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THE PRESIDENT'S HEALTHCARE LAW DOES NOT EQUAL HEALTHCARE ACCESS

THURSDAY, JUNE 12, 2014

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:00 a.m., in Room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Griffith, Bilirakis, Ellmers, Pallone, Capps, Schakowsky, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Also Present: Representative McKinley.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

Staff Present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, O&I; Sydne Harwick, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, O&I; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Chris Pope, Fellow, Health; Chris Sarley, Policy Coordinator, Environment & Economy; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Minority Staff Assistant; Debbie Letter, Minority Staff Assistant; Karen Nelson, Minority Deputy Committee Staff Director for Health; and Matt Siegler, Minority Counsel.

Mr. Pitts. Ladies and gentlemen, if you will take your seats. The subcommittee will come to order.

We are going to have votes shortly, so we are going to run a tight gavel this morning.

The chair will recognize himself for an opening statement.

The President's healthcare law was sold to the American people with a number of promises: If you like your plan, you will be able to keep it; if you like your doctor, you will be able to continue seeing him or her. Advocates of the law made this promise again and again. In fact, President Obama, according to one count, made this promise nearly 37 times.

Yet, as we now know, this promise was simply not true. Last year, millions of Americans had their health plans canceled, were forced to enroll in exchange plans. Americans are also learning another sad truth: Health plans offered in the exchanges are often not providing access -- access to doctors, hospitals, and drugs they need.

Why is this occurring? As we will hear today, many of these problems lie at the feet of the Affordable Care Act. The Affordable Care Act includes a number of benefits -- mandates -- imposed on the plans consumers can buy. The law also adds hundreds of billions of dollars in new taxes that are being passed on to patients. And this leaves insurers with only a few tools to control and manage cost.

As a result, many plans are turning to narrower provider networks

and skimpier prescription drug coverage to keep premiums and deductibles in check. Studies show that, compared with typical employer-sponsored plans, Bronze and Silver exchange plans include far fewer doctors, specialists, and hospitals.

One of our witnesses today, Dr. Scott Gottlieb, in an analysis comparing an exchange plan to a comparable private health plan across several States found dramatically narrower networks for critical specialties, such as cardiologists, oncologists, and OB-GYNs, among others.

As CNN Money reported last October, quote, "Many insurers have opted to limit their selection of doctors in some exchange plans to keep premiums and other costs down. And they are also excluding large academic medical centers, which are often pricier because they tackle sicker patients and more complex cases," end quote.

This trend is particularly dangerous for those dealing with serious diseases that may have to go out of network and, therefore, bear significant cost to find a provider to meet their unique needs.

Even those without serious illnesses have found that their doctors they know and like are no longer participating in their new exchange plans. A constituent from Conestoga, Pennsylvania, wrote to me that, after her policy of nearly 30 years was canceled last fall because it was not fully ACA-compliant, she was unable to find a new exchange plan which included her doctors in the network. Her OB-GYN,

whom she had been seeing since 1989, and her gastroenterologist are now out of network.

Narrower networks are not the only access problem consumers are running into. And, again, in order to manage cost, some plans are simply not covering the most cutting-edge, expensive treatments and drugs in their formularies. Analysis shows that even when expensive drugs are covered, patients in exchange plans pay much higher cost-sharing for them than their counterparts in traditional employer-sponsored plans.

It is this committee's job to understand the negative consequences patients are facing under the Affordable Care Act. And it is also incumbent for us to begin to examine this problem and develop solutions to protect Americans being hurt by the healthcare law.

I thank all of our witnesses for being here today. I look forward to getting your perspective on the challenges patients have and will face under the Affordable Care Act.

I will yield to Dr. Burgess.

Dr. Burgess. No, I think --

Mr. Pitts. Okay. I yield back and now recognize the ranking member of the subcommittee, Mr. Pallone, for 5 minutes.

[The prepared statement of Mr. Pitts follows:]

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

Mr. Pallone. As we prepare to have this conversation today, there has to be some perspective. Republicans again will hammer over and over again the same smears against the Affordable Care Act that they have said year after year, and they will say the President and the law have done no good for the country, but the facts beg to differ.

So let's talk about how the law has led to the largest expansion of health insurance coverage in decades. And I am not just saying that; multiple independent surveys and analysis have shown that, because of the ACA, millions more Americans have health insurance coverage this year than they had last year.

Here are some numbers: 8 million have private health insurance through the ACA's new marketplace; 6 million more now have Medicaid coverage; and millions more have purchased health care outside the exchanges.

Mr. Chairman, Massachusetts' uninsured rate is down to essentially zero percent because of the ACA. Minnesota's is down by 40 percent. And my home State, New Jersey's rate of uninsured adults has dropped by nearly 40 percent, its lowest level in nearly 25 years. And these are real numbers that matter.

So if Republicans want to talk about how to ensure that this coverage equates to better access, let's have that debate. Let's talk about the ways in which we can strengthen the new marketplaces. Let's talk about real solutions. Unfortunately, the Republicans don't have

any. They have no alternative plan that can be put in place through the ACA that would result in the same level of coverage for the millions of people who want health insurance.

If you want to improve upon the law, that is fine. The insurance industry just released a paper yesterday offering ideas to improve the law. But where are the Republicans' solutions? Do you want to guarantee broader doctor networks? Great. Let's discuss the ways in which we can do that. Do you want to mandate broader drug coverage? Wonderful. Let's talk about the best approach to address that.

The law sets key basic standards and then gives States flexibility to address these issues. In fact, we will hear from one of the witnesses today about the flexibility. And so I ask my Republican colleagues, do you want to preempt States?

Meanwhile, insurers, providers, and drug companies engage in private contract negotiations every year to create benefit packages. So are my Republican colleagues saying they would like to interfere in those negotiations?

The truth is, the Republicans aren't saying anything except let's go back to a system that gives companies free range charge to whatever they want without any requirements to actually take care of sick people or help them stay healthy.

We cannot and should not lose sight of the great strides that this law has taken to get health insurance coverage to people who never had

it, who couldn't afford it, who were denied it because they had preexisting conditions. Now, millions of Americans have a health plan that ensures quality coverage with guaranteed benefits and a premium placed on prevention. This is a significant improvement in Americans' access to health care.

So, Mr. Chairman, I am waiting to hear what is the Republican plan to improve access, because the only so-called solution I have seen out of the Grand Old Party is an effort to repeal the law and leave 25 million more Americans uninsured. If we want to improve the new insurance market, let's do so. But, so far, I have not seen any serious effort by the Republicans to improve health coverage for anyone.

I yield the remainder of my time to Mr. Green of Texas.

[The prepared statement of Mr. Pallone follows:]

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Mr. Green. I thank Mr. Pallone for yielding.

The landmark health reform law has enabled 8 million Americans to enroll in exchanges, 6 million to gain coverage through Medicaid and CHIP, and Americans who already have insurance can feel more secure in their coverage, ending some of the worst abuses of insurance companies, providing key new consumer protections and cost savings.

If you want something perfect, don't come to Congress. This law is a result of compromise, and there are so many ways to improve it. If the 24 States that so far refused to expand Medicaid at very modest cost to the States and which was largely offset by savings in cost of services for the uninsured, millions more would be able to access health care.

The Affordable Care Act is so important to pivot from the health-sick system to the true healthcare system. The law has allowed the uninsured rate for Americans to drop to the lowest level since Gallup and Healthways started tracking this data. And I look forward to seeing it decline further and working toward making improvements in this landmark law.

And, again, I thank my colleague for yielding.

[The prepared statement of Mr. Green follows:]

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Mr. Pitts. The chair thanks the gentleman.

I now recognize the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for an opening statement.

Dr. Burgess. Thank you, Mr. Chairman.

And thanks to our witnesses for being here with us today.

Thank you for holding this hearing.

Already been pointed out, we heard it time and time again from the President: If you like your doctor, you can keep your doctor, period; if you like your health plan, you can keep your health plan, period. It sounded great on the stump but is operationally not possible.

The Affordable Care Act cancels the policy that patients wanted, mandates what they must buy instead, and this comes at a cost. The Affordable Care Act overly constricts the health insurance marketplace. It limits choice by imposing hundreds of benefit mandates, leading to higher costs. States like California have imposed even greater restrictions on choice. As a result, they are facing some of the most limited networks and highest out-of-pocket costs for prescription drugs in the country.

Plans have been canceled. Plans sold on the healthcare exchanges are leaving people functionally uninsured. Patients are being subjected to higher and higher deductibles and other out-of-pocket costs. They now lack critical access to their doctors and vital

prescription medication.

I am very familiar with these problems. I did not accept the deal that was offered to Members of Congress in buying health insurance. None of my constituents could do that. So what I did was went into HealthCare.gov and bought on the individual market. My current plan now has a $6,000 deductible. It does not cover medications that I had previously been taking. And I am pretty lucky, I don't have to take many things, but even with that narrow requirement, it could not be met.

This law also negatively impacts those most in need of care. For individuals who do have severe medical needs, pediatric oncology patients, many of the Nation's leading cancer centers and pediatric hospitals are not included in the provider networks or the exchange plans, and access to necessary specialty drugs often comes at a tremendous cost. Analysts have found that the cost of just one dose of some specialty medications could eat up to a third of an enrollee's monthly income, even for so-called high-value plans with lower cost-sharing.

Texas is home to some of the world's best medical centers. The State's cancer centers and transplant centers -- M.D. Anderson, Baylor University Medical Center, Texas Children's Hospital -- treat patients from all over the country. Yet these centers are generally included in less than half of the plans that are offered in the Texas health

insurance exchange.

There is also widespread physician uncertainty about whether having existing contracts with insurers means that they are already included in an exchange plan network. As a doctor, I know this could lead to confusion both for the physician and their patient. So another example of how the Affordable Care Act hurts patients, hurts doctors, and is a strain on our economy.

This committee should continue to hold the President to his word and ensure that patients have the ability to keep their doctor and their choice of insurance. The only way to do this is to rescind or modify burdened laws and regulations.

I yield the balance of the time to the gentleman from West Virginia, Mr. McKinley.

[The prepared statement of Dr. Burgess follows:]

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

Mr. McKinley. Thank you.

And thank you, Mr. Chairman, for holding this hearing on the access to drugs and doctors under Obamacare and allowing me to join the subcommittee today.

The issue of access to good medical care has become a passion of mine. Since introducing the Patients' Access to Treatments Act, I have heard from people all around the country about people that are not able to afford medication that they need, even with private insurance, because of a specialty tier.

Now we hear that under the Obama exchanges some plans are not covering specialty and biologic medicines at all. This loophole is blocking Americans with disabling diseases from getting the necessary care that they need. This is unacceptable.

I am looking forward to hearing from the witnesses this morning on this issue that is extremely vital to the most vulnerable citizens in our Nation.

And I yield back my time. Thank you.

[The prepared statement of Mr. McKinley follows:]

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

Mr. Pitts. The chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

Mr. Waxman. Thank you, Mr. Chairman.

Today's hearing is about access to healthcare services in the new health insurance marketplaces. The Affordable Care Act is the single most important step forward on this issue in the last 50 years. It will expand insurance coverage by over 25 million people, it ensures all plans offer real benefits, and it bans discrimination on the basis of preexisting conditions.

Now, I know my Republican colleagues are in a constant struggle to see who can be the most misleading and most opposed to the ACA, but the premise of this hearing is a stretch even for them.

Republicans are trying to claim that the benefit packages and provider networks in ACA plans are actually limiting access to care. But at the same time, they want to take us back to a world where health plans are free to offer policies that do not cover prescription drugs or hospitalization. They want to go back to a world where a child with asthma can be turned down by a health insurance company because of his or her preexisting condition. Do they really think that would improve access?

If a father has a policy that doesn't cover prescription drugs, what type of access does he have? If a mother has a policy that does

not cover hospitalizations, what type of access does she have? And if a young girl is barred from insurance because of a preexisting condition, what type of access does she have? And if a working family is denied Medicaid because their State won't take 100 percent Federal dollars and expand coverage, what type of access do they have? The answer is obvious: They have next to no access.

So I really can't take Republicans' criticism too seriously today. What I do take seriously is the need for good provider networks and robust benefit packages in the health insurance marketplaces. That is why we wrote the first nationwide network adequacy standard for the private insurance into the law. It is why we ensured that prescription drugs were 1 of the 10 essential health benefits. And it is why we barred discriminatory insurance benefit designs and included essential community providers in all insurance networks.

Insurers' and providers' and drug companies' private contractual negotiations have always been contentious, and regulators have an important balance to strike between broad access and affordability. These challenges are nothing new. As enrollment and competition in the new marketplaces increase, I am confident that we will see more choice and broader range of benefit packages.

For example, in my own district, one of the most expensive and best-regarded health systems in the Nation was not a major participant in the marketplace last year, but after our State's enrollment

dramatically exceeded expectations, they announced they will be in-network next year. That is private competition at work.

As the law moves forward, Democrats will continue to work to step up enforcement of plans that discriminate or improperly limit access and will continue to work to expand choice and improve the benefit packages offered in the marketplaces. And we would welcome the Republicans joining us in trying to accomplish that.

But if Republicans truly share these goals, while we are eager to work with them, Mr. Chairman, what we will not do is go back to the rampant discrimination and dangerous lack of access that we had before reform. And that is what we would have had if any of those votes that passed the House were taken up and passed by the Senate and signed by the President to repeal the Affordable Care Act.

This is a hearing that is all politics and very little substance.

I yield back my time.

[The prepared statement of Mr. Waxman follows:]

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Mr. Pitts. The chair thanks the gentleman.

That concludes the opening statements of the Members. The written statements of all Members will be made part of the record.

[The information follows:]

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

Mr. Pitts. I would like to have a UC, seek unanimous consent to submit three items for the record: a letter from the Association of Mature American Citizens; a sheet of the White House Web site listing "You Can Keep Your Own Insurance"; and a study by the Congressional Research Service entitled "Private Health Insurance Market Reforms in the Affordable Care Act."

[The information follows:]

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

Mr. Pitts. We have one panel with three members today. I will introduce them in the order they speak. First, Dr. Scott Gottlieb, resident fellow of the American Enterprise Institute; second, Dr. William Harvey, chair of the Government Affairs Committee, American College of Rheumatology; and, finally, the Honorable Monica Lindeen, commissioner of the Montana Office of the Commissioner of Securities and Insurance.

Thank you for coming. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize. There is a little box of lights on the table, so when you see the red light appear, we ask that you please conclude.

At this point, Dr. Gottlieb, you are recognized for 5 minutes for your opening statement.

STATEMENTS OF SCOTT GOTTLIEB, M.D., RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE; WILLIAM F. HARVEY, M.D., CHAIR, GOVERNMENT AFFAIRS COMMITTEE, AMERICAN COLLEGE OF RHEUMATOLOGY; AND MONICA LINDEEN, COMMISSIONER, MONTANA OFFICE OF THE COMMISSIONER OF SECURITIES AND INSURANCE

STATEMENT OF SCOTT GOTTLIEB, M.D.

Dr. Gottlieb. Chairman Pitts, Ranking Member Pallone, thank you for the opportunity to testify today before the committee. My name the Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute, and I previously served at positions at the FDA and CMS.

Americans who sign up for insurance under the ACA are finding many of these plans offer very narrow options when it comes to their choice of doctors and drugs. Some argue these narrow benefit designs aren't unique to the ACA, but this isn't entirely true. The construction of the exchanges preordained the wider adoption of these restrictive networks and formularies and certainly made these constructs politically suitable.

Since many plans have little or no coinsurance outside of their networks and formularies, patients seeking care outside of these

arrangements can be saddled with the full cost of these choices. Under many plans, when patients are out of their networks or off their formularies, these costs don't count against deductibles or out-of-pocket maximums.

To get a sense of how restrictive the formularies are and its impact on patients, we looked at drugs used to treat two chronic diseases: rheumatoid arthritis and multiple sclerosis. We examined the drug coverage offered by the lowest-cost Silver plan offered in the most populated county in 10 different States and focused on disease-modifying drugs that are widely prescribed for these patients.

We found that none of the plans provided coverage for all the drugs or covered any of them without significant cost-sharing that would tap out most people's annual deductibles and out-of-pocket limits on spending. The challenge for consumers is that most of the plans have closed formularies where nonformulary drugs aren't covered at all. Moreover, the cap on out-of-pocket spending only applies to costs incurred on drugs included in a plan's formulary.

Among some of our findings, the multiple sclerosis drug Aubagio is left off the formularies of 2 of 10 plans, so patients on these plans could have to pay the full $4,400 monthly retail cost of the medicine, translating to about $53,000 annually. The drug Avonex was left off the formularies of 2 of the 10 plans, potentially saddling patients with the drug's $4,800 monthly cost. That is $57,000 annually.

Extavia wasn't included on 2 of the 10 formularies, at a monthly cost of $4,600 or $55,000 annually. Tecfidera was left off 6 of the 10 plans, at a monthly cost to patients of $5,200.

We found similar results when it came to drugs targeted to rheumatoid arthritis. For example, the RA drug Xeljanz was left off the formularies of 4 of the 10 plans, at a monthly cost to patients of $2,400 or about $30,000 annually. Orencia was left off two plans, at $2,600 a month or $32,000 annually. The RA drug Remicade was left off the formulary of three plans, at about $3,500 for a 2-month supply or $21,000 annually.

The high cost of developing innovative medicines translates into high retail prices. This is a challenge for our healthcare system. But the cost of disease progression and the ensuing disability can far outweigh the cost of effective management with some of these drugs. Many newer medicines are more targeted to these diseases and far more effective.

These findings have been replicated by other analyses. One study by Avalere Health of 22 carriers in 6 States found the number of drugs available in formularies ranged from a low of about 480 to nearly 1,100.

Even if your drug makes it onto the plan's formulary, getting access can still be a costly affair. Another analysis looked at 123 formularies from different Silver plans. More than 20 percent required coinsurance of 40 percent or more for the drugs for one of

seven different chronic diseases, and about 30 percent of plans provided no coverage for at least one key drug for multiple sclerosis.

The same challenges are being seen when it comes to networks of doctors that the health plans offer. More than two-thirds of exchange plans have provider networks considered narrow or ultra-narrow in which as many as 70 percent of local health providers aren't included.

Earlier this year, we released our own analysis that consistently found that exchange plans offer just a fraction of the specialists available in the PPO plan offered by the same carrier in the same region.

In the 1990s, consumers firmly rejected the idea of very restrictive health plans and drug formularies when they spurned HMOs in favor of preferred provider organizations. Yet, the ACA seems premised on a view that consumers were making a bad trade when they chose PPOs over HMOs. Each scheme has tradeoffs, but the ACA all but codifies the HMO model into law, forcing consumers into these restrictive arrangements as a way to pay for the ACA's other rules and mandates.

Congress could reform the ACA by permitting any health plan that previously met State eligibility prior to passage of the law to be offered on the exchanges. This would allow for a much wider selection of plans that make different tradeoffs between benefit design and networks. These restricted schemes are an unfortunate consequence of the way the ACA structured the State exchanges. It is within Congress'

power to fix these rules.

Thank you.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Gottlieb follows:]

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

Mr. Pitts. Dr. Harvey, you are recognized for 5 minutes for an opening statement.

STATEMENT OF WILLIAM F. HARVEY, M.D.

Dr. Harvey. Chairman Pitts, Ranking Member Pallone, thank you for allowing me to speak before you today. My name is Dr. Will Harvey, and I am a practicing rheumatologist at Tufts Medical Center in Boston, Massachusetts.

In addition to my daily duties caring for patients with rheumatic and musculoskeletal disease, I am privileged to chair the Government Affairs Committee of the American College of Rheumatology. As a member of the Coalition for Accessible Treatments, the ACR advocates for, among other things, affordable access to treatments for chronic conditions, including rheumatoid arthritis, multiple sclerosis, lupus, hemophilia, certain cancers, and many more. With these treatments, much of the disability of these diseases may be averted.

But a great tragedy is emerging in our country involving increasing barriers accessing these treatments. Some of these barriers include cuts to provider networks, step and fail-first therapies, co-pay assistance problems, and specialty tiers. I appreciate the opportunity to discuss some of those barriers in more detail with you today.

The first barrier I wish to bring before the committee relates to the practice of co-pays. I have no doubt every member of this committee is familiar with co-pays and their typical structure of generic tiers, name-brand preferred, and name-brand nonpreferred, or Tiers 1 through 3.

Unfortunately, however, we are seeing more and more insurers in plans and exchanges creating a fourth tier for expensive specialty drugs. Data released this week from Avalere shows that for many diseases, including rheumatoid arthritis, 100 percent of the biologic treatments fall within these specialty tiers.

What is more alarming about this fourth tier is that the insurers and plans in the exchanges have often assigned a coinsurance on a percentage basis, ranging from 20 to 50 percent of the total cost of this drug, which, as you just heard, can exceed $20,000 or more a year. This results in patient facing thousands of dollars per year of out-of-pocket costs.

Prior to the ACA, about 23 percent of plans included a fourth tier. Based on this data from Avalere, 91 percent of exchange plans use a fourth tier and 63 percent of them use a coinsurance for that tier.

Because of the cost of coinsurance, many patients are declining treatment. And, in many cases, when patients fail to access these treatments, they become disabled and can no longer remain in the

workforce, thus costing the Federal Government more money to cover disability. Arthritis remains one of the top reasons for disability in the United States, at very high cost to the Federal Government.

Here is a stark example sent to me from a colleague in Wisconsin. "I have a young mother," she tells me, "with rheumatoid arthritis who cannot afford biologic treatments because of high co-pays. As a result, she has damage to her joints, and my concern is that it will affect her ability to remain employed. It has already limited the activities that she can do with her children. I have many other stories," she tells me, "of patients who go without their medications, but this patient is in her 30s, and I have watched her RA erode her joints without being able to help her."

Fortunately, 127 Members of Congress have charted a path forward. H.R. 460, the Patients' Access to Treatments Act, sponsored by Representatives McKinley and Capps, limits the practice of Tier 4 pricing by preventing a percentage-based approach in favor of pegging Tier 4 co-payments to lower tiers. The ACR and the Coalition would like to thank Representatives McKinley and Capps for their heroic leadership in this regard.

It has been noted that a potential consequence of such action is an increase in premiums across all beneficiaries of those plans. We commissioned Avalere to conduct an evidence-based assessment of the likely impact of H.R. 460 on premiums. The results indicated that,

if passed, H.R. 460 would only raise premiums in plans with specialty tiers by approximately $3 per year, or 25 cents per month.

There is too much at stake for patients who might stay in the workforce longer, avoid costlier treatments, and remain productive members of our society to let this practice continue.

Another issue I wish to bring before the committee relates to changes in provider networks where insurers have attempted to control costs by dramatically cutting provider networks. We believe this has begun with Medicare Advantage plans across the country, but there is great trepidation amongst all of my colleagues that it will expand dramatically to plans within the ACA.

In conclusion, I have great faith in the institution of government and that its members will do everything in their power to protect the people of our Nation who suffer from chronic diseases and are burdened with the growing expense of treatments, with less access to the experts who can diagnosis and treat their conditions.

I cannot leave without acknowledging that the ACA has had successes and has been a benefit to many Americans. But the healthcare system is far from fixed, and much work is still necessary.

The committee should take swift action to, first, maintain adequate provider networks to ensure access to care while ensuring truth in advertising by requiring insurers in exchanges and in the broader marketplace to disclose plan changes to provider networks

during open enrollment periods; and, secondly, to prevent excessive cost-sharing by blameless patients with chronic diseases by supporting H.R. 460, the Patients' Access to Treatments Act, which would apply to any private insurer within the ACA exchange.

Thank you again for accepting this testimony. I am happy to address any questions the committee may have.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Dr. Harvey follows:]

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

Mr. Pitts. I now recognize Commission Lindeen, 5 minutes for an opening statement.

STATEMENT OF MONICA LINDEEN

Ms. Lindeen. Good morning, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee. My name is Monica Lindeen, and I am the commissioner of securities and insurance for the State of Montana. And I also serve as president-elect of the NAIC.

I appreciate the opportunity to appear before the committee to discuss these two important topics that have a great influence over the quality of care that QHP enrollees receive.

While I am limiting my spoken comments today to network adequacy, my written testimony also contains information about drug formularies.

As the ACA has been implemented, insurance commissioners across the country have focused on protecting consumers and markets in their individual States. The issues we deal with are complex, but, through the NAIC, our national organization, we have worked cooperatively to address the challenges.

Insurance companies have long used provider network contracts as a way of controlling costs. Providers agree to lower reimbursements in exchange for the increased traffic of patients seeking lower out-of-pocket costs within the network. But there can be problems.

If the networks become too narrow, patients can't get the services they really need. If the regulation becomes too stiff, insurance companies can't organize policies in ways that truly cut healthcare costs.

These concerns have been ongoing for some time, and network adequacy oversight has been and will continue to be a priority for insurance commissioners around the country.

Given the importance of striking a balance, particularly with respect to tradeoffs between breadths of network and cost and the differences in local geography, demographics, patterns of care, and market conditions, it is important that responsibility for assessing the adequacy of networks remain with the States. State-based regulation works and has proven to effectively protect consumers. Networks are inherently local, and you need local expertise to effectively regulate the markets and preserve patient access to the care they need.

Montana has the tools in place to adequately regulate in-networks, and our network adequacy standards are, in general, more protective than what the ACA requires. My staff reviews the network adequacy of every health plan approved for sale inside the Federal exchange as well as those sold outside the marketplace. Because I conduct the same review inside and outside, I am able to ensure a level playing field in our market.

In Montana, we have not witnessed the sale of private health

insurance plans restricted to certain service areas and the very narrow networks do not really exist. The majority of the health plan products offered in Montana are a variation of a PPO product. However, in 2014, two of our three marketplace insurers did offer a narrower network option in two cities. But both of those companies also offered products in all parts of the State with access to their complete network, including the rural areas.

It is very important for consumers to understand the network features of a plan and how those apply to care provided by specific providers. Most of the network adequacy complaints received by my office this past year were rooted in a lack of transparency about available providers and a lack of understanding about how network restrictions work. Consumers found it difficult to find lists of provider networks when they were shopping for insurance, and this made it very difficult to choose the correct plan. The marketplace and insurance companies need to do better job of providing accurate and easy-to-access network lists.

These are not insurmountable problems, and States are focused on fixing these transparency issues. Over the years, insurers have been experimenting with new types of plan designs, and the head-to-head competition on exchanges has accelerated this trend, as competition on prices become more acute.

While I and my colleagues agree that containing cost and bending

the curve is critically important, we must also remember that health care is about more than the bottom line. Some older State statutes may no longer fully accommodate these new plan designs, and so the NAIC has begun working to revise our network adequacy model law, which aims to fully protect consumers while providing regulatory flexibility.

We have spent the last month receiving input from all interested stakeholders before drafting any revisions, which we hope to develop and consider through our open and transparent process and complete by the end of the year. Until that time, we believe CMS should not engage in further rulemaking until the States have time to act.

As I conclude my remarks, let me leave you with this perspective from someone who has been on the ground dealing with implementation. I have traveled across the entire State of Montana in many communities, including all seven of our Indian reservations, a distance greater than from here in D.C. to Chicago. And even on our Indian reservations, whether they are Republicans or Democrats, the folks in Montana don't want to talk about partisan arguments; they want to talk about solutions that are going to help them find their correct doctor and their correct insurance plan and get the care they need for their families. Trying to help answer those questions is what drives my decisions as a commissioner, not what is happening here in D.C.

So thank you for the opportunity to testify.

Mr. Pitts. The chair thanks the gentlelady.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[The prepared statement of Ms. Lindeen follows:]

******** INSERT 1-3 ********

Mr. Pitts. That concludes the opening statements of the witnesses. We will now go to questions and answers. I will begin the questioning and recognize myself for 5 minutes.

At the outset, I want to point out one thing I find deeply troubling. It is now widely acknowledged that the President's promise that if you like your doctor you can keep your doctor under the Affordable Care Act is simply not true for many patients around the country. Given this fact, I think it is unacceptable that the administration continues to give Americans the false impression that this promise is somehow true.

To this day, the White House Web site includes a section entitled "Health Insurance Reform Reality Check." And on the Web site, the promise appears, "If you like your doctor, you can keep your doctor." The Americans don't expect their elected leaders to agree with them on everything, but they do expect and deserve the truth. So I would urge the White House to either take this page down from their Web site or correct the record immediately.

Dr. Gottlieb, many patients with coverage through the ACA's healthcare exchanges are sadly finding out that they may not have real access to their doctor or medicines that they rely on because of narrower networks, restrictive drug formularies, or a complete lack of coverage for a specific provider or drug.

Can you further explain how these patient access issues are being

driven by the design of the President's healthcare law?

Dr. Gottlieb. Well, I think it was a combination of things. The first thing was the costly mandates that the law imposed on what the plans needed to cover, things like mental-health parity, first-dollar coverage for a lot of preventative services. There is no question there are going to be consumers who benefit from those mandated benefits, and I am not debating the merits of that, but they are expensive.

Coupled with that, the law outlawed or restricted a lot of the traditional tools that insurance companies used to control costs. And things like underwriting risk, things like using co-pays to steer patients aggressively, adjusting premiums -- and so what they were left with was the ability to go after the networks and go after the formularies. And since that was the only tool they had left to try to adjust the plans to meet the cost requirements in an environment where they had a lot of mandates imposed on them, they went after them very aggressively.

There were a lot of folks, prior to passage of ACA, in this town, smart folks on both the right and left, who knew that the networks were going to be narrow in these plans and anticipated that and saw it as a -- you know, proponents of the law saw it as a necessary compromise to accommodate the mandates. But I think that, in fact, was the reality of what happened.

Mr. Pitts. Dr. Harvey, in your testimony, you note a study from Avalere showing a dramatic expansion in the use of specialty tiers for prescription drugs in exchange plans relative to coverage before the ACA.

Can you elaborate a little more on how this trend has grown and what it means for the patients you serve?

Dr. Harvey. Certainly.

It has grown dramatically. It seems to have started, to some extent, in the Medicare Advantage plans but has, as you noted, become much more common in the ACA exchange plans.

The impact on patients is profound. Every day, in my practice, I see patients who tell me they cannot afford their medications because of this expensive co-pay. And it is a tragedy, as Congressman McKinley said, unacceptable, that in this country we can have the tools to prevent disability without them being affordable to patients.

Mr. Pitts. Commissioner Lindeen, at the beginning of your written testimony, you state that the President's healthcare law, quote, "has probably accelerated the trend," end quote, toward narrower networks for patients in the individual and small-group market because the law limits underwriting by insurers.

Are there other benefit requirements in the ACA that you believe could be contributing to the trend of narrow networks? Are there other requirements -- for example, the requirement that consumers buy

coverage that includes essential health benefits and that meet minimum actuarial value?

Ms. Lindeen. Thank you for the question.

You know, network adequacies and the narrowing of those networks is really nothing new. This has been going on for years, and I think that, obviously, the ACA has accelerated that process.

And it is market competition at work that is occurring, literally. And while the head-to-head competition in the exchanges are accelerating that trend of narrow networks, it can also be a very effective way of actually reducing the cost of health care. But that doesn't have to, you know, reduce the amount of quality also. And that is why it is really important that we are regulating these networks and making sure that we are not compromising quality.

We also know that, you know, as they are working on these contracts, that they are actually going to -- just to the marketplace. We have already gotten a lot of companies who have talked about the fact that they are getting more contracts in place for this coming year. And so I think that we are going to -- they are responding to what they are hearing from patients and responding to what they are hearing from you folks, as well. So we are going to see this continue to change and improve for the consumer.

Mr. Pitts. The chair thanks the gentlelady.

I now recognize the ranking member, Mr. Pallone, 5 minutes for

questions.

Mr. Pallone. Thank you, Mr. Chairman.

I do have this -- I ask unanimous consent to include this written statement for the record from Claire McAndrew from Families USA.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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

Mr. Pallone. Thank you.

As I said in my opening statement, if Republicans were serious about improving healthcare access, I would be very pleased that we are having this hearing. The ACA takes unprecedented steps to expand access to healthcare services, but I agree that if any American lacks access to the care they need, we have more work to do.

But I can't sit idly by and listen to Republicans claim they want to expand healthcare access and then in the same breath claim that they want to repeal the ACA. I think that is just ridiculous.

So, Commissioner Lindeen, the ACA has led to dramatic increases in health insurance coverage. It has opened up affordable coverage to millions who were previously priced out because of preexisting conditions. Over the next few years, it is projected to reduce the number of uninsured Americans by 26 million.

Can you help us get some clarity on a simple point? Does having health insurance increase people's access to healthcare services? Or put another way, would the 25 million Americans getting covered because of the ACA have better access if the Republicans got their way and they became uninsured?

Ms. Lindeen. Congressman, thank you.

Let me just say this, that in my experience as the insurance commissioner in Montana and having had the conversations that I have had with thousands and thousands of folks across my State, there has

been an increase in coverage for Montanans. And I am certain that that probably is happening in every State.

And I can also guarantee you that there are folks who didn't have coverage previously that have it now. There was one woman I know of, for instance, in Montana who was born with this heart condition and so she had never had insurance in her life because, number one, she couldn't afford it and because of the preexisting condition. She had incredible expenses throughout her life as a result, and then her husband passed away, and she had more of a burden on her in terms of finances. And then she was diagnosed with uterine cancer. She made the decision to actually forego any treatment because she knew that it was going to bankrupt her and her family. I mean, that is a tough decision to make.

Well, as it turned out, the ACA passed about the same time that this occurred, and, as a result, she was actually able to get for the first time in her life access to care that she could afford and is alive today.

And I think that is what we need to remember, is that this is really life and death to many, many people across this country. This is about making sure that they are taking care of themselves and their families.

And really, frankly, the public is tired of hearing the arguments in Congress. What they want is for us, and for all of us, to solve the issues. And I can tell you that insurance commissioners across

this country in every single State, who are Republicans and Democrats, put aside their partisan beliefs every day to try to do what is best for their consumers. And all we ask is that you folks do the same.

Mr. Pallone. I appreciate that. Thank you. And as I have said, if Republicans are serious about improving the ACA to expand access, then I am eager to work with them.

But the ACA includes unprecedented nationwide network adequacy requirements; it requires plans contract with essential community providers that work in underserved communities and offer key services; it bars plans from imposing extra cost-sharing on out-of-network emergency care; and it requires plans to cover essential health benefits, which means that they must have a range of providers in-network.

So I just wanted to ask you, Commissioner, States have a great deal of flexibility in setting their own standards and enforcing those requirements; isn't that correct?

Ms. Lindeen. Yes, they do. We in our States have always had a great deal of ability to set standards. Obviously, we feel like the ACA, in many cases, set a floor and then we can then go above that floor if necessary.

You know, in terms of -- and if I could, in terms of the essential health benefits, you know, insurance is really about spreading risk. Okay? And it is important for things like maternity coverage to be

included in order to help spread that risk. Because if you don't, what happens then is you have folks who can't even afford to get coverage for maternity care, which was happening in some States prior to the Affordable Care Act.

Montana is an exception to the rule. We have had unisex insurance law on our books for over 20 years, and so we have been spreading the cost all this time. And, as a result, every woman in the State of Montana has had the ability to have that kind of care, and affordable care, in order to have coverage for pregnancy.

Mr. Pallone. All right. Thanks so much.

Mr. Pitts. The chair thanks the gentleman and now recognizes the vice chair of the full committee, Ms. Blackburn, 5 minutes for questions.

Mrs. Blackburn. Thank you, Mr. Chairman. And I am delighted we are having the hearing today and having this discussion.

I find it so interesting that my colleagues across the aisle continue to say we have no options to replace Obamacare because, indeed, we do. Indeed, Mr. Scalise and Dr. Roe and I wrote the President on December 10th of last year asking if we could come and discuss with him the American Health Care Reform Act, which would be a replacement. It includes such popular ideas as across-State-line purchase of health insurance, portability, equalizing tax treatment, looking at tort reform.

So we have plenty of options. What we need is people who are willing to listen that there just might be a better way to administer health care than going through a government-run program.

Now, when we talk about repealing Obamacare, we are talking about getting rid of government control of health care. The reason we do this is because history tells us and what we see playing out in front of us shows us it does not work. Look at what is happening with the VA.

And, of course, we all know from some of the Democrat leadership that the stated goal of Obamacare is to have it push us to a single-payer system.

So, with that in mind, I would just say -- and, Commissioner, to you, thank you for joining us, but I have to tell you, in Tennessee, we had an experiment with Hillarycare, the test case for Hillarycare, which became the template for Obamacare. Now, ours was called TennCare. And what we saw is it was an expensive -- far too expensive to afford. It was consuming every new dollar that came into our State.

So what did a Democrat Governor do? And putting aside his partisanship, what he did was to take the program down to -- took several hundred thousand people off the program because we could not afford this. It became 35.3 percent of the State budget.

We know it does not work. Access to the queue and access to the care is not the same thing.

I heard from a woman who had Obamacare. She was excited to get it. She went to her primary care physician, thought she had all these essential benefits. Needs a test, goes over to the medical lab. Guess what? Doesn't pay for the test. Guess what? She didn't have $1,200 to pay for it. So, see, access to the queue and access to the care are a couple of different things.

I have heard from an eye surgeon over at Vanderbilt, and he has a surgery that deals with blindness for those that have diabetes. He is looking at narrowing networks for Medicare and incredibly narrow networks, the process not even covered through Obamacare. And so we are seeing this problem with access to the care that is needed.

And I have to tell you, after living through the issues with TennCare in my State, I think it is just awful that we would give false hopes and false promise to people that really want to access health care and have that available for their families.

And that is what we are seeing play out with Obamacare. That is why you continue to have waivers. It is why you continue to have people seeking to opt out. It is why the administration continues to go around Congress and give different parts of the law different treatment. Not supposed to do that, but they do it anyway because they are dealing with the program that doesn't work.

Dr. Gottlieb, let me come to you. I am so concerned about these narrowing networks and what we saw in TennCare, what we have seen in

Medicare with the narrowing network, such as what I mentioned with the eye surgeon there in my district. And I would like to know your thoughts on if you believe that the same central cost-controlling behaviors are going to happen as we move forward with Obamacare and why you think that is going to happen and the effect that is going to have on access to specialty care.

Dr. Gottlieb. Well, it is happening, and it is happening because I think it is one of the primary cost-control tools that the insurance companies have left to them under the existing rules.

I also think that the compromises that were made in the Affordable Care Act made this politically palatable, if not fashionable, to have these kinds of networks. If we think back to the 1990s, the last time there was a broad movement towards more restrictive kinds of plans, the HMO-style plans, we saw introduction of the patients' bill of rights and a real political backlash. I think that the environment now prevents that backlash from happening, and so you are going to see more insurance companies take advantage of these tools.

And I fully expect that you are going to see these narrow networks start to roll out into other aspects of the market -- the commercial market, the Medicare Advantage market. This isn't going to just be confined to the Affordable Care Act marketplace.

Mrs. Blackburn. I yield back.

Mr. Pitts. The gentlelady's time has expired.

The chair recognizes the gentlelady from Virgin Islands, Dr. Christensen, 5 minutes.

Dr. Christensen. Thank you, Mr. Chair.

And I have to agree with Dr. Lindeen that it is time to stop arguing and just, you know, move ahead. Too many people are benefiting right now from the Affordable Care Act, and, yes, there might be things that we could tweak a little bit, and we have always been willing to do that, but it is time to stop the arguing and take care of the needs of the American people.

The Affordable Care Act is a very important step towards eliminating health disparities. Minorities are far more likely to lack insurance, far more likely to lack access to a regular source of care, less likely to receive key preventative benefits. The ACA's coverage expansion and its focus on prevention is already having a huge impact, positive impact, on minority communities.

Provider networks and prescription drug coverage are key to this impact. The law's requirement that all health plans contract with essential community providers that work with the underserved population is critically important. And I am hoping that, you know, some of the doctors that I have worked with in the National Medical Association and the Hispanic Medical Association are being seen as essential community providers in these networks.

The essential health benefits and cost-sharing protections are

huge steps forward to make sure necessary treatments are available and affordable to the newly insured. Commissioner Lindeen, how do these provisions and other aspects of the ACA help the underserved communities in your State?

Ms. Lindeen. I appreciate the question.

You know, we have a very rural State, as you can imagine, and a large proportion of the population actually falls in that area of low-income, including seven Indian reservations, where there is, you know --

Dr. Christensen. Yeah.

Ms. Lindeen. -- obviously, limited employment opportunities.

And I can tell you that I had a study commissioned by an independent group with, actually, one of the grants as a result of the ACA. I guess it has been almost 4 years ago now. And we, through that process, were able to come up with a number of about 170,000 Montanans who were not only uninsured but actually fell into, in many cases, these -- the same type of -- were the same type of people that you are talking about.

As a result of the ACA and the new marketplace, I can tell you that, in this first enrollment period, we have been able to get coverage for a good number of them, tens of thousands of that 170,000.

Unfortunately, about 70,000 of those individuals still fall into that Medicaid gap. We have not expanded Medicaid in the State of

Montana. And so it is kind of a difficult situation we find ourselves in, where, you know, these 70,000 folks, at least in my State, really have no option -- affordable option. I mean, they are the working poor.

Dr. Christensen. Yeah.

Ms. Lindeen. But we have seen, definitely, thousands of folks who have been able to get access as a result.

Dr. Christensen. Yes. If we could have all of the States expand Medicaid, we would cover probably 95 percent of the people -- of minorities and the poor. So we continue to work and hope that the States will accept Medicaid expansion that have not thus far.

But these are important steps forward. We all need to remain vigilant to make sure that the law is implemented so that it achieves the goals of eliminating health disparities. For example, the law bans insurers from designing their health plans in a discriminatory manner. They cannot set up drug formularies or choose their providers in a way that discriminates against any group or individual with serious health needs.

Commissioner, how are you looking at potential discrimination in the marketplace? And how should we think about this issue going forward?

Ms. Lindeen. Well, I would say that, I mean, I think it is a really important issue that I think every one of the commissioners is very concerned about.

Obviously -- let's just talk about the tiered drug formularies for a second. I mean, it has really proven to be effective in terms of helping to bring down costs and really steer consumers toward generic drugs. But, at the same time, we are also, you know, wary of the fact that we want to ensure that these are being structured in a way that do not keep patients that have these certain medical conditions from actually accessing their drugs. That is in violation of the ACA, it is in violation of State laws.

And so, if there are any nondiscrimination -- or any discrimination occurring, I mean, we will actually investigate that and take measures to make sure that that doesn't occur in the future.

Dr. Christensen. Thank you.

Mr. Pitts. The gentlelady's time has expired.

RPTS BAKER

DCMN WILTSIE

[10:56 a.m.]

Mr. Pitts. The chair recognizes the vice chair of the subcommittee, Dr. Burgess, for 5 minutes of questioning.

Dr. Burgess. Thank you, Mr. Chairman.

Dr. Gottlieb, again, thank you for being at our committee. You are always good to respond when we request, and we appreciate it.

An article that was published in Forbes in December, it's titled, "No, you can't keep your drugs either," are you familiar with that article?

Dr. Gottlieb. Yes.

Dr. Burgess. Well, in the article -- I mean, I have got to tell you a lot of people are not familiar with what a formulary is or what a formulary does, but I suspect even more are not familiar with what a closed formulary is or does.

Could you tell us in a few words what that is.

Dr. Gottlieb. Well, a lot of these formularies are closed formularies, particularly when you look at the Bronze and the Silver Plans.

And what it basically means in most cases is that, if a drug isn't on the list of the plan's formulary, it is not covered at all, there

is no co-insurance, and whatever you would spend on purchasing the drug wouldn't count against your out-of-pocket limits or your deductible.

Dr. Burgess. And that, you know, is such a key point. Again, as I referenced in my opening statement, I bumped up against this myself, not with something that was terribly esoteric.

But at the same time I thought, "Well, I am a free American. I will just buy the darn drug myself, but I will charge it against my deductible." And I was informed that that -- you know, "You are just spending your money. You are not covering your deductible."

Now, of course, the out-of-pocket limits were suspended the first year in the individual market for individuals under one of the President's unilateral decisions on enforcement activity under the Affordable Care Act. So that really doesn't even play.

But the concept of a closed formulary is one that I don't think people are aware of. They need to become aware of it. And, again, like me, they may bump up against it without knowing that that restriction actually exists.

Dr. Gottlieb. I will just add it is very hard to figure out. When we looked at these plans, we had a very difficult time figuring out if these were closed formularies or not. We spent days on it. And I had a very talented research assistant working with me and we had to actually call the plan and even then it was difficult to get that information. So consumers might not know until it is too late whether

they are in one of these.

Dr. Burgess. Correct. It is too late because they are already into their coverage year. Presumably, they could change plans next year.

But, unfortunately, we don't know whether there will be access to plans that will not -- I mean, I think closed formularies are here to stay. I mean, I think it is just one of those things.

I practiced in the 1990s. I remember what it was like with HMOs. But a lot of those practices, even though they have been modified and mitigated with time, they are still with us.

You are still calling a 1-800 number to get approval for your patient who doesn't -- if you don't follow the step therapy for asthma, for example. You have got to do it exactly the way the insurance company says or the product is not covered.

Another piece that I have here of yours is also from Forbes, and this one was published in March, so just a few weeks ago: Hard Data on Trouble You Will Have Finding Doctors in the Affordable Care Act. And then you have a table.

That is some pretty striking information that you revealed there as well. I mean, again, we go back to, if you like your doctor, you can keep your doctor, unless your doctor happens to be a cardiologist in Connecticut, for example, where 177 of the 400 cardiologists are no longer available to you.

Have I interpreted that correctly?

Dr. Gottlieb. You have. And the other thing -- you know, we talk about the sort of popularization of the closed formularies.

The other thing that I think is going to be popularized is something called the exclusive provider organization, which might be a new acronym for a lot of folks, where you are dealing with a network of physicians that literally are countywide.

And once you go outside your network, again, if you are in a closed network, whatever you spend with a physician outside that network won't count against your out-of-pocket limits, potentially

Dr. Burgess. And, you know, I am just like anybody else. When I went and priced this stuff on healthcare.gov -- or when I went and shopped on healthcare.gov, I was only shopping on price.

I think that is what most people do, not anticipating they are ever really going to need their health insurance. But the reality is you can get some serious restrictions and some boundaries on the type of medical care you are able to get under these policies.

Ms. Lindeen, let me ask you a question, and this is a little bit off topic. But since you are the insurance commissioner on the panel, we are all familiar with medical loss ratio and the fact that any insurance company can only have 15 percent of its expenses on the administrative side.

What happens when an insurance company buys a doctor group? Do

those administrative costs then just get automatically transferred to the clinical side because a doctor group has been purchased now by a health plan?

Ms. Lindeen. I have to tell you that I am not an expert on how that works, but I would be definitely willing to go back and get you that information.

Dr. Burgess. I think that is something we are likely to see more and more of. I think it is a loophole, if you will, in the way the -- one of the many loopholes in the way the law was drafted. But I would appreciate your researching that and getting back to the committee on that issue.

Ms. Lindeen. Absolutely. It is my pleasure.

Dr. Burgess. Thank you.

I yield back, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

Now recognize the gentleman from Texas, Mr. Green, for 5 minutes of questions.

Mr. Green. Thank you, Mr. Chairman, Ranking Member. I appreciate you having the hearing today.

I want to start by saying, while health insurance does not necessarily equal healthcare access, having coverage, whether it is through the employer, Medicare, Medicaid, CHIP, or exchanges, the essential first step is to have access to health care.

And I was a State legislator for 20 years -- I tell people before I lost my mind and came to Congress -- in Texas and worked on access and worked on expansion of Medicaid when we had to come up with a third of the money for Medicaid in Texas. Under the Affordable Care Act, it would be 100 percent for a few years and no more than 10 percent.

So I understand -- but my first question is if the witnesses could give us some specific changes or reforms in the Affordable Care Act, or Obamacare, if you will send them to the committee, things that you would see that -- something we could do, because, hopefully, we will get to that point some day in our committee, saying, "What can we do to make it better?"

My frustration is that, in Texas, we didn't expand Medicaid. If we had, 92 percent of all eligible uninsured Texans, or 4.5 million, would qualify for premium tax credits, Medicaid or the CHIP program.

Commissioner Lindeen, some of my colleagues make the argument that having Medicaid coverage is worse than being uninsured. What do you say to that? Have you heard that having Medicaid coverage is worse than being uninsured?

Ms. Lindeen. No. I have not heard that. I am just being honest. Honestly, I have not.

Mr. Green. Okay. What would be your response to it? You know, granted, Medicaid is not a major plan, but it still gives access to a healthcare system.

Ms. Lindeen. Yeah. I mean, I would argue that, if you talk to somebody who actually is uninsured and does not have access to Medicaid, who is in that gap and who has some serious health needs, I would definitely ask them that question.

Mr. Green. It is estimated that States' unwillingness to -- or inability to expand Medicaid is leaving 5 million uninsured who could otherwise have coverage.

What would Medicaid expansion mean to families and the uninsured in your State?

Ms. Lindeen. Well, it would mean the world. I mean, obviously, medical bills are one of the number one reasons for bankruptcy.

And I can tell you that those folks who fall in that gap, if they find themselves in the situation where they are going to have to try to get care and it is going to be expenses that they can't afford, I mean, that is where they are going to end up. They are going to end up bankrupt.

Mr. Green. Well, I don't have a wealthy district.

Ms. Lindeen. I don't either.

Mr. Green. In study after study, Medicaid has been shown to improve access, increase individuals' reported health, and provide significant financial security.

A recent study even demonstrated that Medicaid coverage can improve educational advancement in helping lift people up the economic

ladder.

And I have to admit, even in Houston, Texas, the Greater Houston Partnership was our main chamber of commerce. They encouraged our State legislature during the last session to expand Medicaid.

Hopefully, when the legislature goes in session in January, they will realize that, you know, that is the cheapest way we can cover folks in Texas.

Because in Texas -- in the military, they would call it a target-rich environment. We have the highest percentage of uninsured. We also have the highest number of uninsured.

So Medicaid expansion would help for those qualified for Medicaid, but it would also allow, like you said, for those near-poor Medicaid to be qualified under the Affordable Care Act for the subsidies.

And, of course, Medicaid expansion is funded by the Federal Government and, like you said, most Medicaid is two-thirds Federal funding, a third State funding, although each State has a different percentage, as I found out. Many States are seeing a big influx in funds and are likely to save money over the long term.

Commissioner, when you look at the total picture, is Medicaid expansion worthwhile for States like yours?

Ms. Lindeen. I can tell you that we also commissioned an independent study to look at the effect of Medicaid expansion on the

State of Montana, and the positive economic impact to the State was incredible in terms of the hundreds of millions of dollars that it would bring into the State, as well as the thousands of jobs it would create, not only just any kind of job, but good-paying jobs, mostly in the medical community.

We, too, had obviously legislation that came before our legislature this past year, and I was amazed at the folks who came and testified in favor. It wasn't just the hospitals and the providers, but it was business people.

We had one gentleman who works for an investment company who came in front of the legislature and said, "Listen, if I was a Fortune 500 company standing before you today and saying that, if you were to accept these Federal dollars and it was going to help create all these jobs for my company and my company would come to your State as a result, you would fall all over yourselves to pass it." But because it is not a Fortune 500 company, they refused.

Mr. Green. Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman and now recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes of questions.

Mr. Shimkus. Thank you very much.

Great to have the panel.

And, Commissioner, just -- it is our job to do oversight. So preaching the partisan aspects of Washington, D.C., we need to continue

to do oversight on this law, and that is our job. So I just put that on the table because I have a problem with your tone.

Having said that, what is the population of the State of Montana?

Ms. Lindeen. First of all, let me apologize if my tone --

Mr. Shimkus. No. That's fine. I am running out of time. I only have 5 minutes. So --

Ms. Lindeen. About a million people.

Mr. Shimkus. And in your testimony you mentioned that the ACA is sharpening the competition between insurers.

Can you tell us how many insurers are in the State of Montana.

Ms. Lindeen. Well, we have hundreds of insurers licensed to do business. But in terms of the numbers that are in the marketplace -- the new Federal marketplace, we had three this year.

Mr. Shimkus. Three.

Ms. Lindeen. I know we had one more --

Mr. Shimkus. So some of us would question whether that is vibrant competition. Three is better than two. Two is better than one. We would rather have more versus less and a vibrant market that has a lot of choices for the consumer.

Let me go to another question to the panel as a whole.

Recent stories indicate that emergency room access is increasing. Why do we think that is?

If we pass a national healthcare law which is supposed to provide

people healthcare coverage to access primary care doctors, internists, and to make sure that hospitals aren't -- ER rooms are not being overutilized, why is there an increase in emergency room usage?

Dr. Harvey. So my wife is an emergency room physician. So we have a lot of dinner table conversations about this.

I think a couple of issues. One is that people who are now covered -- or who believe they have coverage don't necessarily understand the fact that treatment in an emergency room comes at much greater cost than treatment in other settings.

Secondly --

Mr. Shimkus. But if they have got care, why are they going to the emergency room?

Dr. Harvey. Well, I think the second point is that there are access issues to physicians not because of any coverage, per se, but because there is a shortage of primary care in particular, but many specialty physicians as well, that has been uncovered by the fact that there are many more people now with coverage demanding the services.

Mr. Shimkus. Could the -- Dr. Gottlieb?

Dr. Gottlieb. I was just going to say I practice at a hospital. So I admit from the emergency room. I think a couple of things that I would just point out.

The first is that coverage doesn't necessarily equal access and coverage doesn't change whether or not a person is a good consumer of

healthcare services.

And what you typically see -- or often see is someone will get coverage. They will be newly on Medicaid or Medicare or private coverage and their patterns won't change at all as a result of the coverage. So just giving someone healthcare coverage really doesn't guarantee that they are going to get care.

And the other thing is that a lot of folks end up in schemes where they are underinsured. And so they still don't have access to doctors who return phone calls after hours, the ability to schedule appointments the day of when a problem arises. And so they still end up in the emergency room.

That is typically what I see when I see newly insured people who are ending up in the emergency room even though they have insurance for the first time.

Mr. Shimkus. Is there a co-pay with a lot of these plans, a high co-pay --

Dr. Gottlieb. A deductible issue.

Mr. Shimkus. The deductible. That is what I mean. The deductible is at. They can't afford the deductible.

Let me ask another question. Is emergency room care more expensive or less expensive than going to a urgent care or a primary care doctor?

Dr. Gottlieb. Well, it is far more expensive and it is far less

efficient.

Mr. Shimkus. And everybody would agree that. Right?

Even, Commissioner, you would agree with that.

Is this driving up the cost of health care or lowering the cost of health care, this issue about emergency room usage?

Dr. Gottlieb. Well, we are going to see healthcare costs go up if we see more people end up in emergency rooms. There is no question about that. We need to do more to try to make care accessible to people and not just hand them an insurance card.

Mr. Shimkus. Thank you.

And my time is expiring. And I will just end on this.

My friends tout 8 million have signed up, actually, Medicaid expansion. I always say there is a sliver of people that have been helped, but I will tell you there have been more people harmed by paying more in their health insurance and getting less coverage.

The Wall Street Journal has said 10 million people have lost their insurance. Part of that 8 million or 10 million who have lost their insurance and -- have to buy new insurance, just like us. We had insurance coverage.

So when you count how many have been added to the insurance roles, you better make sure you are counting the people that have lost their insurance under this new law.

And I yield back my time.

Mrs. Ellmers. [Presiding.] The gentleman yields back.

The chair now recognizes Ms. Castor from Florida.

Ms. Castor. Well, thank you very much.

I want to thank the chairman and the ranking member for organizing this hearing on access to health care.

I don't think anyone can ignore the fact now that the Affordable Care Act has been the largest expansion for families across America and their access to the doctor's office in our lifetime.

And in the State of Florida, it was very surprising. We had a very high rate of uninsured, and we thought, gosh, we are going through all these political fights with what the ACA means. And, in the end, I think these families spoke very loudly.

We thought we would maybe have 500,000 sign up on the Federal exchange or 600,000 would be really great. We had about a million Floridians sign up on the Federal exchange. That is the population of Montana. They are breathing easier now because they have access to the doctor's office.

Is it going to be perfect? No. Part of the problem was they had so many choices. They had the Bronze Plan, the Silver Plan, the Gold Plan, with all sorts of different networks where they might want to go with a more affordable option.

And I think this is going to change over time, but we have empowered the consumer to make that choice by going online and examining

all of the networks. And their health needs are going to change over time; so, their choices are going to evolve.

I think one of the most fundamental of changes in the law is now no one can be discriminated against in America from getting health insurance. Think about your family members, your neighbors, that had a preexisting condition, cancer, diabetes. They can't be barred from coverage anymore.

So when we are talking about access, that is really a fundamental -- it is the fundamental change of the ACA, along with affordability and a meaningful policy. A lot of people wouldn't pay for an insurance policy because it wasn't worth very much, but now the law requires these essential health benefits.

And what hasn't been talked about a lot, it requires that networks in these plans have to be adequate. Now, it is not going to be perfect for everyone.

And I really appreciate it, Commissioner, that the state insurance commissioners are going to have great responsibility in ensuring the adequacy of networks and that there aren't any discriminatory issues.

We had one issue in Florida that has always confounded me, though. Last year during all the political fights the Florida legislature and Governor actually passed a law that said the Florida insurance commissioners no longer have the ability to negotiate rates -- health

insurance rates.

Have you heard of that being done anywhere else across the country, that they restricted the power of the insurance commissioners?

Ms. Lindeen. Yes. Actually, there are all sorts of levels of authority for insurance commissioners across this country in terms of the ability to review or even approve rates.

I in Montana, in fact, have never had -- this office never had the ability to review rates until this past year. We finally convinced the legislature to allow me to review them.

I can't, like, deny the rate increase, but what I can do over the course of that 60-day time period while I am reviewing the rate is actually look at whether or not it is an appropriate rate and reasonable.

And if I find issues, I can go back to the company and I can negotiate it down. And it has already been working.

Ms. Castor. So is that a benefit to the consumer?

Ms. Lindeen. Oh. It is a huge benefit. We --

Ms. Castor. That is why I can't understand why a State would take the action to actually say, "Oh, don't go and review the health insurance rates." That is going to be an access problem.

And I appreciate your emphasis on solving the issues together. We have had the Medicaid discussion. In Florida, they haven't expanded Medicaid. That is about the population of Montana, again.

So when you are talking about what is an important way to expand access, we have got to bring our tax dollars back home to put them to work covering people, helping the hospitals.

I think another one is the ACA also had provisions to improve the healthcare workforce. And I know a number of us are very concerned about primary care: Are we going to have the providers out there?

HHS has not done a good job with following through and, frankly, the Congress hasn't given them the money to go and look at the workforce issues.

My Republican friend and colleague Joe Heck and I have a bill called the CARE Act, the Creating Access to Residency Education -- I know a number of members here have been concerned about that -- that would allow States, insurance companies, local communities, hospitals to put up matching funds for residency positions.

But do you see the primary care situation as one of the problems going forward with access?

Dr. Gottlieb. Look, I think that we are going to face a relative shortage of doctors in certain insurance schemes. I have written that I don't think we are going to face a shortage of doctors overall in this country.

I think, depending on what insurance scheme you are in, it could very much feel like you are facing a doctor shortage.

I see a future where I think physician productivity will continue

to increase. I think we are going to see more -- greater access to non-physician providers, like nurse practitioners, and that is going to alleviate some of the burden.

So I am not a believer that we are going to see a physician shortage as a result of Affordable Care Act or for anything. I think that we will see relative shortages in certain insurance schemes.

Mrs. Ellmers. The gentlelady's time has expired.

The chair now recognizes Dr. Gingrich from Georgia for 5 minutes.

Dr. Gingrich. I thank the chair.

And I just wanted to comment on what the gentlewoman from Florida just said in regard to access. But at what cost? And I think that is the most important thing for us to keep in mind. You improve access by the Affordable Care Act.

In his opening remarks, the ranking member said that it's counterintuitive -- and I am paraphrasing here -- but counterintuitive for Republicans to say that they want to expand access and coverage for the uninsured, yet remain opposed to the Affordable Care Act, suggesting that there is nothing out there except the -- no way to do this except the Affordable Care Act.

And that is categorically untrue. In fact, the vice chairman of the committee, the gentlewoman from Tennessee, pointed that out earlier in a bill that came out of the Republican Study Committee that is a fantastic way to approach this. So we definitely have ideas and have

plans.

Commissioner Lindeen, I want to make sure. I may have misunderstood you in your opening statement. Did you say that, even before the Affordable Care Act, that in Montana you had mandated coverage for OB/GYN for all policies that were sold in your State?

Ms. Lindeen. Yes.

Dr. Gingrich. Would that be mandated for a 55-uear-old bachelor who had had a vasectomy? If he wanted to get a health insurance policy in the State of Montana, it would have to include obstetrical coverage?

Ms. Lindeen. As I said, insurance is about spreading the risk. And in Montana we have a constitutional law that says that you cannot discriminate based on gender. And so that is applied as well to our insurance and health insurance.

Dr. Gingrich. Well, that may be spreading the risk, but I will tell you that that is insane. And that is what the problem here is in regards to the Affordable Care Act.

All of these mandates, all this mandated coverage, comes at a tremendous price, at a tremendous price. And this is only going to get worse. It is only going to get worse.

Chairman Pitts said at the outset -- and I am going to repeat this because I think people need to understand and listen.

He was talking about the suggestion that, if you like your doctor, you can keep your doctor; if you like your hospital, you can keep your

hospital; if you like your medication, you can keep your medication; and, gee, you know, the price is -- it couldn't be better.

And this is just not true; yet, some of my Democratic colleagues have decided in perpetration of this falsehood to keep this information on their Web site. In fact, he talked about the -- I think the ranking member's Web site.

It is time to speak the truth so the American people know. It is time for Washington Democrats to take these statements down because we know that they are patently false, and the American people deserve better.

Now, let me go to Dr. Gottlieb and specifically ask you a question, Doctor.

In Forbes recently, you provided data by physician specialty on the number of providers included in ACA exchange plans versus a typical private health insurance plan.

Can you tell this committee about your findings, particularly as they relate to women's lack of access to OB/GYNs in exchange plans relative to any other private form of coverage.

Dr. Gottlieb. So we looked at PPO plans -- preferred provider organizations -- offered by the same category in the same market relative to what they were offering on the exchange. And, on average, I think the statistic was we found that they had about 50 percent fewer physicians in their exchange-based plans.

It varied across market, but we found some plans with real inadequacies where, you know, a plan didn't include a single Mohs surgeon.

We found a plan in a county in Florida of about a quarter of a million people that had about a dozen pediatricians on the network.

And we found a plan in San Diego that had fewer than 10 urologists for a very big -- the whole of San Diego County.

So we found some plans that had some significant deficiencies with certain kinds of physicians. And the Mohs surgeon is relevant because the plans --

Dr. Gingrich. Dr. Gottlieb, I am going to stop you on that. I want to get one last point in.

And, Madam Chairman, I would like to submit for the record an ABC News article of just yesterday where the chairman of the Senate Appropriations Committee cancelled a hearing because of a fear that Republicans would have amendments to the Affordable Care Act that would bring down costs that Democratic members didn't want to vote on.

So I would like to ask unanimous consent to submit this article from ABC news yesterday.

Mr. Pitts. Without objection.

This is a preliminary, unedited transcript. The statements within may be inaccurate, incomplete, or misattributed to the speaker. A link to the final, official transcript will be posted on the Committee's website as soon as it is available.

[The information follows:]

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

Dr. Gingrich. I yield back.

Mrs. Ellmers. Thank you. The gentleman yields back.

And I will say they are going to call votes soon; so, we are going to try to get as many questions in as possible within this time frame.

So, with that, I would like to recognize Ms. Capps for 5 minutes.

Mrs. Capps. Thank you very much.

And thank you to the panelists for your testimony today.

I have a question for the Commissioner from Montana. I went to high school in Kalispell; so, what you had to say about health care in Montana is important to me.

The Affordable Care Act rollout, in my opinion, was even more impactful than expected. Over 8 million Americans signed up for health insurance, many of whom had been living for years without the security of coverage.

But, as you noted -- and rightly so -- the law is not perfect. It is not perfect in California, where I live, either. It is clear that more could be done to ensure robust provider networks and broader access.

To be clear, in many cases, the insurance companies, not the ACA, have been making these decisions. But this is something I have been working on in my district, an issue that I think does deserve more attention.

There are some tools available through the ACA that would address

this issue right now.

Commissioner Lindeen, what enforcement authorities do you use within the ACA in order to ensure that networks stay wide and people stay covered?

Ms. Lindeen. All right. Well, let me tell you that what we like to do is we really like to look at ensuring access, affordability and transparency, making sure that there are enough providers available based on all sorts of different types of factors.

And those include everything from looking at general provider availability, medical referral patterns, hospital-based providers and whether or not -- and, of course, that can be affected by their willingness to actually contract --

Mrs. Capps. Right.

Ms. Lindeen. -- the geography that exists within the State, ECPs, and, also, making sure that there is, you know, just reasonable access to all these specialists. And we want to make sure that there is good transparency for consumers to make informed decisions as well.

Mrs. Capps. That is great.

Have you done anything that has been working to broaden the networks that you could share with us, to just expand the networks that you do have?

Ms. Lindeen. I can't think of anything really specific off the top of my head, but I will go back and look and get back to you.

Mrs. Capps. It seems to be an area that now could use some additional support. And I want to put on record that I hope there is ways that we can give you more tools or work with you in our individual States to make those networks more available.

But, additionally, as you mentioned, there have been allegations of excessive co-insurance in the specialty drug tier. We know that specialty tiers are a real problem for the patients who need those treatments.

They may not only save lives, they can improve the quality of life of the patient, often helping them to stay off disability rolls and remain engaged in work, with their families and in their communities.

But specialty tiers are not a function of the ACA. They have existed for many years, so much so that some States banned them long before the ACA became law.

That is why I have been pleased to join with my colleague, Mr. McKinley, to introduce legislation to address this and put these specialty drugs back in line with other prescription drug costs, putting these treatments back in research for those who need it most.

And a similar problem exists in Medicare and for cancer patients who are prescribed orally administered chemotherapy drugs, but only have coverage for traditional chemotherapy. These issues are real, but they were not created by the ACA, I believe, and to insinuate them as such is disingenuous.

But if we all now agree that this is a problem, I hope we can also agree that we should fix it. I want us to be able to vote on H.R. 460, the Patients' Access to Treatment Act. I believe we should have a hearing on H.R. 1801, the Cancer Drug Coverage Parity Act.

We can address these issues right now by passing these pieces of legislation. So I hope there is a time when we can have you back and we can tackle these and other pressing health issues that we face without getting into the political gamesmanship like we are seeing much of this hearing focused on today in kind of a biased way.

Strengthening this law, which we know we need to do, will not be accomplished while we continue a kind of drumbeat for repeal or going back to the broken system of the past. I know you are in positions where you see these real needs and that we need to address on a regular basis.

Thank you. And I appreciate again.

I am going to yield back.

Mrs. Ellmers. Thank you to the gentlelady for yielding back.

I now recognize Mr. Griffith for 5 minutes. If you might be able to squeeze --

Mr. Griffith. I will squeeze as quick as I can.

Mrs. Ellmers. Okay. Thank you.

Mr. Griffith. Let me just say that, when you are talking about things like rheumatoid arthritis -- and I have a family member who has

that -- and you are talking about access to care, particularly in my region, we are being limited. There is no gamesmanship being played. The real concern is about what is happening with the Affordable Care Act.

And I bring this up because -- and if we can pull that map up of my district -- I was recently told by not one, but two, of the folks who are in this business -- and if you can look -- they are getting it up there -- I am the green part down there.

And you can see why this is a particular problem. Because what happened in rural Virginia and my part of the State is that, in many of these areas, we only have one company that is under the shop plan or one company under the individual plan. Some places have two. There are not a lot of opportunities.

And what my brokers are telling me is that they are having to go to their small customers in the shop plan -- those are people with small businesses -- and all that is available is an HMO and that HMO limits them -- look at that map -- it limits those people from going to healthcare providers within the Commonwealth of Virginia or one county out.

Now, if you are in the Galax or Martinsville area and even some folks in the Roanoke Valley, up a little bit further on the border with North Carolina, you are used to going to either Duke or Bowman Gray. Can't do it with the new plans. You are outside.

Bristol, Virginia-Tennessee, for those of you who don't know, it's a wonderful city. The main street of the town is the state line. If you live on the Virginia side of the line, you can't go to the Children's Hospital in Johnson City under these new plans -- under the Affordable Care Act's shop plan. You can't do it.

That happens to be the tri-cities area. Bristol, Kingsport, Johnson City have worked really hard so that they have the availability in a relatively rural area to have one of everything.

And while you can certainly get your children treated at other hospitals, the hospital where the money has been spent to have for those high-risk people is in Johnson City.

So if you are living in Bristol, Virginia, on the wrong side of main street -- State Street, but the main side of the main commercial area, you can't go to that hospital. This is not games. We are not playing any games.

Are you seeing that that's a problem in other States or is it just because my district borders so many other States and you can actually get to other States' teaching hospitals quicker than you can get to UVA for many of my constituents?

Is that just a problem because I have an oddly shaped district or is that a problem for other States, Dr. Gottlieb?

Dr. Gottlieb. Well, it seems like a particular problem there, but this is not that uncommon. The Affordable Care Act allows

county-level bidding by the health plans. So sometimes you are seeing only countywide networks as a result.

Mr. Griffith. So it is a problem not only from State to State, but also within counties. I can see where that would be a serious problem.

Are we seeing, also, a narrowing on the ages? I need to ask that question. Are we seeing that they are narrowing services?

For example, if you are an 84-year-old woman whose father died of colon cancer -- yes, I am speaking of a constituent -- you normally would be getting your inspection -- your colonoscopy again, are there any limitations because of the age? Are you seeing any of that?

Dr. Gottlieb. I haven't seen age-based restrictions that go outside of normal medicine convention in terms of when things are recommended in these plans. Certainly that would be a Medicare -- more of a Medicare scenario, too.

Mr. Griffith. Yeah. I appreciate that.

That being said and because they have already called for votes and some others want to ask questions, Madam Chair, I will yield back.

Mrs. Ellmers. Thank you to the gentleman.

The chair now recognizes Mr. Bilirakis from Florida for 5 minutes. But if I could -- if you could, I would love to be able to -- oh. I take that back. I am sorry to Mr. Sarbanes. I apologize.

Mr. Sarbanes. Thank you, Madam Chair. I will try to keep my

questions under 5 minutes.

There is no question that the Affordable Care Act represents disruptive change -- okay? -- but disruptive, I think, in a very positive way, on balance.

It disrupts the situation where there were millions of people who were discriminated against based on preexisting conditions.

It disrupts the situation where millions of young people were having problems affording the coverage -- healthcare coverage.

It disrupts the situation where millions of seniors were falling into the donut hole and not being able to cover that with the out-of-pocket expenses that it represented; so, we are beginning to close that donut hole.

And it disrupts most significantly a situation where one out of seven Americans were being left out of health insurance coverage to the detriment of those individuals and their families but, really, to the detriment of the productivity of our country.

So it is disruptive change and, whenever you have disruptive change, it is going to take a while to sort of get everything in place, get it all rationalized, get the system working as well as the expectations are that we bring to bear.

So, you know, we need to be vigilant, but we also need to understand that it is going to take some time to get all of these pieces in place.

And, frankly, if you look at what the Affordable Care Act itself says about its expectations of the way provider networks will function, you know, it has provisions that require plans to create networks that are, quote, sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

It requires plans to contract with, quote, essential community providers, as that term is understood, that primarily serve low-income and medically underserved individuals. It requires plans to equalize cost-sharing for emergency services, et cetera.

These are requirements that are baked into the law, and it is going to have the effect over time of addressing this -- sort of the startup bumps that we have in terms of restructuring these provider networks.

I mean, it used to be the case that you could keep your cost down. You could say, "Hey, you can go to any provider you want," but the benefits that were available to cover that were pretty minimal in certain situations.

So was that really a good insurance plan? Just looking at the provider network and the expanse of it, you might have said, "That is terrific," but you look at other features of it, not so much.

So I just wanted to ask the Commissioner: Do you have confidence that the tools that you possess, as an insurance commissioner, are going

to be adequate, particularly given these requirements of the Affordable Care Act that you can cite and use and enforce to ensure over time that you will be able to put in place provider networks that can provide the coverage and the access that people deserve?

Ms. Lindeen. I think that, as long as commissioners at the State level are given the flexibility to do that and do their job and be able to enforce those provisions as well -- I think that is going to be a huge help.

But one of the biggest issues that we face is the transparency issue in making sure that consumers really are informed about what is actually in these networks and making good informed decisions for themselves. Because the more informed they are, the more that they are going to impress upon the companies in terms of competition and forcing them to make good decisions that are in the best interests of the patients as well so that they will get them what they need, so to speak.

But at the same time, the other thing that is really frustrating, I think, not only for the regulator and for the consumer and even for the company, is sometimes, with all due respect, this unwillingness to contract by providers. And I think that that is an issue that we are all going to have to deal with.

But, overall, I think that giving States the flexibility to actually do our job and do it based on the fact that we know our market's

better than anyone else is really going to be helpful.

Mr. Sarbanes. Thank you.

I yield back.

Mrs. Ellmers. Thank you to the gentleman.

And now I yield time to Mr. Bilirakis. I do want to say that there are less than 4 minutes left in the vote on the floor.

Mr. Bilirakis. I will be as quick as I possibly can. I will ask just one question.

Mrs. Ellmers. Thank you.

Mr. Bilirakis. I won't make any comments on the ACA. I will go directly into my questions.

Mr. Gottlieb, you have written extensively about the narrow networks. The Leukemia & Lymphoma Society commissioned a report about the narrow networks in the ACA.

According to their data, for the State of Florida, my home State, only 1 of 12 had coverage at the Moffitt Cancer Center in Tampa, Florida, the only NCI-designated cancer center in the State.

All Children's Florida hospital, Jackson Memorial, Mayo Clinic, Miami Children's Hospital, Moffitt, Nemours in Jacksonville, Sylvester in Miami, and Shands in Gainesville only had -- 4 ACA plans out of 12 covered any one of these hospitals, any one of these hospitals.

Mr. Gottlieb, it doesn't seem like it is very accessible. It seems to me that the people most disadvantaged by the law are the sick,

the patients with serious, chronic and complex medical conditions.

Are these narrow networks and closed formularies disadvantaging the sick and the most vulnerable, in your opinion?

Dr. Gottlieb. Well, I think, unfortunately, they will. You are absolutely right. I am on the policy board of the Leukemia & Lymphoma Society. You are absolutely right.

The academic cancer centers have been actively excluded from these plans largely because they are more expensive. And people who have rare cancers will not be able to get care there, and other people who might have more common cancers, but just want a second opinion, won't be able to get it.

Mr. Bilirakis. Extremely unfortunate.

I yield back.

Mrs. Ellmers. Thank you to the gentleman.

I now yield time to Mr. McKinley. And, if you can, try to keep it close. Thank you.

Mr. McKinley. Thank you, Madam Chairman.

Dr. Harvey, if I can direct this to you in the very short time. I have got a question as to how you would handle this scenario that we are facing in West Virginia.

Recently I met a 15-year-old girl from West Virginia. She is suffering the early symptoms of juvenile arthritis -- rheumatoid arthritis. But thanks to biologic medicine and the drug she has been

on, she has been able to participate and actually has become a track star.

I am curious. If her family is ever faced with a scenario that they have to go into an exchange -- and in West Virginia we only have one compared to -- in Montana you have three. We have one.

But her family's income is $50,000. So is it probable and likely that they can afford to go to the cheapest plan within that exchange. So they are either going to be faced with not having biologic coverage or being forced to go to something that is more expensive that they can't afford either.

So if -- in either case, she is either out $12,000 and -- by paying a higher premium where the family has to pay maybe $75,000 to $100,000 a year. What would you advise?

Dr. Harvey. Well, it is a very difficult problem. I think the main option, actually, is to provide cheaper medications, which are usually far more toxic, actually, and there are attendant costs associated with that. There aren't very many other solutions.

The main solution that presents itself is your bill, sir. And I think -- you know, I wear a fork on my lapel that has bent tines, and it is meant to symbolize the deformities that people with arthritis can develop, but, also, the simple tasks that they are prevented from doing.

And you all can help us unbend those tines by providing support

for people so they can afford their co-pays.

Mr. McKinley. Thank you. I appreciate your support for 460. I think we do have to move on that. Thank you very much.

I yield back the time.

Mrs. Ellmers. Thank you to the gentleman.

In the interest of time, I will submit my questions for a written response.

I would like to remind the Members that they have 10 business days just to submit questions for the record.

And I ask the witnesses to respond to the questions promptly.

Members should submit their questions by the close of business Thursday, June 26.

[The information follows:]

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

Mrs. Ellmers. Without objection, this subcommittee is adjourned.

[Whereupon, at 11:42 a.m., the subcommittee was adjourned.]