repeatedly, if you like your plan, you can keep it. Did that turn out to be true for all of your customers?

Mr. Matheis?

Mr. Matheis. No, that was not true for 100 percent of our customers.

Mr. Gardner. Mr. Rodgers?

Ms. DeGette. Time's over.

Mr. Rodgers. Not for 100 percent.

Mr. Gardner. Mr. Evanko?

Mr. Evanko. For over 99 percent of our customers, that was the case.

Mr. Gardner. Mr. Wingle?

Mr. Wingle. Not in all cases, no.

Mr. Gardner. Okay. Appreciate your time.

And I yield back.

Mr. Murphy. Thank you.

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I now recognize Ms. Castor for 5 minutes.

Ms. Castor. Well, thank you very much. And good morning.

And thank you, Mr. Chairman, for calling this hearing to discuss the strong enrollment numbers of the Affordable Care Act.

When the enrollment numbers were released last week, coming from the State of Florida, we were floored. About 1 million Floridians signed up under the Affordable Care Act. This far exceeded our expectations. We thought 600,000, 700,000, but to get to about a million signed up that doesn't include the about 300,000 children that signed up under children's health insurance or our disabled neighbors or children under Medicaid.

And then I learned from our Florida Blue executives Friday -- Florida Blue is the market leader in Florida -- that that million-dollar figure does not include others that signed up with private health insurance companies, so let's add on another probably couple hundred thousand. It's really remarkable, and it has far exceeded our expectations.

So I really -- you know, I just think about all of my neighbors all across the State that are breathing easier because now they have financial security in their lives that they did not have before.

And I want to thank all of our navigators, the insurance brokers, many of the insurance companies that were out providing information, all of our community outreach partners. You have made a fundamental

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difference in the lives of millions of Floridians, and it's going to be very meaningful for them and their families.

It's also good news for neighbors that have insurance already. Most people across America already have insurance, and if you have insurance, what you want most of all is that you want other people to have insurance. Because the cost of these high premium increases and rate increases over time were largely caused by this huge uninsured population. And those costs, when they show up at the hospital for health care, they have to be paid somewhere. So that's what we're hoping then.

And we've heard time and time again the scare tactics here, and we'll see what happens with premium increases, but do we want to go back to the double-digit consistent premium increases of the past? I don't think so. So this is a way that, hopefully, over time we will be able to stabilize the marketplace.

And I think my colleague, Congressman Tonko, was right. I think my Republican friends now are in danger of sounding like they are opposed to people taking personal responsibility and having health insurance. People need to have health insurance to maintain their quality of life, to make sure they don't go bankrupt. And I would hope that my Republican friends could now turn the page and we could get to work on many of the complicated issues with health policy in America.

Now, one of my Republican colleagues' favorite attacks on

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healthcare reform is that it will cause people to lose their doctors. Now, you have to say, okay, even in Florida, where you have over a million people that now have health insurance, they're going to be able to see a doctor, 8 million nationwide. But this is especially bizarre coming from Republicans, because they have long opposed any policy proposals to broaden networks. They have fought efforts to increase reimbursement for primary care providers who serve Medicare and Medicaid patients.

What has been lost in this debate is the fact that the ACA sets important new network adequacy standards that guarantee access to key essential community providers. It ensures that no consumer will ever see a huge out-of-network bill if they're taken to an emergency room. And it gives consumers strong appeal rights. It's a huge step forward in patient access.

Mr. Pratt, can you give us some context here? Providers and insurance regularly negotiate rates and determine who will be inside of a network; isn't that correct?

Mr. Pratt. Representative, yes, that's correct.

Ms. Castor. And if insurers had to include every provider in their network, wouldn't that eliminate their bargaining power and substantially increase premiums?

Mr. Pratt. Congresswoman, I think that is generally correct. I wouldn't characterize the amount of the increase, but it is a very

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important aspect of keeping premiums affordable.

Ms. Castor. Okay.

Can these high-value networks improve care coordination and move us towards a system where we pay for quality rather than quantity in our healthcare system?

Mr. Pratt. Absolutely. Our members are working very hard toward that end.

Ms. Castor. See, I think this network adequacy in the marketplace is an important issue. We need to make sure that consumers have access to providers in their area and that they have enough choices to get the care they need when they need it.

Republicans should not attack the ACA for letting the private market work. And, remember, personal responsibility is fundamental; it's a fundamental tenet of the Affordable Care Act. And it's oftentimes the customer's responsibility to review all of the choices they have, whether it's bronze, silver, gold, platinum, and the networks contained therein, and make their own choice.

So the law sets key new standards and provides important protections, but insurers and providers will continue to negotiate to ensure sufficient access at fair prices.

Thank you very much. I yield back.

Dr. Burgess. [Presiding.] The gentlelady yields back.

The chair recognizes the gentleman from Ohio, Mr. Johnson, 5

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minutes for your questions, please.

Mr. Johnson. Thank you, Mr. Chairman.

Wow. So much to talk about, so little time to talk about it all.

Gentlemen, thank you for joining us today.

You know, one of the reasons this committee has requested this information from you is because the administration has refused repeatedly to provide any data on who is actually paying for the Affordable Care Act. In fact, one White House spokesman told reporters to ask your industry for this information.

So here's the question for you: Do you currently provide any information to the administration on who has paid for their plan? If yes, what information do you provide and how is it provided and how often? Do you provide any information to the administration?

Mr. Wingle. The only information we provide around payment is related to the invoicing we do with the government to get the premium tax credit.

Mr. Johnson. And how is it provided and how often?

Mr. Wingle. It's the process we described earlier. It's a workaround process because the financial management module is not fully constructed on the FFM, and it's done monthly.

Mr. Johnson. And who did you send it to, Mr. Wingle?

Mr. Wingle. Send it to CMS.

Mr. Johnson. Okay.

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Well, it's a little confusing. So the administration will pay your industry a subsidy for potential customers who never even effectuate their enrollment. So if you're not providing the details to the administration on who's paying for the Affordable Care Act, how are they paying you? What are they basing their payments to you on?

Mr. Wingle. I'd only make one clarification. We do not submit information for payment from the government for members who are not effectuated, who haven't made their own portion of the binder payment. We do not do that.

Mr. Johnson. Well, let me dig a little deeper then. So how do you get paid? How do you get paid, and what is that based on? What information do you provide the government, the administration, that gets you paid?

Mr. Wingle. The process essentially works because we have the enrollment file information. We understand the premium for the plan selected by the consumer on that enrollment file.

Mr. Johnson. So you're paid based on enrollment, not on actual payment?

Mr. Wingle. We understand the member's responsibility on that enrollment, and the difference between the premium rate and the member responsibility tells us what the government is. And we roll that figure up monthly.

Mr. Johnson. So if you only submit for effectuated -- I can't

even pronounce that word -- doesn't the administration know the pay rate? Don't they know how much these people are paying?

Mr. Matheis. Yes, sir, they've determined the subsidy eligibility as part of the enrollment process.

And so a file would come to us; we'd bill for the member responsibility. Upon collection of that member responsibility, then we would typically, if the system were working as designed, we would send a file to the government, to the exchange, saying, here are the members that have effectuated enrollment and here's ultimately the payment that is back due to us.

Mr. Johnson. Okay.

So do you believe the administration is currently able to report the payment rate or who is fully enrolled? Do you think they have that information, based on what you give them?

Mr. Matheis. So, to date, the payments that are coming back and forth are estimated. So there's not been a direct reconciliation between our company and the exchange on a member-by-member basis. That's one of the works in progress that we discussed on the back-end discussion we had earlier in the day, sir.

Mr. Johnson. Considering, then, that the administration is able to report who selects a plan on HealthCare.gov, would it would be possible for them to gather information on who has actually paid for a plan?

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Let's start down with Mr. Pratt.

Mr. Pratt. Representative, it's my understanding that that capability is not present yet. I'm not sure --

Mr. Johnson. Mr. Coyne?

Mr. Pratt. -- whether it may be in the future.

Mr. Johnson. Okay.

Mr. Coyne. Yeah, it's my understanding, as well, that that capability isn't ready yet.

Mr. Johnson. Mr. Wingle?

Mr. Wingle. I don't know what the administration can infer from the data they have, but I know the financial management module itself is not available.

Mr. Johnson. Mr. Evanko?

Mr. Evanko. One bit of color I'll add to my colleagues is the submission for APTC is only for those that are APTC-eligible. So there's also people that do not qualify for that that should be in that calculation.

Mr. Johnson. Okay.

Mr. Rodgers?

Mr. Rodgers. Yes, I think my colleagues are correct in their statements, and we're still working on the reconciliation process for payment.

Mr. Johnson. Okay.

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Mr. Matheis?

Mr. Matheis. I would concur with the other statements.

Mr. Johnson. Okay.

Final question: Does the administration know who's paid for their plan?

Mr. Pratt?

Mr. Pratt. Congressman, I don't know the answer to that question.

Mr. Johnson. Mr. Coyne?

Mr. Coyne. I don't know either.

Mr. Wingle. I don't know what the administration knows about the enrollment in terms of who's paid.

Mr. Evanko. I don't know either.

Mr. Rodgers. No, sir.

Mr. Matheis. No, sir.

Mr. Johnson. It's interesting that they sent us to ask you folks.

Okay. Mr. Chairman, I yield back.

Dr. Burgess. The gentleman yields back his time.

The chair recognizes the gentleman from Kentucky, Mr. Yarmuth, 5 minutes for your questions, please.

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

And I'm really glad we had this hearing. That's something I usually don't say very often, but this has been a very illuminating

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hearing, because I think what it's done, very clearly, is to show what our colleagues on the other side's strategy is, which is to try and hold a hearing in which they can grab a headline that will in some way scare the American people about the Affordable Care Act rather than providing true information about what's going on.

And, you know, it's clear from the desperation, once their initial strategy of trying to deal with this alleged failure to pay premiums, now they've moved on to try and scare people about what premiums might increase by later, either next year or in the future.

So, you know -- and I'm glad you all stressed how important it was that you not give up your competitive position, because obviously you're all competing in the markets.

And, you know, I could turn that strategy around and do the same thing and ask you speculative questions like, will the premium increases that we are likely to see approach the 38 percent that we were seeing in 2010 before the Affordable Care Act was passed, and ask you to speculate on that, but I won't do that. And I could ask you about what the rate of cancellations of policies were prior to the Affordable Care Act.

And I could also ask you -- and I think this would be a fair question; I wouldn't expect you to answer -- how many of your insurance companies, because of the success of the Affordable Care Act enrollment so far and the beneficial mix of younger people, has prompted you to

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explore doing business in other States, as has been reported in the media. And I think that would be a question that I would love to have the answer to.

I know, for instance, in Kentucky, the co-op, the nonprofit Kentucky co-op, which is competing in the exchange, is now getting ready to do business in West Virginia, because they don't have a co-op and they see an opportunity there. And I think the Maine co-op is planning to do business in -- or, I'm sorry, the Massachusetts co-op in Maine, because they see an opportunity there.

So I think all these things are indications that the Affordable Care Act, far from being the train wreck which many have suggested it would become, is actually getting a great deal of traction as it speeds down the tracks.

And just to put it in perspective, in Kentucky, we have insured in the period of 6 months roughly half of the previously uninsured population of the State. We have -- 411,000 people now have coverage in Kentucky under the ACA. Three-quarters of those -- in answer to one of the questions that was asked earlier, three-quarters of those we know previously had no insurance. And 52 percent of all that 411,000 people are under 35.

So we know things are working in Kentucky. And, as Ms. Castor mentioned, things are surprisingly successful in Florida, despite an administration there which has done everything it could to sabotage

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the Affordable Care Act.

So, you know, we can speculate about and argue about the level of success, whether it's a success or a train wreck, but, you know, the markets certainly have had something to say about how they view the Affordable Care Act, in terms of your businesses. I look at those share prices of the companies represented here and one based in my own State. Humana is based in my district. When the Affordable Care Act was enacted, their stock price was 44; now it's 110. Aetna's was 33; now it's 72. UnitedHealthcare was 27; now it's 75. And Cigna's was 34, and now it's 83, roughly.

So the market has made a judgment, I think, about the fact that, at least in terms of your business, the Affordable Care Act has offered a significant financial benefit.

So I think, again, this is -- one of the things that's fascinating about this hearing is we know what the Republicans have tried to do, and that's to scare the American people and to use every little indication of a problem to reflect some kind of a doomsday scenario that we are looking at.

And, fortunately, the facts on the ground, whether it's the marketplace, whether it's the experience in Kentucky or Florida or California, where literally millions of people, by one estimate, 20.8 million people, got coverage under the ACA or bought coverage because of the ACA in the private markets outside the exchanges, we

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are doing -- it's doing exactly what we intended it to do.

We know there have been glitches, we know there have been problems. Any undertaking of this magnitude would experience those. But, again, I thank you for your participation, and I thank you for this hearing.

And I yield back.

Dr. Burgess. The gentleman yields back.

The gentleman from New Mexico is recognized for 5 minutes, Mr. Lujan, for your questions, please.

Mr. Lujan. Thank you, Mr. Chairman.

Mr. Matheis, your company's CEO said last week that the surge in enrollment in March included a higher percentage of young people than in earlier months. Isn't that correct?

Mr. Matheis. That is correct, sir.

Mr. Lujan. And, Mr. Evanko, your CEO said something similar last week, as well. Isn't that correct?

Mr. Evanko. That's correct.

Mr. Lujan. And, as a general matter, all else being equal, a higher percentage of young people in the risk pool will help lower premiums. Isn't that correct?

Mr. Evanko?

Mr. Evanko. That's a complicated question. It's an important one, but it's a complicated question.

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Mr. Lujan. I think that all that we've heard and from all the actuaries is that the answer is, yes, we need more young people in. It lowers premiums.

Mr. Pratt, insurance company premiums are market-sensitive information that companies are not eager to let their competitors know until the last minute. Isn't that correct?

Mr. Pratt. Representative, it is competitively sensitive information. I don't know that I could speak to their particular perspective on that question.

Mr. Lujan. Well, it seems like they'd want to keep it to themselves as long as they're able to so that competitors aren't able to get their hands on it and adjust accordingly. Is that correct? Is that fair?

Mr. Pratt. It's fair to say it's competitively sensitive information.

Mr. Lujan. And is it correct that many insurance commissioners around the country have the authority to review rates and that the final rates consumers pay are sometimes lower than the rates that are actually filed?

Mr. Pratt. Yes, Representative. Typically speaking, rates are filed with the States, and the States review those rates.

Mr. Lujan. Very good. I used to sit on a regulatory body that the superintendent of insurance was under our jurisdiction, so I

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appreciate the answer to that. Because I know what we saw when I was there, as well, sir, so I'd certainly agree that.

Is it also true that the ACA contains a series of policies -- reinsurance, risk adjustment, and risk corridors -- to help mitigate potential premium increases?

Mr. Pratt. Congressman, one goal of the 3Rs program, the so-called 3Rs program, is to stabilize premiums in the early years of implementation.

Mr. Lujan. And a final question to the panel is: Before the ACA, wasn't it common for insurance premiums to increase significantly year to year, often by double digits?

Anyone?

Is there anyone that would disagree that premiums increased by more than 50 percent between 2003 and 2010?

Hearing none, I guess the answer to that is that there's agreement.

The 8 million figure only includes people who have signed up for insurance directly through the Federal and State marketplaces that my colleagues are trying to dismiss, but people can also sign up for private ACA-compliant plans outside of the marketplaces. We don't have a lot of conversation about that.

Mr. Pratt, are individuals able to enroll in some of the plans that AHIP represents outside of the Federal and State marketplaces?

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Mr. Pratt. That's correct.

Mr. Lujan. The CBO estimates that 5 million people will purchase ACA-compliant plans outside of the marketplace this year. These individuals will obtain the same protections and be a part of the same risk pools in each State as those who enrolled via the marketplaces.

Mr. Rodgers, how many of HSCS's enrollments have been outside of the marketplace?

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RPTS ZAMORA

DCMN ROSEN

[12:17 p.m.]

Mr. Rodgers. As I said in my opening testimony and was provided in written form to the committee, I believe we had about 230,000 off-exchange applications during the open enrollment period ending April 15.

Mr. Lujan. And about how many applicants have you received overall?

Mr. Rodgers. We've received, overall, about 830,000 applications across our five States.

Mr. Lujan. So that sounds like it's representing about 1.2 million culvert lives. So about 28 percent of your enrollees signed up outside of the marketplaces; that's a significant number. And I understand that payment data is not complete but in the earlier months of this year, what percentage of individuals enrolling in plans outside of the marketplace have paid?

Mr. Rodgers. In my written comments to the committee, I shared with you the on-exchange and off-exchange payment rates because there is some difference. Typically, the payment completion rates are a little bit higher. Off exchange versus on exchange, and you should have that data.

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Mr. Lujan. So from what I was able to get from your testimony was that between January and April, 90 to 93 percent; and in May, 63 percent today, and we can verify that in there. Does that sound accurate, though?

Mr. Rodgers. That's correct. That's in my written comments.

Mr. Lujan. Can any of our other witnesses provide us with information on how many off-exchange enrollments they have had to date? If not -- Mr. Evanko.

Mr. Evanko. We have approximately 40,000 off-exchange ACA enrollments. That's about one-third of our total ACA compliant book.

Mr. Lujan. And what I'd like to do is ask our witnesses if they'd be willing to provide the committee with detailed information on their off-exchange enrollments. Would that be okay with everyone?

Mr. Rodgers. Yes.

Mr. Lujan. Very good. I appreciate that.

You know, later on today we're going to having some other hearings in other areas, despite the demonization and demagoguing of the Affordable Care Act, over 8 million enrollees, can you imagine what it would have been if Democrats and Republicans would have worked together to fix issues that needed fixing but we were able to get more people covered? Who knows where that number would have been.

But later on today, we're going to be having a hearing on taking away someone's Fifth Amendment rights. We have my colleagues that are

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still refusing to release 39 interview transcripts at an IRS hearing. There is going to be other hearings. Another request on a hearing with Benghazi, even though there's been seven other hearings, 50 repeal attempts on the Affordable Care Act.

I think there's a lot of important pressing business that we as the Congress need to get our hands around. And I am certainly hopeful that in the history and tradition of this committee, with all that I've learned from our senior members, there once upon a time was an effort for us to work together and get along, and I certainly hope that those days return. Every time I'm home, that's what we hear.

So all the witnesses that are here today, thank you so much; chairman, again, for your being here, as well, and the hearing being brought together today, an important conversation I hope that we're able to bring more facts into the debate. Thank you very much.

Dr. Burgess. [Presiding.] Gentleman's time is expired.

The chair recognizes Ranking Member DeGette for follow-up.

Ms. DeGette. Mr. Chairman, I just wanted to follow up on Mr. Lujan's questioning with the off-exchange enrollments, because as we've learned, there have been a number of off-exchange enrollments in addition to the enrollments in the ACA, both in the Federal exchange and the State exchanges.

So I would ask unanimous consent; the committee has made a request of 160 plans, including plans from this panel here, that they provide

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information about enrollment figures and premium payments for those plans that are under the Affordable Care Act exchanges. I would ask also if we would ask those same plans for that same information on the off-exchange enrollments.

Similar to the data that we got from Blue Cross Blue Shield, it would be helpful to know how many off-exchange enrollments we have had from these 160 plans and what the premium payments have been, so I'd ask unanimous consent that we also ask for that information.

Dr. Burgess. Without objection. The gentlelady yields back.

I recognize myself for follow-up. And I would just say on the off enrollment, I'm one of those members. I actually had both Blue Cross Blue Shield and HealthCare.Gov on hold, or they had me on hold on December 23 and December 24, and it was kind of a race to see who would have a live person answer the phone first. And I think, if I recall correctly, Blue Cross went off that day, so I was probably an off-exchange enrollment, so you may count me as that.

I would just like to ask each of you in follow-up, many of the products you're offering are only affordable because the government subsidizes part of the premium cost. Do you know what percentage of the plans with paid premiums and effectuated enrollment received some form of subsidy from the taxpayer? Mr. Coyne, I'll start with you and we'll just go down the line.

Mr. Coyne. We don't have that information at this point.

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Dr. Burgess. Would you provide it for the record?

Mr. Coyne. Yes, we'd be happy to when we get it.

Dr. Burgess. Mr. Wingle.

Mr. Wingle. Our experience probably comports with generally-available published information on that. It's a majority of our membership.

Dr. Burgess. And again, can I ask you to submit that for the record?

Mr. Evanko.

Mr. Evanko. For our on-exchange customers, 80 to 85 percent are eligible to APTC.

Dr. Burgess. Mr. Rodgers.

Mr. Rodgers. Yes, I believe we submitted that information, if I understood your question, in the two submissions for April; and with the May 20 submission, we'll provide something similar.

Mr. Wingle. As did we.

Dr. Burgess. Mr. Matheis.

Mr. Matheis. Yes. As you know, that number is a moving target, but it is around 79 percent for us.

Dr. Burgess. And would you do your best to give us an accurate representation for the record.

What about a situation where an individual enrolls but then cancels their plan? Are you only to pay the subsidy monthly or would

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you be responsible for returning a portion of the subsidy throughout the year? Mr. Coyne, let's start with you.

Mr. Coyne. We don't have that information.

Dr. Burgess. And will you submit that for the record?

Mr. Coyne. Yes.

Dr. Burgess. Will you try to find that for us?

Mr. Wingle.

Mr. Wingle. Could you repeat the question, please, Mr. Chairman.

Dr. Burgess. A situation where an individual enrolls but then cancels their plan. Are you only paid the subsidy monthly, or would you be responsible for returning the portion throughout the year?

Mr. Wingle. Returning the portion of premium paid or --

Dr. Burgess. The advanced premium tax credit.

Mr. Wingle. The subsidy. The subsidy, you know, under the 3-month grace period rules, we retain until cancellation.

Dr. Burgess. So you would not be required to return that?

Mr. Wingle. No, not until a member has canceled.

Dr. Burgess. If the member just simply doesn't pay, they make their first payment, maybe their second payment and then they stop. At the end of that 3-month grace period, do you have to return the money for those months where the patient didn't pay?

Mr. Wingle. In compliance with the 3-month grace period rules,

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we retain any premium tax credit received during the period to help us cover any claims experience we had during the time the member was enrolled.

Dr. Burgess. So you retain the advanced premium tax?

Mr. Wingle. According with the design of the rules, yes.

Dr. Burgess. Mr. Evanko.

Mr. Evanko. Well, at the end of the 90-day grace period, if the individual has not paid any more premiums, then we owe that money back to CMS and we credit that in the next month's reconciliation process.

Dr. Burgess. Interesting.

Mr. Rodgers.

Mr. Rodgers. I'm not familiar with that particular aspect of the grace-period payments in terms of the return or not, but I believe that we're only entitled to the money that's for the time the policy is in effect.

Dr. Burgess. And Mr. Matheis.

Mr. Matheis. That's my understanding, as well, sir.

Dr. Burgess. Mr. Coyne, do you know how much your company has been paid in advance premium tax credits?

Mr. Coyne. Blue Cross and Blue Shield Association does not actually sponsor any of the products that are on the exchanges; our member plans do. So we wouldn't be paid premiums or APTC.

Dr. Burgess. Mr. Evanko.

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Mr. Evanko. We received four payments so far for the months of January through April, and it's in the range of $30- to $40 million.

Dr. Burgess. Mr. Wingle.

Mr. Wingle. We obviously have that data, we can supply the committee with that data.

Dr. Burgess. And I do need for you to submit that for the record.

Mr. Rodgers.

Mr. Rodgers. We've received some payments. I don't know the value of the payments to date.

Dr. Burgess. And will you find that information and submit for the record, please.

Mr. Rodgers. Certainly.

Dr. Burgess. Mr. Matheis.

Mr. Matheis. Yes. I don't have that number ready today, but we'd be happy to get it for you.

Dr. Burgess. The metal plans, you're all familiar with them. I keep hearing about a copper plan that's going to be offered. Are you any of you familiar with that? Are you going to be offering copper plans, Mr. Coyne?

Mr. Coyne. I'm not familiar with that at this point.

Dr. Burgess. Mr. Wingle.

Mr. Wingle. Under the current rules for central health benefits and the rules for qualified health plans, we're not currently

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authorized to offer anything at the so-called copper level. Our plan benefits start at bronze unless somebody qualifies for catastrophic care, and that's of the lowest actuarial value we're allowed to offer presently.

Dr. Burgess. Mr. Evanko.

Mr. Evanko. In the event that copper plans were introduced as something that's allowed, we would certainly consider it. Cigna believes in choice as one of our core principles for our customers.

Dr. Burgess. Thank you.

Mr. Rodgers.

Mr. Rodgers. Currently we're not approved to offer the copper plans. That's certainly something that we believe, that members need more cost-effective programs. I expect that we would offer those.

Dr. Burgess. Mr. Matheis.

Mr. Matheis. My comments would be similar to my colleagues, sir.

Dr. Burgess. Let me just ask each of you, what is your payment rate for products in the large-group market? Starting with you, Mr. Coyne, what are your payments for products of large-group market?

Mr. Coyne. Individual group plans have that information rather than the association.

Dr. Burgess. I see.

Mr. Wingle.

Mr. Wingle. I carry no responsibility for large group. I'd have

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to get back to you on that.

Dr. Burgess. Mr. Evanko.

Mr. Evanko. I am not familiar with the large-group payment rates either. I'm sorry.

Dr. Burgess. Your company, though, is, I mean, you're in the large-group market.

Mr. Evanko. We are, sir, yes.

Dr. Burgess. Will you get that information for us?

Mr. Evanko. Sure.

Dr. Burgess. Thank you.

Mr. Rodgers.

Mr. Rodgers. I don't have that information with me.

Dr. Burgess. But you will provide it for the committee?

Mr. Rodgers. Certainly.

Dr. Burgess. Mr. Matheis.

Mr. Matheis. I'm not sure I understand the question. Could you clarify it for me, please.

Dr. Burgess. Well, the question was, what are your payment rates for products in the large-group market?

Mr. Matheis. So is that what our average premium is or?

Dr. Burgess. How many people pay?

Mr. Matheis. Sorry, sir, I'm still not following the question.

Dr. Burgess. Well, what we've generally been talking about today

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is how many people, what percentage of people have paid. So following along that --

Mr. Matheis. I'm sorry. I was a little slow in the uptake there. Typically, we would experience somewhere around a 98 to 97-percent premium payment in the large-group market.

Dr. Burgess. Very well. Thank you all for your attendance today. I ask unanimous consent that members' written opening statements be introduced into the record. Without objection, the documents will be entered into the record.

In conclusion, I'd like to thank all the witnesses and the members who participated in today's hearing. I'd like to thank everyone who stuck with us in until the end, and that would be the witnesses. I remind members they have 10 business days to submit questions for the record, and I ask the witnesses to all agree to respond promptly to the questions. The committee now is stands in adjournment.

[Whereupon, at 12:28 p.m., the subcommittee was adjourned.]