



PPACA Enrollment and the Insurance Industry

by

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**for the
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I. Introduction

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am Mark Pratt, Senior Vice President for State Affairs at America's Health Insurance Plans (AHIP), which is the national association representing 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. My role includes daily involvement in issues relating to the state-based Exchanges and state Medicaid programs, working with leading stakeholder organizations and government officials from across the country. I previously was employed as head of government affairs for Anthem Blue Cross and Blue Shield in Virginia, as a principal for a Washington DC-based public affairs consulting firm, and as Executive Director of the Virginia Association of Health Plans.

AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to testify on enrollment in the new health insurance Exchanges and other issues relating to implementation of the Affordable Care Act (ACA). Throughout the ACA implementation process, our members have worked closely with federal and state officials to address a broad range of regulatory and operational issues to help consumers get the coverage

they need. Health insurers remain strongly committed to continuing to serve consumers and participate in the new marketplaces established by the law.

Our testimony focuses on two broad areas: (1) our members' experience in the ACA's initial open enrollment period for 2014, including issues surrounding the payment of premiums by consumers who have signed up for coverage; and (2) our members' priorities for improving access to high quality, affordable health insurance coverage in 2015 and beyond.

II. Our Members' Experience in the Open Enrollment Period for 2014

Since the enactment of the ACA, our members have been working to implement the law's many requirements with a strong focus on delivering high-value coverage options in the most affordable and least disruptive manner possible. To give consumers greater peace of mind about their health care coverage, health plans have implemented some reforms ahead of schedule and, as we discuss below, provided consumers greater flexibility with payment deadlines to help avoid potential gaps in coverage. Helping consumers obtain the secure, affordable coverage they need has been our central goal throughout the implementation process.

As part of this process, health plans have worked diligently to comply with the thousands of pages of regulations, directives, information requests, guidance, and other regulatory documents that the Department of Health and Human Services (HHS) and other federal agencies have issued to implement various statutory provisions of the ACA. While working on operational issues

related to ACA implementation and providing recommendations to policymakers, our members consistently have focused on several major goals:

- Minimizing disruptions for consumers, businesses, states, and stakeholders;
- Ensuring the workability of the operational architecture of Exchanges and allowing state flexibility;
- Maximizing coordination to prevent redundant state and federal regulations and data collections and focusing on ways to reduce administrative cost burdens;
- Maximizing choice and competition; and
- Addressing specific ACA provisions to make health coverage more affordable for consumers and purchasers.

On a broad range of 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 and the healthcare.gov website. They also have devoted significant resources to performing manual processes and work-arounds that were necessitated by the problems that surfaced in the days and weeks following the October 1 launch. Under ever-changing deadlines and operational guidance, they processed enrollment files and payments in short timeframes. They also supported consumers through the open enrollment process by providing online

educational resources, increasing customer service call center hours and support (in response to unprecedented numbers of phone calls from consumers who needed help navigating the enrollment process), and partnering with community groups, health care stakeholders, and faith-based organizations to reach under-served communities. Despite the challenges our members encountered, we are proud that they ultimately were successful in offering a broad range of high-value coverage options to consumers who are enrolled in Exchange plans for 2014.

HHS has reported that approximately 8 million individuals signed up for Exchange plans during the initial open enrollment period for 2014. While there is some uncertainty 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. We appreciate the committee's interest in learning more about this issue, particularly in light of the information you released last week based on data provided by insurers participating in the federally-facilitated Exchange.

One reason there is uncertainty about the number of Exchange enrollees who have paid their premiums is that some insurers – to provide peace of mind for consumers and to protect them from potential gaps in coverage – have voluntarily decided to provide flexibility in the deadline by which Exchange enrollees must pay their first month's premium. This flexibility is allowed under an interim final rule published by HHS on December 17, 2013.

Other factors also contribute to the uncertainty about how many Exchange enrollees have paid their premiums:

- **Changing enrollment:** In early February, CMS implemented the functionality for Exchange enrollees to voluntarily terminate their plan or to report a “life event” (i.e., a change in circumstance, such as a new baby or job, which allows a special enrollment period). While this functionality serves a valid purpose, it creates challenges in calculating accurate enrollment data and payment rates.
- **Duplicate enrollments:** Because of the challenges that surfaced with the launch of the Exchanges in October 2013, some consumers were advised to create a new account and enroll again. As a result, insurers have many duplicate enrollments in their system for which they never received any payment. In cases where an insurer has a new enrollment for a consumer who previously enrolled, they are not expecting that original policy to be effectuated – even though that data is still reported.

In the coming weeks, as we move further past the conclusion of the open enrollment period for 2014, 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 data, and we anticipate that more announcements will be forthcoming. However, given the significant variation in enrollment that occurs in the individual marketplace, it may be a matter of months before system-wide numbers on premium payments are available. Our members will continue their ongoing outreach and communication efforts to encourage Exchange enrollees to pay their premiums.

III. Our Members' Priorities for 2015 and Beyond

Looking forward, we continue to believe that affordability must be the central priority – for Congress, the Administration, the states, and stakeholders – as we focus on further expanding access to high quality, affordable health insurance coverage in 2015 and beyond.

Repeal of ACA Health Insurance Tax

One critically important step that Congress can take to make coverage more affordable is to delay and eventually repeal the ACA's health insurance tax. The health insurance tax began in 2014 and will exceed \$100 billion over the next ten years. The tax is set at \$8 billion in 2014, and increases by over 40 percent to \$11.3 billion in 2015, and to \$14.3 billion by 2018. In subsequent years, the tax will increase annually based on premium growth.

We are deeply concerned that implementation of the new health insurance tax is undermining efforts to control costs and provide affordable coverage options. An Oliver Wyman study¹, commissioned by AHIP, has concluded that the health insurance tax alone will increase the cost of family coverage in the individual market by an average of \$5,080 over the ten-year period of 2014-2023. This study also estimated that the health insurance tax will increase the cost of family coverage in the small group market by an average of \$6,830 over the same ten-year period. Additionally, a state-by-state analysis² by Oliver Wyman has provided per-person and cumulative estimates of the impact this tax will have on individual market consumers,

¹ Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. October 2011.

² Carlson, Chris. "Annual Tax on Insurers Allocated by State." Oliver Wyman. November 2012.

employers, and Medicare Advantage enrollees in all 50 states, as well as the impact on state Medicaid managed care programs.

The findings of the Oliver Wyman studies reinforce our deep concern that the new health insurance tax is having a significant negative impact on the affordability of coverage. To address this concern, we strongly support bipartisan legislation (H.R. 763) to fully repeal the health insurance tax, introduced by Reps. Charles Boustany (R-LA) and Jim Matheson (D-UT). To date, 230 House members have cosponsored this bill, including 30 members of the House Energy and Commerce Committee. We also support – as a short-term solution – separate bipartisan legislation (H.R. 3367), introduced by Reps. Charles Boustany (R-LA) and Ami Bera (D-CA), that proposes a two-year delay in the ACA health insurance tax.

Regulatory Changes to Make Coverage More Affordable

Throughout the ACA implementation process, 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. We have cautioned that regulatory policies that increase the cost of coverage or restrict consumer choice may encourage individuals to forego purchasing coverage until after they are sick or injured. This is particularly true for young and healthy individuals who are extremely sensitive to the cost of coverage and who are a key demographic of the reformed marketplace. We remain concerned that adverse selection and unnecessarily high costs will occur in the absence of broad participation in the new Exchanges. These serious concerns – along with the experience of our members at the

operational level – have shaped our comments and recommendations to the agencies on a broad range of regulatory issues.

Long-Term Policy Options for Improving Quality and Affordability

Additional steps to make coverage more affordable are outlined in a document we released in December 2013 – “A Roadmap to High Quality Affordable Health Care for All Americans.”³

This report discusses the health care cost challenges facing our nation, the innovative programs health plans are implementing to promote value and reduce costs, and policy options for promoting a sustainable, high quality health care system.

The policy recommendations in our report focus on improving quality of care and enhancing value for consumers and patients by building upon existing innovations in the private sector and public-private collaborations. We recommend action in the following areas:

- **Advancing a state-based gain sharing program to encourage innovation and cost savings.** The program we propose would provide shared savings incentives to reward states that are able to reduce future increases in health care costs through innovative programs and collaboration with stakeholders.
- **Accelerating health system and delivery reforms to transform the health care system and promote value.** This includes improving Medicare/Medicaid integration for “dual eligibles,” implementing financial incentives for providers that improve patient safety, expanding the use of patient-centered medical homes, encouraging broader adoption of

³ “A Roadmap to High Quality Affordable Health Care for All Americans,” AHIP, November 2013.

“bundled payments” to promote greater value and quality of care, encouraging accountable care models that promote effective collaborations between insurers and providers for improving quality and lowering cost, streamlining high-value quality measures, and removing barriers to allow stakeholders to advance global payment models as a way to realign financial incentives toward high quality, lower cost care.

- **Addressing underlying health care cost drivers and paying for care that is proven to work.** This includes tackling barriers to transparency, incorporating the findings of comparative effectiveness research into coverage and reimbursement decisions by both public and private payers, reducing the exclusivity period for biologics and biosimilars, prohibiting anticompetitive patent settlements between drug companies, and adopting quality measures that evaluate generic prescribing practices.
- **Strengthening the health care infrastructure.** This includes reducing administrative overhead and costs through administrative simplification, and improving quality through medical liability reforms.
- **Stamping out fraud and abuse.** This includes fighting fraud in public programs with “best practices” commonly used in the private sector, employing the next generation of information technology tools, and ensuring that collaborations between health plans and public partners accelerate the fight against fraud based on a flexible partnership.

IV. Conclusion

Thank you again for this opportunity to testify. Our members remain strongly committed to working with Congress, the Administration, the states, and other stakeholders to expand access to high quality, affordable coverage options.