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ADVANCING PATIENT SOLUTIONS FOR LOWER COSTS AND BETTER CARE

Friday, June 10, 2016

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 9:16 a.m., in Room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

Present: Representatives Pitts, Guthrie, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Bucshon, Brooks, Green, Schakowsky, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff Present: Adam Buckalew, Professional Staff Member; Paul Eddatel, Chief Counsel, Health; Bob Mabry, Fellow, Health; Graham Pittman, Legislative Clerk, Health; Jennifer Sherman, Press Secretary;

Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Deputy Chief Health Counsel; Dylan Vorbach, Assistant Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Arielle Woronoff, Minority Health Counsel; and C.J. Young, Minority Press Secretary.

Mr. Pitts. Good morning. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Today's hearing will examine legislation designed to modernize the current health insurance market by empowering States to better regulate markets tailored to their unique conditions. Previously, this committee examined healthcare solutions that centered on promoting patient choice and innovation in the design of health coverage. This hearing is a natural follow-on to that.

Current law is leading to an increase in healthcare premiums. Double-digit premium increases are hurting, not helping patients. It is no surprise that a recent Gallup poll revealed that healthcare costs top American families' financial concerns. Almost daily, headlines across the country offer frightening news on healthcare cost. This undoubtedly is contributing to the fears of the American people.

And here are some of the numbers. In Virginia, nine insurers are looking to raise premiums at high as 37.1 percent. Three of the requests in Oregon are over 29.6 percent. One plan in New York is asking for a shocking 89 percent increase. For Texas, the biggest plan wants to raise its rate 60 percent. In Colorado, Golden Rule is seeking a 40.6 percent hike, Rocky Mountain HMO is seeking a 34.6 percent boost, and Colorado Choice wants a 36.3 percent increase. Connecticut has three plans wanting increases from 12 to 27 percent. In my home State of Pennsylvania, one insurer is seeking a 48 percent increase, while the insurance department says the average request is 23.6 percent for individual plans.

And this is why we are here today -- to offer better care at a fair price. Our solutions aim to help patients stabilize the insurance markets, restore flexibility, provide more choices, and keep costs in check.

Health care is the most personal of any political issue. When Congress gets involved in health policy, we are changing people's lives. Decisions we make in Washington can have a tremendous effect on the well-being of families and their budgets. States, on the other hand, are great innovators. When given the flexibility to tailor coverage and conditions, patients are the winners, with greater choices and more affordable options.

The five bills before us today offer a variety of options to begin to reduce cost, including the Flores bill to align grace periods, the Blackburn bill, which requires eligibility verification, the Brooks bill, which adjusts age rating ratio for healthcare pricing, the Griffith-DeGette bill that allows individuals and families to purchase stand-alone dental plans either on or off the exchanges, and the Rick Allen bill, which establishes an audit process for failed State exchanges.

Any unallocated or misspent Federal funds would be returned to the U.S. Treasury. The first thing health reform should accomplish is to stabilize or reduce the cost of health care. The number one complaint people have about health care is the rising cost.

Yet the current law has done little to decrease healthcare spending. In fact, many Americans are paying higher premiums and

deductibles for health insurance and care as a result of the law. We can do better. We must make healthcare costs more transparent, give people the freedom to choose the insurance they want, with the benefits they value most, at a price that is fair.

More government bureaucracy, regulations, and spending never successfully reduce the price of health care. Yet, that is exactly the premise of how health insurance is regulated today, with top-down mandates that empower Washington and remove control over healthcare decisions from States, small businesses, families, and individuals. And this has to be changed if we truly want bottom-up solutions that provide better care at lower costs for patients. The bills before our committee today will do just that.

Is there anyone seeking recognition on our side?

With that, I will yield back and recognize the ranking member, Mr. Green, 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

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Mr. Green. Thank you, Mr. Chairman. And I agree that the increases that are requested, although having served as a State legislator in Texas in the 1970s and 1980s and the very early 1990s, I think we saw the same requests. Of course the health insurance market was not regulated in the State of Texas. But as a small-business manager, we saw 25, 30 percent increases over the years. So increase in health insurance cost is not new to the American public.

Prior to the Affordable Care Act, the individual market on health care was deeply broken. People were sold junk plans at high cost. Individuals with preexisting conditions were essentially locked out of the market altogether. Women would be charged more just because of their gender. And plans could drop you at the moment you got sick, the time when you need the coverage the most.

Three years after the Affordable Care Act, major health expansion went into effect. Approximately 13 million people have coverage through the marketplace and 15 more through coverage of Medicaid. Since the law was enacted in 2010, 20 million more Americans are no longer uninsured and the uninsured rate is at a historic low. Both the newly insured and previously insured are protected from the worst abuses of issuers and what plans must cover is significantly more robust than ever.

Overall, the coverage expansions are improving Americans' access to health care, the marketplaces are competitive and creating value for customers, and premium stabilization programs are working. The evidence is clear that the ACA is a success. The majority of people

enrolled in marketplace plans or Medicaid report that they would not have been able to access or afford their care prior to getting their new insurance.

It is important to recognize that marketplaces created under the Affordable Care Act are in their relative infancy. As with almost every new market, particularly in the healthcare space, there will be changes and adjustments in early years. Insurers will both enter and exit as they navigate the landscape to the millions of new consumers, protections, and requirements. Medicare, when it was first created, experienced growing pains, as did Medicaid Advantage and part D plans.

The Affordable Care Act is working. But like any law, it is not perfect. As I have been known to say, if you want something done perfectly, don't come to Congress. That is why, after passing major reforms, Congress revisits legislation coming together and improve on it.

Of the five proposals we are considering today, aligning children's dental health coverage stands out as a bipartisan bill that has improved pediatric dental coverage. I am supportive of this legislation and appreciate that the committee is paying attention to this important technical fix for children. However, I am concerned that this bill was included in the legislative hearing evaluating several more controversial and I think irresponsible plans.

The other legislative proposals we are considering today constitute a step backwards for consumers by forcing people out of the exchanges, making it more difficult for consumers to access affordable

coverage using premium tax credits. We should be looking for ways to make the law work better on behalf of the American people rather than roll back reforms and protections designed to get more value from hard-earned dollars spent on coverage and put insurance back in charge at the expense of the consumers.

Making it easier and more attractive to get coverage, expanding Medicaid, targeted outreach, these are ways to bring more stability and affordability to the health insurance market. Instead, most of the bills we are considering today will make it harder for people to get coverage, more expensive for people who need insurance, or only serve to help insurance companies rather than people.

Health insurance is a product that Americans want and need and the Affordable Care Act is creating a system that lends truth to the principle that health care is not a privilege for the few but a right for all Americans. And while I welcome productive conversation on how to improve and make the ACA even better, we must not do anything that would undermine the progress that this important law has already made.

And I look forward to hearing from our witnesses, Mr. Chairman, and I yield back.

[The prepared statement of Mr. Green follows:]

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Mr. Pitts. The chair thanks the gentleman.

Now filling in for the chairman of the full committee, Dr. Burgess, 5 minutes for an opening statement.

Mr. Burgess. Thank you, Mr. Chairman.

This is a very good hearing for us to be having right now and I am very grateful that you have called it. I am very grateful for the members that have participated and provided us bills for consideration today. We have got an excellent panel of witnesses in front of us this morning, with whom I have either agreed or disagreed over the years, but I know them to all be the best of the very best in healthcare policy, and I am looking forward to their testimony this morning.

Regardless of how you feel about the Affordable Care Act, I don't think there is any question that the fractures are becoming apparent and they are growing. And somewhat ironically, at the very last weeks of the Obama administration, these fractures are likely to become fractures and real people are going to be affected by those fractures.

It is important that we be talking and we be talking now about what we can do to help people when those inevitable failures do occur. The bills in front of us today make significant moves towards fixing some of those problems, but I am also anxious to hear from our witnesses what they see when they look over the horizon, not just for next year, but the year after, the year after. If something does not change, the likelihood is that we will have some very profound and real difficulties within the insurance market, within the provider space, and of course for patients themselves in this country.

So, Mr. Chairman, I think you are to be commended for holding the hearing today. Certainly you have put a great panel of witnesses in front of us. And I will now yield to one of the authors of the bill, Mr. Griffith from Virginia, for his comments.

[The prepared statement of Mr. Burgess follows:]

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Mr. Griffith. Thank you, Mr. Chairman.

And thank you, Mr. Burgess. I appreciate that very much.

I just want to let folks know that my little bill along with Diana DeGette, 3463, will in fact level the playing field by applying the same rules to coverage options for dental care offered on the exchange and off the exchange. Currently, unfortunately, the way the language has been interpreted, you can buy a stand-alone dental plan if you are in the exchange, but if you are out of the exchange it has to be wrapped into your health insurance.

Oftentimes parents want to buy a better pediatric dental care plan for their kids than what is offered in a basic health plan. And so this bill would allow them that option and allow them to go out and buy a stand-alone dental along with a health insurance plan that otherwise qualifies except for the dental portions so that they are not just having their children's dental care taken care of after deductibles are met or taking care of for cleanings but not for filling cavities, et cetera.

I think it is a good bill. And I appreciate Mr. Green saying that they recognize that it is an attempt to fix a little glitch and is a bipartisan bill.

And with that I would be happy to yield to anyone else that wishes time.

[The prepared statement of Mr. Griffith follows:]

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Mr. Pitts. Anyone?

Mr. Griffith. I yield back to Dr. Burgess.

Mr. Burgess. I yield back to the chair.

Mr. Pitts. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement.

Mr. Pallone. Thank you, Mr. Chairman.

Congress passed the Affordable Care Act to ensure that all Americans had access to affordable quality health insurance and the goal was to achieve universal health coverage. Six years later, our uninsured rate is at an all-time low and our uninsured rate among young adults has dropped by 47 percent. Twenty million more people now have health insurance, and a new University of Michigan study shows that the ACA has reduced racial and ethnic disparities in coverage.

And this is all good news. But we have a lot more to do. I believe there are ways we can strengthen and improve the law. However, I am concerned that this hearing is taking a cynical approach to doing so. Rather than have a legislative hearing on bills that would help get more people health coverage, three of the bills being discussed today are designed to make it more difficult for people to get healthcare coverage.

One of the bills we are reviewing today would allow insurance companies to charge premiums that are five times as much for older Americans. Even more troubling, under this bill, a State could establish an age ratio even higher than 5:1. Many older Americans

can't afford to pay five times as much as people who are younger than they, and we purposely included in the ACA ways to ensure that younger people have access to health insurance, such as staying on their parents' plan until the age of 26. So I am concerned this will force older Americans to go without coverage at a time when they need it the most.

There are also potential unintended consequences. Studies have shown the 5:1 age rating band charges overcharges older consumers and undercharges younger consumers. Meanwhile, the increased tax credits to accommodate these higher rates for older Americans could cost billions of dollars.

Another bill we are reviewing today would make it more difficult for people to enroll in coverage during a special enrollment period, known as an SEP. SEPs are necessary for people to enroll in coverage when something changes in their lives outside of the open enrollment period.

It is important for SEPs to maintain some flexibility so that individuals can get coverage in a reasonable amount of time as they transition through important life events, such as the birth of a child, a marriage, or a permanent move. We have heard from insurers that SEPs aren't strict enough and are subject to gaming, and that is why the administration has taken major steps to prevent this. They have eliminated seven SEP categories and now require documentation to prove SEP eligibility for the five most common life events.

In addition, starting June 17, CMS will require individuals

asking to enroll in coverage through an SEP to provide documentation by a specific deadline. The individual will lose their coverage if the appropriate documentation is not received in time or is incorrect, and these are reasonable guardrails.

Yet, although CMS is implementing stricter verification requirements, this bill goes a step further and requires someone to prove their eligibility for an SEP prior to gaining coverage, and I am concerned that collecting and submitting this documentation may prove difficult and could lead to gaps in health coverage. Cancer patients can't wait a month to get their health treatments.

In addition, the Urban Institute estimates that fewer than 15 percent of people eligible for SEPs use them to enroll in marketplace coverage and the rest are likely to remain uninsured. So I worry that stricter documentation requirements could deter all but the sickest individuals, since they are the most motivated to get coverage, while healthy individuals may choose to remain uninsured, and creating more barriers to access is only going to serve to keep more people out of the insurance market.

I am also concerned by the bill that would shorten the grace period for those lower-income Americans who qualify for tax credits. Grace periods were put in because many of the people who were signing up are doing so for the first time. That population that is eligible for tax credits is also lower income and has more fluctuation in income, which is why we wanted to give them a chance to keep their insurance as part of the ACA. And under the bill before us today, just one missed or

partial premium payment would result in someone losing their coverage until the next year, and this isn't good for consumers.

I think I will yield. I have less than a minute left, and I would like to yield that to Ms. Matsui.

[The prepared statement of Mr. Pallone follows:]

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Ms. Matsui. Thank you, Mr. Pallone.

Because of the passage of the ACA, millions of American families have access to affordable quality health care and our country's overall uninsured rate has fallen to a historic low. We have come a long way from the days when patients were denied care because of preexisting conditions and young people were left without coverage as they searched for employment.

There is much we can and should be doing to build on the success of the ACA and keep moving our health system forward and ensuring that patients get the right care at the right time in an efficient way. We can continue looking at models of care that reimburse value over volume. We can infuse technology into medical practice and more.

Some bills we are considering today would, unfortunately, reverse some of the important progress we have made. I oppose any legislation that disrupts the continuity of care for patients. As families seek health insurance, we cannot make the process more burdensome for them by asking them to jump through unnecessary hoops. I hope that instead we can continue to build on the progress of the ACA in a way that benefits American families.

Thank you, Mr. Chairman. I yield back.

[The prepared statement of Ms. Matsui follows:]

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Mr. Pitts. The chair thanks the gentlelady.

As usual, all the members' written opening statements will be made a part of the record.

I have a UC request. I would like to submit the following documents for the record: statements from AARP, the Association of Mature American Citizens, a group of seven organizations on H.R. 3463, and the Blue Cross/Blue Shield Association.

Mr. Green. No objection.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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Mr. Green. Mr. Chairman, we also have some to submit for the record. Letters from the American Federation of State, County, and Municipal Employees, the AFL-CIO -- and I think AARP sent us both the same letter -- and the Alliance on Retired Americans, I would like to ask unanimous consent to place in the record.

Mr. Pitts. Without objection, so ordered.

[The information follows:]

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Mr. Pitts. At this time, I will introduce our panel of experts. We have three witnesses. I will introduce them in the order of their testimony. And your written statements will be made a part of the report. You will be each given 5 minutes to summarize your testimony.

On our panel today we have, first, Ms. Grace-Marie Turner, founder, president, and trustee of the Galen Institute; secondly, Mr. Douglas Holtz-Eakin, president of the American Action Forum; and finally Ms. Sara Collins, vice president of health coverage and access, Commonwealth Fund.

Thank you very much for coming today.

And at this point, Ms. Turner, you are recognized for 5 minutes for your summary.

**STATEMENTS OF GRACE-MARIE TURNER, FOUNDER, PRESIDENT AND TRUSTEE,
GALEN INSTITUTE, INC.; DOUG HOLTZ-EAKIN, PRESIDENT, AMERICAN ACTION
FORUM; AND SARA COLLINS, VICE PRESIDENT OF HEALTH COVERAGE AND ACCESS,
COMMONWEALTH FUND**

STATEMENT OF GRACE-MARIE TURNER

Ms. Turner. Thank you, Chairman Pitts, thank you, Ranking Member Green and members of the committee, for the opportunity to testify today on legislation that I believe would advance patient solutions for lower costs and better care.

The ACA was designed to provide people with choices of private insurance, with States in the forefront of organizing a new system of coverage. States had had decades of experience in regulating health insurance, but a battery of ACA rules really overrides these State laws that have been forged by decades of experience and I believe really threaten the future of the ACA and its stability.

For health insurance to attract customers, policies must be affordable, and everyone in the pool must pay their premiums over time so that their insurance coverage is there to pay their bills. If people only purchase health insurance when they need expensive care, the pools break down. It would be like allowing a family to purchase health insurance only when their house is on fire. If too few younger people purchase health insurance, costs will soar and many of the young people

will continue to drop out, increasing coverage for everyone, and that is one of the problems, I believe, with the age rating provisions in the ACA.

Under these rules, insurers can charge their oldest policyholders no more than three times their youngest customers. However, the average 64-year-old consumes six times more, in dollar value and health costs, than the average 21-year-old.

One of the top experts on the workings of the ACA is Timothy Jost. He noted early on that age rating compression is going to force younger people to pay more in the individual market as older individuals pay less, making insurance too expensive for younger people. And we need people, not just the 26-year-olds, but people that are up to 35, 40 years old in these pools. They drop out and it means that health insurance actually costs more for older people as we wind up seeing a spiral.

Likewise, the special enrollment verification are designed to help people, as you said, Mr. Green, to obtain health insurance coverage through major life events, but we are finding that more and more people are purchasing health insurance when they need medical care and then dropping it after they receive the medical services they need. This really undermines the concept of insurance.

The claim costs, according to the actuarial firm Oliver Wyman, found that in the first 3 months in 2014, for people enrolling in the special enrollment periods, their claims costs times were 24 percent higher than those who had enrolled during the regular enrollment

period. In 2015, the difference increased to 41 percent. And these people are more than twice as likely to drop their policies after a short period of time.

The administration has indeed taken preliminary steps to verify eligibility, but more needs to be done. I commend Congresswoman Marsha Blackburn for taking the lead on legislation to verify eligibility before allowing an individual to enroll in an exchange via the special enrollment period.

Robert Pear has a piece in today's New York Times talking about the expected significant increases in many places in 2017 for premium increases, and talking with experts and actuaries from Geisinger, for example, about why this is happening, and they are finding that people are gaming the system also through these grace periods. The law allows people to stop paying their premiums and still obtain coverage for another 90 days.

Unfortunately, the incentives are basically designed to undermine the concept of real insurance. McKinsey & Company found that nearly a quarter of consumers stopped payment on their premiums in 2015, yet most repurchased a plan in the exchange the next year, many of them the same plans, without the need to pay their back premiums. Insurers must build the cost of this nonpayment of premiums into their costs for the following year, and this raises premium costs for everyone.

Additionally, doctors and hospitals are on the hook to continue to provide coverage even for those patients who are no longer insured. Representative Flores' legislation would end this abuse by aligning

the grace period for nonpayment of premiums before coverage ends with grace periods under State law. A 30-day rule would provide greater incentive for people to keep and maintain coverage, basically the standard in State law before the ACA overruled this legislation.

Also, the failed State health exchanges, I think, is really an important issue to address. I know that your committee has issued a report, "Misleading Congress," on this particular issue, focusing on the testimony by Acting CMS Administrator Andy Slavitt. States have decided that they can sue their IT managers who set up their Web sites when their Web sites have failed, and then they want to keep that money. That is really an abuse of taxpayer dollars.

The Federal Government spent \$5.5 billion in helping these States to set up their own exchanges. Oregon received approximately \$305 million to establish an exchange. If it wins this lawsuit, it wants to keep the money. That is really not something that serves taxpayers well.

And then finally, I also commend Representative Griffith and also Representative DeGette for your legislation, bipartisan legislation, to address the issue of really streamlining and unifying the dental plans for pediatric dental care.

Thank you, Mr. Chairman. I will look forward to your questions.

[The prepared statement of Ms. Turner follows:]

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Mr. Pitts. The chair thanks the gentlelady.

And I now recognize Mr. Holtz-Eakin 5 minutes for his summary.

STATEMENT OF DOUG HOLTZ-EAKIN

Mr. Holtz-Eakin. Thank you, Chairman Pitts, Ranking Member Green, and members of the committee for the privilege of being here to discuss these five proposals to make changes to the Affordable Care Act in the interest of having State insurance markets work more efficiently and protecting taxpayer dollars. I think these are important issues.

Let me begin with the issue of restrictions in the age variation of premiums. The ACA does restrict the variation to a ratio of 3:1, of the oldest versus the youngest, and the proposal is to allow this to go to 5:1 or a number that the State would pick. This matches some things that we know about the operation of insurance markets. It matches the ratio of average spending of 64-year-olds to 21-year-olds in a recent CBO study, in February 2016.

We know from work we have done at the American Action Forum that this would lower premiums for younger purchasers of insurance by something like 6 to 8 percent for single individuals, by 7 to 10 percent for families. That would bring millions of additional young and healthy people into these exchange pools.

That is something that the ACA needs. Right now, only about 28 percent of the pool is 18- to 34-year-olds versus 36 percent of the

eligible population. The absence of those low-risk purchasers is one of the problems in the ACA. And older purchasers of insurance would benefit over the long term from this change because, without those balanced pools, we are going to see increasingly higher premiums that older and sicker individuals will have to face for their insurance. So this is something that would stabilize those risk pools, bring people in that the ACA exchanges need, and benefit everyone in the long run.

The special enrollment periods. It is a sensible request that we require verification prior to having the insurance. The purpose of a special enrollment period is to allow coverage for those people who are eligible for coverage, and it is a sensible thing to verify eligibility.

It also turns out to be quantitatively important. About a fifth of the people in the exchanges got there through a special enrollment period, through a SEP, and these turn out to be more expensive risks in the pool. They are anywhere from 10 to 55 percent more expensive depending on which source you go to. They appear to be becoming increasingly more expensive over time, and thus their impact as an issue of shifting cost to others and pushing premiums up, is becoming more important, and understanding their eligibility is important.

And they are much more likely to lapse in their premium payments. And so this is a population that is, in its practice of purchasing insurance and letting it lapse, shifting their costs to others, undermining the functioning of an insurance market. And I think it is a good idea for the committee to look closely at this.

Finally, the grace periods and their impact I think are important as well. The proposal to change from 90 days to 30 or 31 to match State law does provide some basic equity between those who buy their individual market policy on the exchange versus those who buy it off the exchange. And getting the same treatment, I think, is an important matter of fairness.

These generous grace periods do invite abuse. We know that in 2015 about a fifth of individuals stopped paying for their policies, and then half of them turned right around and bought exactly the same policy. This is cost shifting in the most fundamental form. Those costs don't go away. They show up as higher premiums. The higher premiums have proven to be undermining the ability of the ACA to provide broad, well-balanced pools. And that is a concern that I think the committee should address.

And then lastly, on failed exchanges and dental coverage, these strike me as things that the committee should simply just move ahead with. It is always in the interests of the committee to protect taxpayers against the abuse of their dollars. To audit and rescind the unobligated balances is, I think, a very sensible and straightforward thing to do, a matter of program integrity that everyone should endorse. And a technical correction on a bipartisan basis to pediatric dental coverage is something that no one should object to, and I applaud the committee for doing that.

I appreciate the chance to be here, and I look forward to your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

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Mr. Pitts. The chair thanks the gentleman.

And I now recognize Ms. Collins 5 minutes for your summary.

STATEMENT OF SARA COLLINS

Ms. Collins. Thank you, Mr. Chairman and members of the committee, for this invitation to testify today on advancing patient solutions of lower costs and better care.

Three years after the Affordable Care Act's major health insurance expansions went effect, nearly 28 million people are estimated to have coverage either through the marketplaces or Medicaid. There are 20 million fewer people uninsured since the law went into effect in 2010.

There is considerable evidence that marketplace and Medicaid coverage is improving people's access to health care. The Commonwealth Fund's ACA tracking survey of 2016 finds that majorities of enrollees who have used their health plans, either marketplace or Medicaid, report that they would not have been able to access or afford this care prior to getting their new insurance. Majorities of marketplace or Medicaid enrollees are satisfied with their insurance. Federal data are indicating nationwide declines in consumer out-of-pocket spending growth, cost-related problems getting needed health care, and medical bill problems.

Challenges remain. While the uninsured rate has fallen significantly among working-age adults, differences persist between

lower- and higher-income adults. This is driven in part by the fact that 19 States have yet to expand their Medicaid programs, as well as dwindling resources for outreach and enrollment. News reports about high premium requests by several insurers and United Health Group's decision to pull out of several State marketplaces next year have raised concerns about the stability of the marketplaces.

There are several reasons why these developments don't portend disaster: Most marketplace enrollees won't pay double-digit increases in 2017, insurers premium requests are subject to State review, and 83 percent of marketplace enrollees receive tax credits to help them pay their premiums. Most of the increases will be absorbed by those credits.

Research is finding that the marketplaces are competitive and creating value for consumers. Most participating insurers remain committed to the marketplaces in 2017. While risk pools remain in flux, the premium stabilization programs are working for the most part. However, the phase-out of the reinsurance program this year will likely lead carriers to adjust their rates upwards to accommodate the loss.

Three bills under discussion today are aimed at addressing concerns about the marketplace. One bill would increase the amount that carriers could charge older adults from three times to five times that of younger people. Research by Rand finds that this change would only modestly increase insurance coverage among young adults but would come with the hefty price tag of \$9.3 billion in Federal spending and a loss of coverage for 400,000 older people. Premiums would increase

much more for older people than they would decline for younger people.

Another bill would require verification of eligibility for special enrollment periods. The Urban Institute finds that 33.5 million people are actually eligible for the special enrollment periods, the vast majority because of job loss, but only 15 percent actually are using them.

CMS has made adjustment to the special enrollment periods, including a new confirmation process that requires documentation to verify eligibility. People can still enroll while the verification process is underway. The proposed bill goes a step further by not allowing people to enroll until they have submitted this documentation. These tighter standards could lead to even lower enrollment through the special enrollment periods. Only the most motivated people might enroll, those who are most in need of health care, leading to less healthy risk pools.

The third bill would decrease the grace period for nonpayment of premiums from 3 months to 30 days. While some have suggested that people use these periods to game the system, the rules governing them are restrictive and aimed at discouraging this behavior. This policy change could mean a loss of enrollment in the marketplaces among enrollees of very modest means and an increase in the number of people who are uninsured or have gaps in their coverage. The policy change would also seem to favor those who are the most motivated to retain their coverage, those in poorer health.

It is encouraging that the committee is considering ways to

improve the marketplaces. In considering these policy adjustments, it is important to remember that the fundamental purpose of the marketplaces is to provide coverage to those who currently lack health insurance and thus cannot get needed care and are currently suffering unnecessarily as a result.

Thank you.

[The prepared statement of Ms. Collins follows:]

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Mr. Pitts. The chair thanks the gentlelady.

That concludes the opening statements of the witnesses. We will now begin questioning, and I will recognize myself 5 minutes for that purpose.

Ms. Turner, in my opening statement I spoke about the tremendous premium increases that are dominating headlines across the country, and we are looking for some solutions to this. In your testimony, you said that the President's healthcare law was designed to provide people with choice. Would you expound on that, explain that? Under current law, do you think patients have choice? Please elaborate.

Ms. Turner. Increasingly, unfortunately, Mr. Chairman, they don't, because many of the plans are dropping out in areas where they find that they are losing too much money to stay in the exchange market even though they made a commitment earlier on to try to participate in this marketplace. And one of the reasons is particularly because of the gaming of the system that that these bills are designed to address.

I think it is very important, if we want to have a stable market of more affordable coverage, that these bills help stabilize the market. I know that there was a consumer advocate quoted in that New York Times article today from Pennsylvania who said that over time these markets will stabilize, that this is just a spike, because people are getting care that previously did not have health insurance. But it is not going to stabilize if people only pay their premiums when they need coverage and if they have paid their premiums for only 9 months

and try to get 12 months of coverage.

So I am concerned this is going to actually exacerbate problems going forward if these bills aren't allowed to address the problems.

Mr. Pitts. And in addition to the premium increases, what about the deductibles? Can you speak to that?

Ms. Turner. And the deductibles are much higher. I mean, many people are faced with a \$6,000 deductible. They are paying \$500 a month in premiums. And \$12,000 out of pocket is often more than their mortgage payments. And so increasingly we have got to address this to give people more choices rather than the cookie-cutter kinds of plans that the ACA requires.

Mr. Pitts. Thank you.

Mr. Holtz-Eakin, you remarked that the President's law was signed with the goal of providing accessible, affordable health insurance. And I mentioned my home State, the percent increase in premiums for individual plans. And the numbers provide factual evidence that plans have little room to innovate and adapt in today's government-controlled exchange market. Might the bills in front of this committee today lead to lower patient cost as a result of giving States flexibility and plans the fairness to innovate? Would you elaborate on that?

Mr. Holtz-Eakin. I think that is right. Our estimate, for example, of the benefits of allowing wider age rating bands is that something like three million younger Americans might be able to move into the exchanges. That would be an incredibly valuable addition of low-cost purchasers into these exchange pools.

One of the deep concerns that I have is that we are seeing these exchange pools become progressively more expensive, that we are not in a dramatic death spiral yet, but we are moving in that direction. That serves no one well. Those who remain in the pools pay higher premiums. Others are excluded from health insurance coverage that was the basic goal of the law.

Finding ways to innovate and allow low-cost insurance options instead of four colors that are getting increasingly expensive I think would be a very valuable thing, and the approaches that the committee has in front of it are a start on that course.

Mr. Pitts. Ms. Turner, you mentioned that everyone must play by the rules. Can you talk a little bit about how people are gaming the system that hurts working families who are playing by the rules?

Ms. Turner. I think that is really the important point, is that those people who figured out that they can get 90 days of coverage after they stop paying premiums, that really hurts the people who are playing by the rules and paying a full year's of premiums to get their coverage.

So increasingly people will figure out: Oh, well, I can stop paying my premiums on October 1 and I can still get coverage until the end of the year and I can then go back and enroll in the same plan without having to pay the back premiums. That means that the insurance company has to build that nonpayment of premiums into the premium costs for next year, which gets to the problem that you asked Dr. Holtz-Eakin about, is that fewer and fewer people buy the coverage, making it more expensive for everyone.

Mr. Pitts. And real quickly, so it is your view that giving States flexibility on grace periods and age bands, while tightening the special enrollment periods, could lead to lower costs for families?

Ms. Turner. Absolutely. And States have much more experience, decades of experience, in learning that those kinds of regulations really do help to stabilize the market so it can become more affordable.

Mr. Pitts. My time has expired.

The chair now recognizes the ranking member, Mr. Green, 5 minutes for questions.

Mr. Green. Thank you, Mr. Chairman.

And thank our panel for being here.

Prior to the ACA, the individual market was deeply broken. And, again, having worked in health insurance, which wasn't regulated in Texas, we did regulate some policies, but the ACA has made great strides and to make coverage more meaningful and affordable and expand access and stabilize the individual insurance market. Many of the challenges in the individual market are intrinsic to the market and have been around long before the ACA. One example is this churn. It is a term describing people moving in and out of coverage every year.

Dr. Collins, can you talk about the churn and how the individual market was previously broken and why changes like churn are not unique and will continue to happen?

Ms. Collins. That is absolutely correct. The individual market has long been characterized by high rates of turnover. But prior to the Affordable Care Act it was extremely difficult for people to get

policies when they tried to buy them. They were very expensive. People were priced out of coverage if they had a preexisting condition, or even turned down. We estimate, the Commonwealth Fund Biennial Health Insurance estimates that about nine million people who tried to buy a plan in 2010 were turned down or charged a higher price or had a preexisting excluded because of their health and didn't end up buying a plan.

So the market was broken prior to the Affordable Care Act. The provisions that have been put in place under the law have made it vastly more accessible for people with health problems and people who have low incomes and couldn't afford to pay a premium.

Mr. Green. Okay. Of the legislative type proposals we are considering, I am particularly concerned about the bill that would change the current 90-day grace period to 30 days. It is worth mentioning that Medicaid Advantage has 60-days grace period, Medicaid has a 60-day grace period. After reading the bill, I am worried my colleagues have become focused on that fraction of the people who try to game the system that historically have always tried to game the system, and that they have forgotten the realities of everyday life.

Under this bill, a person who is eligible for an advanced premium tax credit misses a single premium payment, they would lose their insurance after 30 days and not be able to get coverage until the next enrollment period. I understand the need for oversight, but especially for this population we should be looking for ways to keep people insured and not the opposite.

Dr. Collins, can you talk a bit about the population that is eligible for this advanced premium tax credit?

Ms. Collins. Right. So people who are eligible for the tax credits have incomes under 400 percent of poverty, low and moderate incomes. The vast of people who are currently receiving tax credits have incomes even lower than that, more in the 250 percent of poverty and below.

I would also like to correct some statements that have been made about how the grace period works. Carriers are only on the hook for the first month of nonpaid premiums and they get a tax credit to cover those expenses, this claims cost in the first month. They are not on the hook for the second and third months of that grace period. They receive a tax credit, but they do not have to pay claims costs. Those tax credits have to go back at the end of the year.

Also, individuals who don't pay their premiums for the full time of the grace period have to pay their tax credits back for that first month and also continue to owe the premium paid in that first month. So it is not true that carriers are on the hook for those claims costs in the second and third months when they are not receiving reimbursement.

Mr. Green. Okay. What impact do you think this policy would have on consumers in the risk pool?

Ms. Collins. One of the biggest issues with enrollment right now is that we need to encourage people to come in rather than discourage them to come in. What a more restrictive grace period would do would

make it more likely that healthy people would drop out because of failure to pay a premium in the first month. People who are highly motivated to stay in, the less healthy people, would likely try to make that premium payment in that first month and stay in. So it would skew the risk pool away from healthy people and more towards sicker people.

Mr. Green. Well, one of the concerns I have on this legislation, some of it may be adjusted, but the biggest concern I have is in our district in Houston, Texas, I have 50,000 people who would be covered if the State of Texas expanded Medicaid. I think that is something we ought to be concerned about instead of that.

But also what happened because of the Supreme Court decision, we have people who are not poor enough to get Medicaid, but they also don't earn enough money to get the subsidies. So they are caught in the middle, and that is something maybe we ought to look at and see how we can fix that for these people who are not the poorest of the poor but very close to it, because in Texas you have to be pretty destitutely poor to get Medicaid.

Mr. Chairman, thank you for the time.

Mr. Pitts. The chair thanks the gentlemen.

And I now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. Murphy. Thank you, Mr. Chairman.

I thank the panel too for being here to give us some important insights.

One of the subcommittees of this overall committee, the Oversight

and Investigations Subcommittee, which I chair, has been conducting some pretty robust oversight over the State exchanges for more than a year. And specifically the subcommittee has been and continues to examine the expenditure of Federal funds on State-based exchanges' activities and long-term sustainability challenges that these State exchanges face. And another significant component of this work is examining CMS' oversight over these.

Ms. Turner, in its oversight of the State exchanges, the subcommittee has held hearings and requested CMS on the State-based exchanges produce documents and information to our subcommittee and to the full committee. But most recently the subcommittee released a report detailing Acting Administrator Slavitt's misleading testimony before the O&I Subcommittee on December 8, 2015, about \$200 million supposedly being returned from State-based exchanges.

Based on its ongoing oversight, our committee remains very concerned about the long-term sustainability challenges the State-based exchanges face and CMS' lack of oversight over them. So given all this, I want to ask you, do you believe that CMS is performing adequate oversight over these State-based exchanges.

Ms. Turner. I don't believe that there is significant evidence that they are. I believe that they have their hands full with many of the other provisions of trying to run this law and I think oversight of the States has really been lax. In particular with the failed State exchanges, they should have probably been more alert in the beginning to begin to see that States like Oregon and Maryland and Massachusetts

were failing.

And I commend you for the report, because when Acting Administrator Slavitt said that about \$200 million had been returned and your committee found that his own data showed that only a little bit more than \$21 million had been returned, I do think that they need to square what one CMS agency is saying with what the Administrator is telling Congress and really get to the bottom of that. The taxpayers require that.

Mr. Murphy. Yeah. And it is very important to us. Look, we want to make sure people have adequate health care, but between that unaccountability and other errors and fraud, we have heard from CMS that billions of dollars are unaccounted for. It is a problem for us. So what steps would you recommend that Congress take to make sure we have adequate oversight of these?

Ms. Turner. Well, I think what you are doing with the hearings and with the oversight, and if it requires subpoenas to get the information about why there is this disconnect between what he is telling you in your hearings and what the reports are showing, I think that the taxpayers need to have that information. Continued oversight, I think, is tremendously important. Thank you for that.

Mr. Murphy. So given that, are there any indications that CMS is actively trying to recoup taxpayer dollars that were provided to States for the purpose of providing these state exchanges? Do you see any evidence? I mean, we would like to know if there is anything positive.

Ms. Turner. Well, I understand that they have provided some very limited and highly redacted memos to your committee. It does not appear that they are being as responsive as they need to be in order, once again, to make sure that taxpayers are being well served and their money is being spent on the intent of this law, as you point out, to provide affordable coverage to millions of people.

Mr. Murphy. Thank you.

Mr. Holtz-Eakin, good to see you again. I have a question for you on this issue about the most expensive plan can only cost three times more than the least expensive plan when it comes to the patients' ages, and this 3:1 band has led to some problems.

I received a letter from an association last evening that said modifying age variation in premiums would help balance risk pools and stabilize markets, and that is one of the bills this committee is reviewing. Is it fair to say that working families and sick patients would benefit from other balanced risk pools and stabilize the marketplace overall? Do you think so?

Mr. Holtz-Eakin. I believe so. I am concerned that we will see these exchange pools become increasingly unbalanced and thus expensive for those who remain in them and crowding some people out --

Mr. Murphy. Particularly the younger?

Mr. Holtz-Eakin. -- and working families unable to purchase insurance. That is at odds with the intent of the law. And I think stabilizing the pools is a priority.

Mr. Murphy. So one of the things we keep coming up with in

reality, as was described among the panel here too, is that people may sign up for something and then drop it. It is sort of like people will buy car insurance when they need to get their car, and then they drop it immediately afterwards. I experienced that once being hit by a driver who dropped their car insurance. Didn't help me at all.

But the issues here, do you think that lowering that price and balancing those risk pools will be an enticement to have people stay in with insurance?

Mr. Holtz-Eakin. I do. I know there is an immediate concern about the older consumer under this proposal, and I understand that. But those consumers of exchange insurance are going to be increasingly harmed by unbalanced risk pools. It is in their long-term interest to get the young and healthier into the pools. This is one way to do that.

And in the end, if you look at all of the things that are being considered in this front, costs don't go away. If they are not paid by an insurance company, they are going to be put into providers' rates and they are going to show up in insurance premiums regardless. And so having people pay for the medical costs they incur through the insurance that they have bought is the primary objective and anything that aligns those incentives you should pursue.

Mr. Murphy. Thank you.

I yield back. Thank you.

Mr. Pitts. The chair thanks the gentleman.

Now I recognize the ranking member of the full committee,

Mr. Pallone, 5 minutes for questions.

Mr. Pallone. Thank you.

The Affordable Care Act has made great strides in expanding health coverage to an additional 20 million Americans, but there are still Americans who we have not reached. Unfortunately, 2.9 million Americans lack coverage because their States because their states have not expanded Medicaid. But in the private insurance market there are still more than 10 million Americans who are uninsured and eligible for marketplace coverage, and 7 million of them are eligible for tax credits to help them pay their premiums.

Before we consider revising or even backtracking on the progress we have made, one important thing we can do to stabilize the individual insurance market is to grow it, and we need to reach these people so that they know they are eligible. And the more people enrolled, the greater the risk pool, and the more stability we will see.

So my questions are of Dr. Collins. What can we do to reach the uninsured? Can you describe the importance of outreach efforts and navigators and the role that you might see navigators occupying as we move forward?

Ms. Collins. A lot of research has shown that outreach is critical to both letting people know about what their options are and helping them enroll. We see greater enrollment among people who get assistance in the enrollment process.

I also think on the issue of young adults, this is particularly important. Most young adults who are eligible for coverage under the

law have incomes that make them eligible for the tax credits, incomes that make them eligible for Medicaid. But disproportionate numbers of people enrolled in Medicaid are actually young people.

So the change in the rate banding really won't have much of an effect on enrollment of young people. It is really getting young people to enroll in the marketplaces and find out that they are eligible for subsidies, find out that they are eligible for Medicaid. States expanding their Medicaid programs would also significantly increase enrollment of young adults in the pools.

The other important point about young adults is that they actually are a relatively large percentage of people enrolled in the marketplace. It is about 30 percent of people currently enrolled in marketplace plans are between the ages of 19 and 34. Forty-six percent of those enrolled in Medicaid among the adult population are young people.

So it is not really true that we don't have any young adults in the marketplace. This is actually a pretty sizeable number of people who are enrolled who are in that age group.

Mr. Pallone. Now, what about navigators, do you want to talk about that and what role they could play as we move forward?

Ms. Collins. So navigators continue to be very important. We do see that people are much more likely to understand the options they have available to them when they are choosing marketplace plans if they have some assistance. People are much more likely to complete the enrollment process if they have navigation.

Mr. Pallone. Now, I use that term "navigators." How would you define "navigators," basically?

Ms. Collins. Basically someone who helps people through the enrollment process. Brokers can also help people through the enrollment process and they have also been critical to getting people enrolled.

Mr. Pallone. Just talk about insurance brokers. I think a lot of people don't even realize they can still use an insurance broker. Is that an area where maybe we need to do more, to have actual insurance brokers play a bigger role?

Ms. Collins. So brokers can absolutely help people enroll in plans. They have been critical. They have also been very important for small businesses getting coverage under the --

Mr. Pallone. But even for an individual, right, can use a broker, right?

Ms. Collins. Even individuals can use a broker.

Mr. Pallone. But not that many do, it seems. I am just doing anecdotally. I don't have any statistics. But it seems to me that people in the individual market rarely go to brokers.

Ms. Collins. Right. So part of the outreach efforts could be to inform people that they can get help if they aren't able to do it on their own.

Mr. Pallone. All right. Then the last question, would the bills before us today help to enroll the uninsured in any way?

Ms. Collins. The bills today would likely have a depressing

effect on enrollment, particularly the change in the special enrollment periods, making people provide documentation. We know that very few people are actually using special enrollment periods. They were designed expressly for people who lose coverage between open enrollment periods and most of those are as a result of a job loss. And so we should be trying to make this process easier, make people aware of it.

The reduction in the amount of time for the grace period would also likely lead to a loss of enrollment in the marketplaces and probably among less healthy people. The rate banding change would mostly affect older adults. Many of them would see their costs go up exponentially. They actually will pay much more in premiums than their average expenses.

And there would be only a marginal effect on enrollment of young adults. And most of the change in the enrollment of young adults that Rand is showing comes from a shift out of employer coverage and into the marketplaces.

Mr. Pallone. Thank you very much.

Thank you, Mr. Chairman.

RPTR HUMISTON

EDTR HOFSTAD

[10:13 a.m.]

Mr. Pitts. The chair thanks the gentleman and now recognizes Dr. Burgess, 5 minutes for questions.

Mr. Burgess. Thank you, Mr. Chairman.

And, first off, let me just address the special enrollment period. You know, I can remember some hearings we had in the past and maybe even some forums we did in the Health Caucus where we talked about community rating and guaranteed issue and the experiments that were tried in some States in the 1990s and the predictable effect of escalating premiums and then, subsequent, people dropping out of coverage.

It did come up in my district. We had a constituent case earlier this year. Right after the closure of the open enrollment period, a fellow who actually has a medical background in my district -- he is a pharmacist, and he called, and he said, "One of my employees is a really, really sick. I am afraid she might have cancer. She has no insurance. Do you have any advice for me?" And I said, well, you know, the open enrollment period had just closed. Why didn't you buy -- why didn't you encourage her to buy insurance then? He said, "Well, she wasn't sick then."

And, you know, that just kind of underscores -- here is, again, someone with some medical knowledge. It just underscores the

difficulty of what the special enrollment period can engender. Now, this individual, it turns out, our office helped, and she did have a legitimate claim to a special enrollment period and did receive the retroactive coverage.

I don't know if the -- I have an email that I received from healthcare.gov, and I don't know if you can read that well enough, but I actually had an unsubsidized individual market policy in the Federal fallback exchange in Texas. And I had that for a couple of years until it got too expensive and I had to find something else. But it was hard to get into ObamaCare, and then it was hard to get out of. And I do want to stipulate, this was unsubsidized. These were my own dollars that I was paying for this coverage.

Three months, 4 months after I have left ObamaCare, I am getting these emails. You know, "The open enrollment period is closed, you missed your chance, but, doggone it, you can still get in." And there is a big, yellow button there that you can click on, and we can perhaps help you find a backdoor back into ObamaCare if you would like.

Now, the good news for people who are worried about us spending too much money, the yellow button didn't work, and so there wasn't really a way back in.

But it just underscores the problem that we have with the special enrollment period. It really does lead to, again, what was found to be a very difficult time in an experiment with guaranteed issue/community rating in some States that tried that back in the 1990s.

I just wondered, Ms. Turner or Dr. Holtz-Eakin, if you had any

thoughts on that.

Ms. Turner. This really gets to what you said earlier, Dr. Burgess, about where is this going. And I think that you have to look at the incentives that these provisions allow. They allow people to wait until they are sick to get coverage. They allow people to really game the system in a number of different ways.

And if people figure out they can do that, then you are going to wind up with unstable pools, you are going to wind up with higher and higher costs, and someone has to pay those costs. Maybe most of the people in the exchanges are subsidized, but the taxpayers are paying those costs. So, one way or the other, we are going to be paying for laws that encourage people basically to do the wrong thing.

The individual mandate was designed to try to keep people -- have insurance and can keep it, but these provisions really undermine that goal and, I think, undermine, therefore, the goal of the law.

Mr. Burgess. Well, and I of course opposed the individual mandate and continue to oppose it, but I guess it begs the question, is the individual mandate just not harsh enough? Are we not penalizing people enough to force them into these insurance policies?

Ms. Turner. Doug Holtz-Eakin mentions that in his testimony.

Mr. Holtz-Eakin. You know, we testified last year on alternatives to the individual mandate, because it is clear it is not doing what it was intended to do in principle. And so some other approaches might be necessary.

I mean, I think the history of those States that had guaranteed

issue/community rating speaks for itself. I lived in New York State, and that was an insurance market that had self-destructed, and there is not a happy history on that.

I think it is ironic that we are having this discussion today about shifting costs and there are some who would defend the cost shift, because the entire Affordable Care Act was premised on the notion that it was inappropriate to have these cost shifts and we had to get everybody in the pool. That same principle should apply in the discussion today.

And it is also important to recognize, as a matter of arithmetic, you can't count on the tax credits to cover all ills. ACA spending is projected to grow at a rate of 7.7 percent per year over the next decade -- much faster than our economy, much faster than revenue, which is going to be 4 percent, and the most rapidly growing Federal health program. There are not infinite dollars to solve all problems.

Mr. Burgess. Thanks, Mr. Chairman. I hope we will have time for a second round. I will yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. Castor. Thank you very much.

Thank the witnesses for being here.

And I want to yield just a few seconds to Gene Green, because he wanted to follow up on a point.

Mr. Green. After this exchange -- you know, I have been around a while. It seems like in the 1990s the Heritage Institute is the one

who recommended the individual mandate because people ought to be self-reliant. Is that correct? Do you all remember that statement?

Ms. Turner. The Heritage Foundation did. And they --

Mr. Green. Seems like in 1993 and 1994 --

Ms. Turner. -- have since rescinded that.

Mr. Green. -- when we had the Clinton plan that that was one of the recommendations for that, so -- but anyway.

Thank you, and thank my colleague for yielding.

Ms. Castor. Thank you.

Well, thanks again.

It is very important for us to continue to focus on improving the Affordable Care Act, but you can't deny the success on behalf of the families we represent back home. I mean, we are at the lowest uninsured rate in the history of the country, at about 9 percent. That is pretty remarkable, and that has been a godsend to so many families. The ability to end discrimination in health insurance so that our neighbors and family members with a cancer diagnosis or some serious preexisting condition, they now can access affordable health insurance.

The policy that you buy is so much more meaningful than what it used to be in kind of this scattershot pre-ACA market. Plus, the policies usually promote better health because we focus on wellness and there are certain incentives for preventative care, like no co-pays for certain things.

And then all of my neighbors that rely on Medicare, Medicare is stronger now after the Affordable Care Act. And one of the stats that

I love for the State of Florida is how much money the ACA has helped put back into the pockets of my older neighbors -- it is about \$980 million -- just because of the closing of the doughnut hole and their savings on prescription drugs.

Also, in Florida, we were the leader in the Federal exchange. We had a very high uninsured rate, a completely unbalanced market. So 1.7 million Floridians now have been able to access affordable coverage. And it is important to focus on the cost. In Florida, 72 percent of the Florida marketplace enrollees obtained coverage for \$100 or less. That is after the tax credits.

And the competition is key. And in some States that don't have these robust marketplaces, one of the things we need to focus on is how we incentivize greater competition. In Florida, consumers could choose from an average of 42 health plans for 2015, and we think this coming year it will be about that, if not a larger number of issuers and plans.

And Ms. Collins is right that, prior to the ACA or as we were working through the early years, people were very concerned that younger folks would not enroll, but it is not true now. We have been pleasantly surprised that it is pretty balanced, and in Florida about 525 consumers under the age of 35 are signed up for marketplace coverage. That is 33 percent. So that is pretty good.

So, as a reminder, open enrollment begins November 1. Go to healthcare.gov to check out your options.

Americans are doing what they do best; they are going shopping.

It is another surprise that they are actually looking at these plans and switching. We thought that many people would just stick with that one issuer, but they are pretty discerning if they have the information they need. So that is another area where we could work together to improve, to ensure people know the providers and the doctors that are being offered.

But I would like to focus on premiums, because I think we all agree it is incredibly important that premium prices on the exchanges remain affordable. But I worry that the bills that are under discussion today will actually increase costs and also harm access to insurance.

And I am afraid that some of the headlines in the press sensationalize the premium rates and confuse consumers. For example, despite headline predictions in 2015 that, based on preliminary rate filings, there would be double-digit rate hikes in the marketplaces in 2016, the average cost of marketplace coverage for people getting tax credits went from \$102 last year to \$106, a 4-percent change, just \$4 per month. And, in Florida, the premiums rose only 2 percent, the monthly costs of -- or average monthly cost of \$84 in Florida with the tax credits.

So, Dr. Collins, why did the preliminary rate filings differ from the actual rates? Maybe you can help clear this up a little bit.

Ms. Collins. So there are a few different reasons for that. The high prices that were seen by some requests -- requests by some insurers are preliminary. They are subject to rate review. And in many States --

Ms. Castor. At the State level. I mean --

Ms. Collins. At the State level. At the State level. Many States will just adjust those down.

The other major factor is that people will shop around. So just because carriers are charging high prices in some markets doesn't mean people are actually going to buy those plans. As you mentioned, 43 percent of people that shopped for plans changed plans last year. And we see the effect in the increases in premiums that people actually paid as opposed to those that we are hearing about now.

So it is both -- it is the rate review, it is people shopping, choosing the highest value plan for them, and it is the tax credits that protect them from these --

Ms. Castor. And active State regulators that will push back on some of the insurers' requested rate increases.

Ms. Collins. That is right.

Ms. Castor. Great. Thank you very much.

I yield back.

Mr. Pitts. The chair thanks the gentlelady and now recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. Lance. Thank you, Mr. Chairman.

And good morning to the panel.

I would like to concentrate on cost-shifting.

Dr. Holtz-Eakin, you say that the ACA is likely to increase 7.7 percent -- was that the figure you gave? -- over the next several years, regarding the costs?

Mr. Holtz-Eakin. In the most recent CBO baseline, the average annual increase in ACA spending is 7.7 percent per year over the next 10 years.

Mr. Lance. And this is clearly higher than anticipated growth in the economy. Is that accurate?

Mr. Holtz-Eakin. Yeah. The economy will grow at 4.1 percent, nominal, over the 10 years in their projection.

Mr. Lance. And, therefore, in your professional judgment, how will the difference be made up?

Mr. Holtz-Eakin. It will come arithmetically by either cutting spending in other programs, raising taxes, or borrowing even more.

Mr. Lance. And I would certainly like the expert view of the other members of the panel -- Dr. Collins -- regarding that issue. And do you agree with the figures that have just been presented?

Ms. Collins. Well, 7.7 percent is actually -- what we are seeing in the marketplaces, in terms of rate increases, are very similar to what we are seeing in employer-based plans.

Mr. Holtz-Eakin. It is not a premium. It is a Federal spending number.

Ms. Collins. Right.

But, also, the other important thing to keep in mind is that costs have been much lower than were originally projected by the Congressional Budget Office.

Mr. Lance. I am speaking about where we are now, not where we may have been in the past. Are you in agreement that this is likely

to be 7.7 percent each year, compounded I assume, over the next decade?

Ms. Collins. I think that we can expect some growth in costs over the next year. We have seen a reduction in the rate of growth in healthcare costs --

Mr. Lance. A reduction in the rate of growth. That is different from an increase.

Do you agree or disagree -- that is why we have experts on this panel who not necessarily are in agreement. Do you agree that it is likely over the next decade, a 7.7-percent increase in each of the next 10 years? And perhaps Dr. Holtz-Eakin is wrong. I am asking your professional opinion.

Ms. Collins. That is a relatively moderate rate of growth in healthcare costs, relative to the past, over the next few years.

Mr. Lance. I am sorry. I didn't understand that response. Is it likely to be 7 percent? Is it likely to be 2 percent? Or perhaps Commonwealth Fund doesn't know.

Ms. Collins. I think that you have to look at estimates in the context of where we have been in the past, what was projected. And these are likely in line, maybe slightly higher. But they will vary over time. Estimates are estimates, and we will have to see how that plays out.

Mr. Lance. Ms. Turner, your comments on what I am suggesting? I am persuaded that it is likely to be roughly 7 or 8 percent, and, of course, only time will tell. And, from my perspective, the economy is not going to grow at that rate. I wish it were, but I don't think

it is. And, therefore, I am asking where the difference has to be made up. And perhaps you disagree with me, but I would like your comments.

Ms. Turner. Well, certainly, if it is 7.7 percent, as CBO says -- and Dr. Holtz-Eakin, as former Director of the CBO, I think is our most expert witness on this panel --

Mr. Lance. Yes.

Ms. Turner. -- would suggest that it is growing much faster than economic growth.

Mr. Lance. Yes.

Ms. Turner. And if, in fact, these provisions, which could help stabilize pools and, therefore, premium rates, do not go into effect --

Mr. Lance. Yes.

Ms. Turner. -- then you are going to wind up with higher and higher costs of premiums. And even if the individual policyholder isn't paying that, the taxpayer is. And that is really what this number is about, is overall taxpayer spending, the rate of growth of spending on health care.

Mr. Lance. Right. From my perspective, taxes could be increased. Those who were formerly insured and remain insured will have their premiums increase. Or, alternatively, as is always an option, there will be further deficit-spending in this country. I have seen estimates that the deficit annually is likely to increase at the end of this decade. We have done a better job since Republican control of the House of Representatives: \$1.4 trillion, \$1.3 trillion in the first 2 years of the Obama Presidency, now roughly \$450 million. In

my judgment, it is going to go up again unless we get a handle on this. And these are the issues that concern me greatly.

Thank you. I yield back 18 seconds.

Mr. Pitts. The chair thanks the gentleman, now recognizes Mr. Schrader, Dr. Schrader, 5 minutes for questions.

Mr. Schrader. Well, thank you, Mr. Chairman. And I appreciate the hearing. It is fun to actually be talking about ways to, you know, improve the delivery of health care, so I appreciate the opportunity to embark on that.

I notice that the title of the hearing is "Patient Solutions for Lower Costs and Better Care" and point out for my colleagues here that myself and Congressman Bilirakis have introduced a bill that talks about lowering drug costs through competition. I would like to maybe get a hearing on that at some point in time. As you know, some of these folks come in with their hedge-fund money and buy up these drug companies and then charge exorbitant prices that no one can afford. And so this is a nice market-based solution for that.

Just a little perspective -- and maybe I am wrong. We have experts that can correct me. But, you know, the individual market that we are worried about really constitutes only about 5 or 6 percent of the total insurance market out there. We have Medicare, we have employer plans and everything else. So while we are working very hard to fix the individual market in particular, keep it in perspective. It is a small portion of our healthcare market.

That doesn't mean we shouldn't work on it. It doesn't mean that

some of what happens there will influence certain healthcare costs in other arenas also. So I think this is worthwhile.

I would also point out that the instability in the market is I don't think unexpected. I did not expect, with the advent of the ACA, everything was going to be great. No one had any idea of what the uninsured population out there would really bring. The rate at which young people would sign up was always in question. And maybe some of these ideas will hopefully address that.

Some competing information that I am going to be looking at from Commonwealth versus some of the other studies, the McKinley study for instance, it would be very interesting to get to some of these things. And I, for one, would be interested in working on it.

Let's talk about the age bands a little bit. My biggest concern isn't to the consumer; it is to the government. I mean, if we go to that 5:1 age band -- I think, Ms. Collins, Dr. Collins, you alluded to it -- the costs to the government could be significant. My understanding is the subsidies will go up, you know, to match the increased premiums for a lot of these people.

So the out-of-pocket expense to the senior, who is going to be paying a higher rate, may not be that much more, but the cost to the government could be in the billions of dollars.

Could you comment on that, Doctor?

Ms. Collins. That is right. So this is from research that RAND has done. And what happens is that people -- the higher rate bands means that premiums go up for older adults significantly, and

because many of them are eligible for tax credits, it means the costs of those plans will go up --

Mr. Schrader. Yeah.

Ms. Collins. -- on the order of \$9.3 billion. So that is the big source of --

Mr. Schrader. So I think, as we discuss this, we want to make sure we know how we are going to pay for that. You know, is the taxpayer on the hook?

Mr. Eakin, do you have a --

Mr. Holtz-Eakin. If I could, that is one piece of the story, but, remember, there would be a reduction in premiums for younger Americans, and many of them will be having subsidized insurance coverage as well.

As the Congresswoman from Florida pointed out, preventive care is an important part of the design of the ACA. Presumably, getting those young people in and undertaking preventive care will make them less expensive risks when they age, so they simply won't show up and be expensive, which is a cost the government would ultimately have to pick up. And an unbalanced pool is the greatest threat to the budget and to the premium costs.

Mr. Schrader. Agreed.

Mr. Holtz-Eakin. I think you have to look at all those factors, not just the rifle shot to older purchasers, in the moment when you make the change.

Mr. Schrader. Well, we have to because CBO will score this, and we have to find a way under the current rubric to find a way to pay

for it.

And I agree with you that, over the long term, the ACA will be a huge plus because of the preventative care. And we are in the worst possible situation right now. We have to pay for the expensive population that hasn't had good health care and, at the same time, spend money to do the preventable healthcare work so that it won't cost us too much later.

On the grace period, I think, clearly, 3 months is too long. It is interesting to hear about the gaming of the system. I think 1 month is way too short. And I think there is -- you know, listening to some of the testimony, maybe we keep it consistent with Medicare and some of the other insurance plans we have. Two months -- pick a number -- I think that would be something that could be a little more reasonable opportunity for folks.

And I guess I will stop there, Mr. Chairman. I will stop there. And I yield back.

Ms. Collins. May I just make one quick point on the tax credits?

There actually aren't any savings for young adults that enroll, on the tax subsidies, on the tax subsidy side, because they are already receiving subsidies. So when the premium goes down for them, the premiums only go down very marginally, and there is really no offsetting savings for the young. There is very little offsetting savings from the lower premiums for young adults.

Mr. Pitts. Did you want to continue, Mr. Holtz-Eakin?

Mr. Holtz-Eakin. I will just agree to disagree and would be happy

to provide our analysis.

Mr. Pitts. All right. Thank you.

The chair thanks the gentleman and now recognizes Mr. Griffith, 5 minutes for questions.

Mr. Griffith. You know, as I hear the various folks talking today and I hear both sides talking about costs increasing and costs not increasing as much, I am reminded that when the American public was sold this plan that the President said repeatedly it was going to save the average or typical family \$2,500 in their insurance premium a year.

Nobody is arguing that we are anywhere close to that. The question is are the costs going up more than they would have otherwise. This is a failed promise that was made by this administration, and there is no way around that.

Now, where are we at? We have some bills in front of us. I have heard a lot of discussion about some of the bills, and I am glad that folks realize that I am just trying to fix something with my little bill that ought to be fixed.

But I also know that my colleague Mr. Allen has a bill that basically says that if a State exchange fails and says, "We are done," that there ought to be an audit to make sure that any moneys that the Federal Government has given those State exchanges -- we can see what happened to it. We can figure out later if there is money left over and try to get it back, but if there is no money left over, we may not have an opportunity.

And I am just wondering if the three of you all would comment on

that, because I haven't heard anybody comment on that today.

Mr. Holtz-Eakin. I will repeat what I said at the outset, which is I believe this is absolutely what the committee should do. These are taxpayer dollars. They should be spent wisely, and there should be the oversight to make sure that is taking place. And if there are moneys left over, they should come back.

Mr. Griffith. Do any of our panelists disagree with that?

Ms. Turner. Absolutely not.

And I think that Congressman Allen's bill is very responsible. If a State exchange fails, then the Federal Government will go in to conduct an audit to require States to return any unspent funds to the Treasury. I mean, it is really hard to argue with being responsible for Federal taxpayer dollars, as this bill does.

Mr. Griffith. Ms. Collins, any comment?

Ms. Collins. I completely agree. Unspent funds should be returned. Spent funds is another issue.

If anything, the marketplaces right now are struggling and in need of more dollars for outreach. So the issue before in much of the discussion has involved enrollment. States are facing dwindling resources for outreach and enrollment, so, if anything, more resources are needed to increase enrollment in the marketplaces.

Mr. Griffith. Another part of the original plan included various levels. And we have heard some discussion today about how many different plans are available in various parts. I represent probably the most rural part of Virginia that you can get as a district in toto.

And in many of my areas, there is only one provider, so we are having some difficulties with choice in some of the areas. Some of the areas have two or three, but there are areas in my district -- I represent 29 different geopolitical subdivisions, so it is a mix, but some of them only have one provider.

And then I saw a headline recently that caused me concern, and that was that Group Hospitalization and Medical Services, a unit of CareFirst Blue Cross Blue Shield, will not offer the bronze-level plans through Virginia's health insurance exchange in 2017. And, of course, the bronze level was that lowest. You have to buy a plan, but you can buy the cheaper version if that is what you want. You know, if you were relatively healthy and you didn't want to go to the expensive plans, you could buy this one.

And some people think this might be an omen for the future that a lot of other companies will drop the bronze plan. But, in 2016, 23 percent of the purchasers in the exchange were bronze-level purchasers.

I am just wondering if any of you all have any comments on what -- is that an omen, that this group has decided not to carry the bronze plan or offer the bronze plan? And what does this mean for rates for those folks who are trying to buy the insurance but are on the end where they either don't want to spend more money or can't spend more money to get the silver or better plan?

Ms. Turner. It is certainly not a good omen for participation in the marketplace by people who are just trying to afford the coverage

they are required to buy. And if those policies aren't offered, I think we will see fewer people in the pools, leading to the kind of spirals we have been discussing today that really wind up harming everybody that is in the pools and discouraging others from purchasing insurance.

Mr. Griffith. Is this just another sign of failure of the plan overall, the ObamaCare plan overall?

Ms. Turner. I think it is a sign of the failure to be able to have the flexibility to provide the kinds of policies that people want. If they don't purchase the policies that are offered -- and they are very cookie-cutter plans -- then more and more people won't buy them, and I think we will see a destabilized market, really undermining the goal that I believe we all share of what health reform should do, and that is provide more affordable coverage to more people.

Mr. Griffith. I don't have any problem, Mr. Chairman.
Mr. Holtz-Eakin wants to say something, but I am out of time.

Mr. Pitts. He may proceed.

Mr. Holtz-Eakin. I just want to emphasize that, on top of the issues that Grace-Marie has raised, the issue of high-quality competition, making sure there are many providers, many plans in every piece of geography, is a concern for me.

And we have seen, you know -- we have seen, if you do apples-to-apples comparison of the same plan that existed last year and then this year, in the most recent year the weighted average increase is 10 percent. That is sort of apples to apples. That is what is going on. With diminished competition, you can expect even

worse performance, and I think that is a concern for the future.

Ms. Collins. Most people are actually enrolling in silver-level plans, so the majority of the marketplace is at the silver plan level. That is where the tax credits are. That is where the cost-sharing reductions are. So most people are enrolling in those plans.

That is where the price competition really is, and we are seeing very strong competition in many markets. Some markets, some rural markets, maybe less so. But, on average, competition is really high. It is delivering value to consumers.

Ms. Turner. But many of the people purchasing the bronze plans aren't eligible for those subsidies. And we want them in the plans -- we want them to participate in insurance, as well. And that is a real concern.

Ms. Collins. I agree that there should be a range of choices.

Mr. Griffith. I yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. Schakowsky. Thank you, Mr. Chairman.

You know, I am the co-chair of the Senior Task Force of the Democratic Caucus, so I am particularly concerned about the impact a 5:1 age rating policy could have on older Americans and on the marketplaces in general.

Dr. Collins, the Commonwealth Fund conducted a study on this very issue last September, and one of the most striking and almost, I would say, counterintuitive findings from this report was that implementing

a 5:1 band, age differential, would increase total Federal spending by \$9.3 billion.

Can you elaborate on that?

Ms. Collins. That is right. So RAND found in its analysis that, first, about 400,000 older people would lose their coverage because of the rate band change, but people who remained, older people who remained in the marketplaces would see their premiums go up, and that triggers an increase in their tax credit amount.

The amount of that tax credit RAND estimates to be \$9.3 billion a year, so a big, big increase in cost from the rate band being changed.

Ms. Schakowsky. Well, thank you.

And, Mr. Chairman, I would like to put at least a summary of the Commonwealth Fund report into the record.

Mr. Pitts. Without objection, so ordered.

Ms. Schakowsky. Thank you.

[The information follows:]

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Ms. Schakowsky. And I have another one from the Urban Institute, "Why the ACA's Limit on Age Rating Will Not Cause Rate Shock." If I could put that in the record, as well.

Mr. Pitts. And, without objection, so ordered.

Ms. Schakowsky. Thank you.

[The information follows:]

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Ms. Schakowsky. I wanted to discuss the results of a different study about the Urban Institute study. This study concluded that a 5:1 age band would actually undercharge young adults relative to their actual expenses and overcharge older adults relative to their actual expenses.

I wonder, Dr. Collins, if you could discuss this finding and any other relevant findings from these two reports.

Ms. Collins. That is right. So the Urban Institute looked at people's average costs over their lifetime, and the 3:1 rate banding actually tracks those expenses pretty well. So people who are young pay close to what their average costs are, maybe somewhat higher. People who are older pay a little bit lower than their average costs are, or around the same, in a 3:1 banding.

When you change this to 5:1, you get premiums that are much higher for older adults relative to their actual spend, premiums that are lower for younger adults relative to their actual spend. So it actually is less efficient in terms of what people's actual spend is over their lifetime.

Ms. Schakowsky. Thank you.

I also wanted to go back to an issue that has been discussed before, and that is changing to a 1-month grace period. We have been getting a number of calls from people about that, and let me just tell you and give you a couple examples.

A family of four from my district was told that their subsidy was included in their premium payments. When there was an error processing

her subsidy, the insurance chose to terminate the coverage. Now this family is facing thousands of dollars in bills for the care they received during the months when their coverage was terminated, and it was really no fault of their own.

Another constituent, who used auto-pay to make their premiums, received a letter stating that their insurance had been terminated because of some kind of glitch in the auto-pay that was from the insurance company. And despite making those payments, the insurer continues to refuse to reinstate their coverage, claiming they violated the 3-month grace period. And now they will be without insurance until the open enrollment period.

And what this means for people, if they got kicked off in February and the next enrollment period isn't until January, they could be without insurance for a long time.

So, you know, this idea of gaming the system, we are talking about the most vulnerable people. Because they are getting subsidies, that means they make no more than 400 percent of the poverty level. And it just seems to me that 90 days, you know, would make -- or is it 60? No, no, it goes to 30, but from 90, right?

Yeah, that changing from the 90 to the 30, I think, is really unreasonable, and that 90 is not unreasonable.

I guess I am out of time. That must have to qualify as a statement then. Thank you.

Mr. Pitts. The chair thanks the gentlelady and now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. Bucshon. Thank you, Mr. Chairman.

First of all, Ms. Collins, you said that there is a decline in out-of-pocket costs. Which group of patients are their out-of-pocket costs declining specifically? And be short. Because that is just -- I just don't believe that.

Ms. Collins. So that estimate comes from CMS, from the national spending account data. And what they showed between 2013 and 2014 was a slowdown in the rate of growth and out-of-pocket expenses.

Mr. Bucshon. Okay. Let me just repeat what you just said. It is a slowdown in the rate of growth. That is different than a decline in out-of-pocket costs. Okay. There is no --

Ms. Collins. But they also found a decline in --

Mr. Bucshon. You are on my time.

Ms. Collins. Sorry.

Mr. Bucshon. Okay. Thank you.

Ms. Collins. Sorry.

Mr. Bucshon. So it is a slowdown in the increase.

And the reason I say that is because that is very important, because if a deductible goes from \$1,000 to \$6,000, if you have a medical problem, your out-of-pocket costs are going to be six times as much. And what I am hearing, you know, from all of my constituents -- I mean, I hear this every day, every business, every individual -- deductibles are way up.

So, you know, a decrease in the rate of growth of out-of-pocket costs is totally different than saying there is a decline in

out-of-pocket costs. That is just factually not true. And so you can respond to that.

Ms. Collins. Well, right, there is a decline in the rate of growth. This is across the population. But they also found an actual decline in out-of-pocket spending on hospital care. And that is really --

Mr. Bucshon. For which group of patients?

Ms. Collins. That is the entire --

Mr. Bucshon. Now, in fact, that could be Medicaid, because --

Ms. Collins. Right.

Mr. Bucshon. -- it is true that if somebody had no Medicaid before and now they have Medicaid, of course their out-of-pocket costs are down, because now they have coverage. Because there is no deductibles or anything for the Medicaid population, right?

So I am going to --

Ms. Collins. Right. But this is across the --

Mr. Bucshon. I am going to need to move on.

Ms. Collins. Uh-huh.

Mr. Bucshon. Thank you for that.

And the other thing you said is they need more money to tell people that coverage is available to them. I can tell you, over the last -- since ObamaCare was put into law, if you don't know that there are possible options out there to get healthcare coverage in this country, you haven't turned on the TV or listened to any -- I mean, the constant thing that "more people will sign up if we just convince

them, if we just get the message to them that they can do this" is just not factually true. The reason people aren't signing up is because it is too expensive and because they are making a personal choice not to acquire health care.

And, by the way, 9 percent of the American people is 28 million or 30 million people. And the number of uninsured before was about 47 million or 48 million people. So, you know, I just want to make sure that we get all that stuff correct.

So, normally, Dr. Holtz-Eakin, how do insurance companies determine their pricing? I mean, is it just a general -- I mean, if you are an insurance company and you are going to determine prices for auto insurance, how do they do that normally?

Mr. Holtz-Eakin. You look at the projected -- based on history, the projected frequency of accidents, you look at the cost per accident, what kind of vehicles people are driving, and repairs are increasingly expensive, and you look at the structure of the policy and whether people would be paying deductibles, and look at what is left. And what is left, the premiums have to cover.

Mr. Bucshon. Right. And you look at the type of risk you are assuming, right?

Mr. Holtz-Eakin. Yeah, who is driving.

Mr. Bucshon. I mean, a 16-year-old who just got his license is much more risky. And, I mean, you know, you can't necessarily extrapolate that to health care, but the 16- -- they are generally higher-cost people, right?

Mr. Holtz-Eakin. Right.

Mr. Bucshon. And the rate is set by professional actuaries --

Mr. Holtz-Eakin. Yes.

Mr. Bucshon. -- that determine this. So, you know, what we are doing in the ACA is we are creating a not-actuarially-sound system, so we are getting the result that we would expect. Would you agree or disagree with that?

Mr. Holtz-Eakin. I would agree. I think the actuaries are struggling to price, and we are seeing these large premium increases as a reflection of their past failures, given the instabilities.

Mr. Bucshon. Yeah.

So, you know, the average, it has been said, was one-five before, approximately? Just the average marketplace, the pricing difference, on average, was about that before, somewhere in that range?

Mr. Holtz-Eakin. Yeah. I think this is an important issue. I mean, the CBO in February put out a report that said that the spending for 64-year-olds versus 21-year-olds, the ratio is 4.8:1. So that is the data on what is going on. The pricing should reflect that. And so 5:1 doesn't seem unreasonable.

And I just want to emphasize, nobody in this individual market, on average, is paying the costs. It is a heavily subsidized market.

Mr. Bucshon. Right.

Mr. Holtz-Eakin. And so, on average, no one is paying their insurance costs.

Mr. Bucshon. Yeah.

And, you know, I was a practicing physician before, I was a cardiac surgeon. And so a lot of people ask me -- because they know that -- when I am in my district, they ask me about this subject. And, you know, when you create -- and this will be a statement, and I will end, Mr. Chairman.

When you create a non-actuarially-sound system, you get the expected result. We are just trying to make some modest changes here to get us back on track so that we can accomplish the goals that we all believe in and get everybody health coverage.

I yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes Mr. Cardenas, 5 minutes for questions.

Mr. Cardenas. Thank you very much.

I appreciate the opportunity to hear from you and your perspective on this important issue.

And thank you for holding this hearing, Mr. Chairman.

I was happy to see that the administration announced a series of actions which included a proposed regulation to help consumers who turn 65 make the transition to Medicare so the older consumers are served by the program designed for them to meet their healthcare needs.

So, Ms. Collins, can you talk a little bit about how the administration's actions will help seniors strengthen themselves and help the marketplace pools, as well?

Ms. Collins. So that is right. So helping people move into the coverage that they are eligible for is very important. There

are multiple different paths to coverage across the age spectrum and also dependent on income, Medicaid, marketplace plans. And now the transition to Medicaid is very important.

So helping people move into the coverage that they are eligible for is extremely important, getting the appropriate subsidies for them and making sure that they are getting the coverage and the care that they need.

Mr. Cardenas. So one of the fundamental things of anything -- private sector, public sector, et cetera -- is if something is designed with actuarials in mind and formulas, et cetera, that are truthful and honest about how that should work if it plays out appropriately, part of that is that, in this case, that people are actually in the particular pools or in the particular categories, that helps it play out more to the reality of how it would work better than if it falls apart loosely.

In this case, if people are not aware of their eligibility and they stay in one category versus another, that is part of what hurts any system. Right?

Ms. Collins. That is right. So it is very helpful that people, as they age into Medicare, enroll in the Medicare program. And it is also better for them. If they continue on in marketplace plans, they are obviously losing subsidies. So it is very important from a financial perspective, from a coverage perspective that they are able to make that transition and are aware of it.

Mr. Cardenas. Okay. Thank you.

One of the things that frustrates me as a legislator when I was at the State level and the city council level and now in Congress is that when we start arguing about what is wrong with the current system or policy and yet at the same time we are not being honest with the public by juxtaposing that against what the system was like before the change.

Like, right now, one of my colleagues extracted from some of the panelists some of the truths. You know, a lot of complaints from our American citizens here that, you know, their deductibles go up a little faster, what have you, it is uncomfortable, they don't want to spend that money, et cetera.

But isn't it true that, under the ACA, that the overall cap per individual, single person in a plan is \$6,850 and it caps? And then, therefore, there is no more out of pocket. The plan takes care of the rest. And if you are a family, it can go no higher than \$13,700. Isn't that part of the ACA currently, that fact?

Ms. Collins. That is correct.

Mr. Cardenas. Okay.

Secondly is, under the ACA, a person, whether they are on a public plan or private plan, et cetera, marketplace plan, they are not allowed to be kicked off for a precondition. Isn't that current, the law in the United States, when it comes to healthcare coverage? Fact?

Ms. Collins. That is correct.

Mr. Cardenas. Okay.

But, see, the thing is, what I think it is important for me to

do in the last minute and a half of my time here is to point out that, before the ACA came into law, what was the deductible cap in America for healthcare coverage?

Let me help because of the limited time. Did it cap at \$100,000? Maybe in a particular plan. Did it cap at \$200,000? Maybe in a particular plan. Wasn't it legal for someone to sign up for a plan, an insurance company to give them that plan and have an unlimited deductible?

For example, if a family member or several family members under one plan actually got cancer, you could have deductibles of eventually 20 percent of whatever the expenditure was. So if that cancer treatment in that family was a million dollars -- which is not unlikely, correct, panelists? That is possible, right, in America?

Okay. That being the case, then the family could be on the hook for \$200,000 in 1 year's worth of coverage. But, today, the worst-case scenario for a family if you have cancer is \$13,700.

And my last point that I want to make is that it is inappropriate for us as legislators to remind America about the things that we don't like about the Affordable Care Act without reminding them that if that family got cancer and then next year, for example, the father lost his job or what have you and then had to go to a different plan, before the ACA, they might not be able to find a plan because they had the right to be denied because of a precondition.

And under today, one last question to the panel is, under the ACA, isn't it illegal for someone to be not allowed to have coverage if they

have a precondition? Aren't they required to be able to be provided coverage by the private sector or the public sector?

Ms. Collins. Yes.

Mr. Cardenas. Yes.

Yes?

Yes?

Thank you very much.

I yield back.

Mr. Pitts. The chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. Guthrie. Thank you. Thank you so much.

And the cap would actually lessen the impact of a rating band change, because if people are at the cap and it went from 3:1 to 5:1, then they still wouldn't -- they actually wouldn't see an effect if they were at the cap, so the cap would fix that.

But one thing that we are talking about and, you know, trying to reach out to encourage more people to get into the exchanges without spending Federal dollars, if the marketplace worked like it should, then the insurance companies would be doing that. They would be marketing themselves and trying to attract people to come into their insurance companies, because that was kind of the concept. And so it puts into perspective what the problem is: The insurance companies are exiting the exchanges.

And a month ago, we talked about plans, including the Nation's

largest insurer in the exchange. United has pulled out of over 25 States because they project \$650 million in losses this year.

And this hurts patients. Plans exiting exchanges has the potential to severely limit competition in some States where patients may have only one option. And Alaska is an example. This week, their State legislature acted out of desperation to save their last remaining plan from running away from ObamaCare. They set up a \$55 million bailout fund, paid for by insurance companies, to subsidize enrollees that can't afford ObamaCare's premium hikes.

In the next decade, the Federal taxpayer will spend \$568 billion on premium subsidies, \$130 billion on cost-sharing programs, and, still, exchanges are collapsing. So all those people are getting benefits, but they are also coming at costs to the taxpayer that we have to balance.

So, Ms. Turner, is the answer to a failed Federal program more Federal intervention?

Ms. Turner. No. At some point, I think you realize that the rules and regulations of the ACA are becoming counterproductive because people are figuring out how to game the system. And I think that is really what we have to look at. Where is this going?

And could I just correct the record earlier about Dr. Collins saying that the 3:1 age band really reflects more the consumption of individuals? It is really closer to 6:1.

And the 5:1 rating band that would be allowed under this legislation really still gives the States the authority to override

this. So it basically says, States, we understand you have been regulating health insurance for a long time. If you know best, then you do that, but let's not use wrong data.

Mr. Guthrie. Well, Mr. Holtz-Eakin, would the age rating band change? How would that affect what is happening in Alaska today? Would that have a benefit to try to keep people into the marketplace?

Ms. Turner. Absolutely. Absolutely. If you want to get more young people in and if you --

Mr. Holtz-Eakin. I agree with her.

Mr. Guthrie. You agree with that?

Ms. Turner. Oh, I am sorry. Was he asking you?

Mr. Guthrie. Okay. Yeah, you agree.

Well, I asked for that, but that is fine.

And in the time I have left -- I was going to yield some time to Dr. Burgess, but he just stepped out, I guess. In the time I have left, I would like to call attention to another number. There are 23,000 -- 23,000, that is the number of Alaskans that State lawmakers are hoping to save with a \$55 million cash infusion.

This is real life in the current law. It is not working.

And, with that, I don't see him here. I will yield back.

Mr. Pitts. All right. The chair thanks the gentleman and recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions.

Mrs. Brooks. Thank you, Mr. Chairman.

I am really pleased that our committee is focusing on market

reforms for our healthcare system, particularly those that might give States greater flexibility to operate their individual markets in ways that reflect their respective needs.

Before 2010, 42 different States allowed an age band rating of 5:1. In 2010, of course, it was restricted to 3:1. As we have heard, this change has resulted in higher premiums for younger Americans, who have stayed out of the marketplace. And with fewer young Americans in the marketplace balancing out the premium costs for older Americans, this is leading to that more older and more costly insurance pool, which is providing no cost relief to seniors' rates. So it seems to me to be a no-win situation, but it should have a solution.

The State Age Rating Flexibility Act would give States the right to establish age rating bands that best fit their insurance market to be more reflective of the needs of their population. And it seems that our goal should be to attract younger, healthier patients to the healthcare plans. This would benefit everyone, the young and the elderly.

And so I would like to continue to focus on that, and I will start with you, Ms. Turner. You indicated in your testimony making health insurance too expensive for healthier young people that we want in these insurance pools drives them away, increasing the cost of the insurance for everyone else who remains.

Can we go deeper on this issue? And studies you have seen, analyses you have seen, moving that ratio back to 5:1, would it have an immediate impact on the cost?

Ms. Turner. Actually, I think Dr. Holtz-Eakin may have some data here that would inform that.

Mrs. Brooks. So, Dr. Holtz-Eakin, please.

Mr. Holtz-Eakin. This is not -- average premiums for singles and for families -- this includes both the older and the younger ones -- would fall in these markets. That is a benefit. That is going to lower the out of pocket, the sort of premium costs for individuals. It is going to lower the taxpayer costs for subsidies. This is a beneficial move. It matches the data on spending by those groups, and it leads to better long-run stability.

So I would be happy to provide this analysis for the record.

Mrs. Brooks. We would certainly like that analysis provided for the record.

[The information follows:]

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Mrs. Brooks. And, I guess, Ms. Collins, how do you refute those studies?

Ms. Collins. The RAND analysis shows an increase in premiums for someone who is 64 years old -- this is the silver benchmark plan -- of \$2,000, relative to a decline, only a marginal decline, in someone who is 21 years old of about \$700. So much bigger increases in premiums for older adults.

Mrs. Brooks. And so, Dr. Holtz-Eakin, how would you compare what that RAND -- because I am sure you have seen that RAND study that differs from the studies that you have. So how do you explain this discrepancy?

Mr. Holtz-Eakin. To be honest, I can't at the table. But I would be happy to provide, along with ours, our analysis of the RAND study and why they have come to a different conclusion. That seems perfectly reasonable.

Mrs. Brooks. Okay. I think that would be important to clarify this.

Ms. Turner, would you like to comment?

Ms. Turner. I think one of the things that -- there is a new study out, actually, this week by the Council for Affordable Health Coverage that shows that fewer than 40 percent of enrollees in the exchanges are younger than 35 years old, although they are 50 percent of the potential exchange market.

So I think that really shows that the premiums, even now -- and the first year, 2 years really did not reflect as much experience in premium setting as I think subsequent years were -- already we see a

smaller percentage of young people signing up for the exchange than are eligible for them. And I see that if we continue this same trend, allowing the gaming of the system and other provisions in this law, that is going to get even worse and we are going to see even more young people dropping out. And the costs are going to go up for older people in the exchanges, no matter what, if young people are not participating.

Mrs. Brooks. That is the point that I think is so important here.

Would you agree, Ms. Collins, that if fewer young people don't get into the exchange, prices will go up for seniors?

Ms. Collins. That is exactly right. And --

Mrs. Brooks. And our goal --

Ms. Collins. Right.

Mrs. Brooks. -- is to try to bring as many young people into the pool because that would lower the cost for seniors.

Ms. Collins. Right. But most young adults who are outside the pool, outside the marketplace right now actually have incomes that make them eligible for the subsidies. So they wouldn't actually be affected by the change in the rate.

Mrs. Brooks. Could you all respond to that?

Ms. Turner. We want more people in the exchanges who are not eligible for subsidies. And the only way to attract them is to make the policies more affordable.

Mrs. Brooks. Okay.

Dr. Holtz-Eakin?

Mr. Holtz-Eakin. And it is not a bad thing to have premiums be

lower and have the subsidies be less of a drain on the taxpayer.

Mrs. Brooks. Thank you.

I yield back. Thank you very much.

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

Mrs. Blackburn. Thank you all. And I know we are going to be running up against votes, so I am going to move on through this.

I have legislation that would deal with this open enrollment period. And I am so appreciative of you all being here. And, you know, this is a particular concern of mine because of what we lived through in Tennessee with TennCare, which was the test case for HillaryCare.

And, Ms. Turner and Mr. Holtz-Eakin, I know that you both are familiar with the failures of that program and some of the strain that was put on that program because of extremely generous open enrollment and not doing the verification on eligibility.

And, Mr. Holtz-Eakin, I appreciated that you had called the ObamaCare special enrollment period extremely generous. That was how we defined what was happening in Tennessee.

Back in December, Chairman Upton asked CMS for details about the special enrollment, and we were trying to get numbers. We are told the insurance companies have those numbers, that CMS does not have those. But what we did get was a list of the special enrollment exceptions, which is loss of minimum essential coverage, a permanent move, a birth, adoption, placement for adoption, placement for foster

care, child support or other court order, or marriage.

So my question would be -- and, Ms. Turner, I will come to you because you had made the comment -- and we saw this in Tennessee too -- that a growing number of people are using ObamaCare as just-in-time insurance. They only get it if they think they are going to need it.

So, in your view, would going into a pre-enrollment verification process and applying that to special enrollment avoid part of this problem that we are seeing with the special enrollment programs and the just-in-time insurance?

Ms. Turner. Yes. And you can't, Congresswoman Blackburn, have a system in which people aren't following the rules of insurance. If you are going to have private health insurance system, it has to work like private health insurance. And if people can only buy the coverage when they are sick and then drop out afterwards and buy coverage again if they get sick again later, that is not going to work at stabilizing these pools over time.

And people are figuring it out. A study with consulting firm Oliver Wyman said that people who enrolled during the special enrollment period were 24 percent more likely to have high costs in the first 3 months than regular enrollees and 41 percent more likely in the next year. So, over and over, we are seeing that this is a trend, and it is not a trend that is going to be sustainable over the long term.

Mrs. Blackburn. Well, based on that, wouldn't you say that doing

pre-enrollment verification is really a fairness mechanism to be fair to everybody?

Ms. Turner. Absolutely. And there should be exceptions. If somebody has problems with the electronics of the system, which some people do, then certainly there will be exceptions to protect people who are trying to play by the rules, but to make sure people who are not are not incentivized to misuse this insurance.

Mrs. Blackburn. Uh-huh.

Ms. Collins, would you agree with that, that the pre-enrollment verification would be fair to everybody involved in the process?

Ms. Collins. You know, I really think it actually would discourage people from enrolling. And we really do need to make sure we have a lot of people in the risk pools, have young adults -- have young adults in the risk pools.

Mrs. Blackburn. Wait a minute. You think that having to prove worthiness would be unfair?

Ms. Collins. The new guidance by the administration, by CMS, is requiring people to submit documentation proving that they lost their job, proving that they got married, proving that they had a baby, which is probably the big source of costs that insurers are seeing. Babies are, by definition, more expensive when they are born.

And the other thing the administration is doing, they have made an adjustment in their risk adjustment program to allow for --

Mrs. Blackburn. Okay. Let me get back to the --

Ms. Collins. -- partial enrollment.

Mrs. Blackburn. -- topic, though. But you would say that to submit to pre-enrollment verification would be an unfairness?

Ms. Collins. I think that people should be able to enroll before they provide documentation. So we don't want to --

Mrs. Blackburn. Oh, so you think --

Ms. Collins. -- discourage people from enrolling.

Mrs. Blackburn. -- they ought to be able to get the benefits before they prove who they are. I am going to disagree with you on that one.

And, Mr. Holtz-Eakin, I am going to come to you on this. Because we are hearing that stability and balance in the programs, that is the goal -- stability. And we know that verification leads to that.

So wouldn't it behoove these programs to do their verification on the front end before they let somebody in, rather than letting them in, letting them get what they want, paying the bills, and then kicking them out, or them just not paying the bill?

Mr. Holtz-Eakin. I think we have to look closely at this. The reality is that the term "special enrollment period" suggests, you know, the exception to the rule, a tiny thing. One in five of the enrollees comes through these SEPs. They are disproportionately expensive, so more than one-fifth of the costs are coming through this. They are disproportionately likely to stop paying their premiums, so cost-shifting comes from this.

It seems to me a simple matter to make sure that if those phenomena are going to happen they should happen only with people who are

genuinely eligible for the coverage.

Mrs. Blackburn. Thank you.

I yield back.

Mr. Pitts. The chair thanks the gentlelady.

And, without objection, we will go to Mr. Flores, who is a member of the full committee, for questions, 5 minutes.

Mr. Flores. Thank you, Chairman Pitts. I want to thank you and Ranking Member Green for allowing me to be part of this important hearing today.

This hearing is about finding solutions that will better the healthcare outcomes for our constituents. And one of the issues before us today is grace periods, which we are trying to address in my legislation as set forth in H.R. 5410.

As I understand it, under current law, patients with subsidized exchange plans have up to a 3-month grace period to maintain coverage when they don't pay their health insurance premiums for a given period of time. During that 3-month grace period, the plan they subscribe to cannot discontinue the service for the nonpayment of premiums.

Given this payment structure, this means that patients receiving the advanced premium tax credits can pay for only 9 months of health coverage but receive a full year of coverage.

Ms. Turner, is this correct?

Ms. Turner. Yes, that is absolutely correct. And a growing number of people are doing that, as studies are showing, and it --

Mr. Flores. We will dig into that in a minute, so thank you.

Mr. Holtz-Eakin?

Mr. Holtz-Eakin. Yes.

Mr. Flores. Ms. Collins?

Ms. Collins. No, that is actually not correct. So if they don't pay their premium in the first month, their claims cannot be paid and --

Mr. Flores. No, no, no, no. Are they receiving coverage? They can go to the doctor, right, during months two and three and get treatment, correct?

Ms. Collins. But their claims are not covered.

Mr. Flores. Go read the --

Ms. Collins. Their claims are not covered.

Mr. Flores. Go read the law. It does say that.

And my second question is, in the first month, the plan must cover claims. And here is where you are correct, Ms. Collins, is that in months two and three, the plan may hold the claim, but the patient is still insured. And that is where you are incorrect. And after 3 months, the plan may finally discontinue the coverage and reject the claims from the second and third months, and then the provider, the doctor, is on the hook to recoup the outstanding payments from the patient.

So three questions for you.

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[11:13 a.m.]

Mr. Flores. The first one is, what effect does this have on the economics of health care? The second one is, what effect does this have on premiums? And the third one is, what effect does this have on the providers, our doctors, to their cost and how do they have to recoup that?

So, Ms. Turner, again, on the economics of health care.

Ms. Turner. I think, in particular, that we have to look at doctors because doctors and hospitals are on the hook for this. And one of the things that that does is discourage them from wanting to take exchange patients.

Mr. Flores. Right.

Ms. Turner. And so that is going to wind up having access problems, if people have a history of not paying their claims, because people are often repeat offenders in misusing this.

Mr. Flores. Now also, now, what happens -- let's say, you know, if a doctor has to provide 12 months' worth of procedures to a patient, let's say you have got a chronically ill patient, but 2 of those months the doctor doesn't get paid for that. What does the doctor do with that 2 months that they have to charge off?

Ms. Turner. Yes, they eat the cost.

Mr. Flores. And what happens then?

Ms. Turner. Their practices are increasingly threatened by nonpayment of premiums -- or of bills and --

Mr. Flores. How do they recoup it? They are not --

Ms. Turner. They have to go after the patient.

Mr. Flores. Okay. But if the patient doesn't pay, then what happens? They have to raise the cost for everybody else. Right?

Ms. Turner. That is right.

Mr. Flores. Okay. Mr. Holtz-Eakin -- and what effect does it have on premiums, Ms. Turner? I am sorry. I didn't mean to -- on premiums.

Ms. Turner. Well, of course, it increases premiums because that has to be built in.

Mr. Flores. Okay. Mr. Holtz-Eakin, on the economics of health care.

Mr. Holtz-Eakin. Costs are incurred.

Mr. Flores. Right.

Mr. Holtz-Eakin. And they will be paid in one form or another somewhere in the system.

Mr. Flores. Right.

Mr. Holtz-Eakin. They simply don't disappear.

Mr. Flores. And so, theoretically, premiums would go up to offset the loss, the high claims but low premium receipts. Right?

Mr. Holtz-Eakin. The insurers piece, they will try to raise premiums to cover theirs. The providers' piece, they will try to raise price to cover theirs. And if they can't do that, they will stop seeing

those patients or leave practices entirely. You will have fewer providers, costs will go up anyway.

Mr. Flores. Okay. So this law is supposed to be about fairness, yet doesn't this 3-month gap work as a penalty to patients who follow the law and follow their plans and pay for 12 months' worth of coverage as compared to those who get 12 months of coverage but only pay for 9 months? Mr. Holtz-Eakin, does that sound fair to you?

Mr. Holtz-Eakin. No. Deliberate gaming of the system is inappropriate.

Mr. Flores. Okay. Ms. Turner, does that sound fair to you?

Ms. Turner. Absolutely not. And it is going to discourage the people who want to play by the rules from doing so.

Mr. Flores. Ms. Collins, does that sound fair to you?

Ms. Collins. There is very little evidence that people are gaming the system. If anything --

Mr. Flores. Well, I disagree with you on that because I have got -- I am not running out of time here. As Mr. Holtz-Eakin -- this is in response to you, Ms. Collins. As Mr. Holtz-Eakin points out, this same report goes on to say that 57 percent of the patients who stopped paying for coverage are medium or high risk, and roughly have the patients admitted that they stopped paying for their plan in 2014 as well.

So, Mr. Holtz-Eakin, as you note, and the current process could easily allow individuals to take financial advantage at the expense of other paying consumers and taxpayers. What defense is there in not

closing this gap?

There is not any. Okay.

And I will just end by reading a quote from Ms. Turner's testimony that I found to be particularly alarming, and that is, "Abuse of the grace period is undermining the concept of insurance and driving up the cost of coverage for others." If we all bought 12 months' worth of car insurance and only paid for 9 months, then we would all wind up paying for 12 months of car insurance somehow somewhere.

So thank you, Mr. Chairman. I yield back.

Mr. Pitts. The chair thanks the gentleman. That concludes the first round of questioning.

I have a UC request. The statement by America's Health Insurance Plans submitted for the record. Without objection, so ordered.

[The information follows:]

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Mr. Pitts. We are going to go to one followup per side.

The chair recognizes the ranking member, Mr. Green, 5 minutes for a followup.

Mr. Green. Thank you, Mr. Chairman. I appreciate the chance to do a followup. Again, I want to be sure we are trying to get more -- you know, the whole point of the Affordable Care Act was trying to expand coverage. The three bills limiting grace periods, special enrollment periods, prior authorization, and age rating would make it much harder to get and even to keep coverage. And I understand the churn because that happens every day. People buy auto insurance and then they get their card, in Texas, because you have to have mandatory liability, and then they cancel. And that is part of the system, whether it is Affordable Care Act or the private sector.

So my concern is, Ms. Collins, would these three bills limit that opportunity to get more coverage instead of less coverage? Again recognizing it is a checkerboard. Because if the states didn't expand their Medicaid, even though for the first 3 years it would be 100 percent reimbursement -- which, by the way, I introduced a bill that would require Congress to do it instead of just -- because all my legislators said: Well, how do we know you are going to do it? Well, let's put it in the law and make sure that happens.

But will these three bills limit the ability to expand coverage under the Affordable Care Act?

Ms. Collins. It will definitely limit enrollment. The new -- requiring people to provide documentation before they enroll

in a special enrollment period will definitely moderate or modulate people's ability to do that. And we -- there is an under use, if anything, of special enrollment periods among people who are eligible for them, particularly people who lose their jobs. So they are experiencing gaps in coverage. We know there is much more likely to have a cost-related access problem or not get care when you have a gap in coverage.

So that would definitely -- and the reduction in the grace period would also make it likely that people wouldn't -- and I think most people probably think when they don't pay a premium in one month that their termination -- that their coverage is over. So allowing people, making sure people are aware that they have a 3-month period to make up that premium would ensure that they are able to continue that coverage throughout the year rather than just drop it and be uninsured for the rest of the year.

Mr. Green. Well, I have to admit when I first saw the posting on these bills, I thought: Well, good. We are getting to some level that we can work on the problems with the ACA and expand coverage at the same time. And I think my colleague from Oregon mentioned, you know, we might be able to work on the, you know, the grace period, you know, to match it with some other Federal -- like some other Federal -- but that is not going to happen.

And again, I think the bottom line when we do some day get into saying: Okay. Let's fix what is wrong with the ACA, the goal still ought to be to make sure we have more coverage. Because that is what

the intent was and -- of the bill or the law now. And I would hope that is the intent, to provide opportunity for people to have health care in our country instead of making it harder. And, again, the free market will do it.

If I owned an insurance company, believe me, I would want to make sure everybody was healthy. We used to have examples, well, we will -- for seniors, for even Medicare Advantage I heard: If you can walk up these two flights of stairs, you can -- we will say you are Medicare Advantage. You know, that is not something we need to do. People need health care no matter what their illness is.

Now, again, ratings is ratings. But -- and age is age. But the whole goal is to expand the coverage for people who don't have it. Because right now we are paying for it. You know, the private sector is paying for it. If someone shows up in our emergency rooms in Houston and maybe -- and uncompensated care fund, I think they may get 10 percent of whatever they -- but believe me, those for-profit, even nonprofit, are somehow going to get reimbursed from someone, whether it be through the regular insurance market, the folks who have it. But to get those folks to have something, even if it is just Medicaid.

Thank you, Mr. Chairman. I will yield back.

Mr. Pitts. The chair thanks the gentlemen and now goes to Dr. Burgess, 5 minutes for a followup.

Mr. Burgess. Thank you, Mr. Chairman.

Ms. Collins, earlier this year the news reports were that UnitedHealth Group was withdrawing from covering in the exchanges. Do

I understand that correctly?

Ms. Collins. That is right.

Mr. Burgess. Do you know why they made that decision?

Ms. Collins. Well, if you look at the data on UnitedHealth Group, they were very price -- uncompetitive in most of the markets that they were operated in. So they were rarely the second lowest cost silver plan in most of the markets they were operating in. So they actually were probably not the choice of many consumers just because they weren't pricing very competitively.

Mr. Burgess. Or perhaps they were pricing more sanely because they -- clearly, I mean, if a big group like that thinks they can make money in the system, they are likely to stay. And if they think they are going to lose money, they are likely to withdraw. Do you think they saw something that the other companies didn't see earlier on?

Ms. Collins. Well, they had very little experience in the individual market prior to entering the marketplaces. So they knew less about their risk pool than some of the other carriers that had more experience in the individual market, so which might have been reflected in their higher premium rating.

Mr. Burgess. Might have been, but they also may have had the ability to peer over the horizon a little bit. Now, a company that does have extensive experience in the individual market in my state, in Texas, Blue Cross Blue Shield, and they have asked for a 60-percent increase for next year. Does that seem reasonable that they would come in with that sort of request?

Ms. Collins. It seems very high. Again, these are preliminary rates, so they will be adjusted by regulators through the rate review process. And it is very unlikely that consumers would end up paying that size of increase, both because they may choose to enroll in different plans that are lower priced in Texas or that the tax credits will actually protect them from that -- from that kind of increase.

Mr. Burgess. Yeah. But someone like myself who is in the individual market in an unsubsidized plan, there is no protection from a subsidy. You either pay the price or you don't buy the product. Right?

Ms. Collins. Right. But if you have other choices that are lower priced, then we have evidence that about 43 percent of people switched plans last year.

Mr. Burgess. I don't mean to interrupt you, because time is short. What evidence do we have that the number of choices in a marketplace like Texas are going up?

Ms. Collins. The plan offerings between 2015 and 2016 were relatively stable. We do know that most carriers -- UnitedHealth Group is an exception, really, to the rule. Most carriers are committed to the marketplaces in 2017.

Mr. Burgess. I guess we will find out if that is correct.

Let me just ask a couple of questions on the 90-day issue, because you made some comments earlier in the testimony that on the nonpayment part, after we have gone the 30 days, the carrier is on the hook for the first 30 days, I believe you said, then beyond that the insurance

carrier is no longer on the hook for that. But the recipient, the insured, perhaps they would be required to pay the part that now was in arrears. Is that correct?

Ms. Collins. Right. So if they didn't pay -- if they didn't pay their premium in the first month, and they don't pay in the second month or the third month, they are responsible for continuing to pay the premium in the first month, but they also have to pay their tax credit back in that first month. The claims that they incur in the second and third months would not be covered by their insurance coverage. So by restricting -- and by the design of that, of the grace period allows people who have fluctuating incomes, low income, who can't come up with the premium payment in that first month, it gives them time to make up that -- to pay that premium. It makes providers happier because their second month they will get coverage for their care. Third month, be able to get coverage for their care. Cutting it off at one month, they will continue to get care but have no health insurance for that care. Providers would be on the hook too.

Mr. Burgess. But let's talk about that 60 days after the first 30 days. That insured is no longer receiving the tax credit in those months. Is that correct?

Ms. Collins. The carrier receives it, but the insured is not covered.

Mr. Burgess. Is the carrier then required to pay that tax credit back?

Ms. Collins. The insurer has to pay the tax credit back, if the

premium is not paid in the second or third month.

Mr. Burgess. Does any portion of that recovered tax credit go to offset the cost of the care that was delivered to the insured that was being carried during those 30 days? 60 days?

Ms. Collins. In the first month.

Mr. Burgess. No, I am taking about specifically the second or the third month, the second -- the 60-day outlier part of that.

Ms. Collins. Right. The carrier is not responsible for covering the claims in the second and third month the premium is paid.

Mr. Burgess. So is any portion of that recovered tax credit from the insurance company, does that go to somehow offset the cost of the care that was delivered?

Ms. Collins. I do not think so.

Mr. Burgess. Yeah. And that is inherently the problem here. And as much as -- with all the affection that I have for Dr. Holtz-Eakin, doctors generally cannot increase their prices. We generally work under contracts. I know it is supposed to be a free market, but generally we sign contracts with insurance companies to provide at a set fee. So it is very difficult for the -- particularly for the individual provider to raise fees to cover that what is not -- which was not covered by the time the patient was in arrears.

I thought you turned me off because my time was up. You let me go on. I do want to again thank the panelists for being here. It was an important hearing. I am glad we have had this opportunity today.

Thank you, Mr. Chairman, and I yield back.

Mr. Pitts. The chair thanks the gentleman. That concludes the questions from the members present. We will have follow-up questions in writing that we will provide to you. We ask that you please respond.

[The information follows:]

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

Mr. Pitts. I remind members that they have 10 business days to submit questions for the record. That means they should submit their questions by the close of business on Friday, June 24.

Very interesting hearing, interesting back and forth. We thank you very much for your presentation today.

And I understand, Ms. Turner, we should wish you happy birthday today. Thank you for spending your birthday with us.

Without objection, this hearing is adjourned.

[Whereupon, at 11:28 a.m., the subcommittee was adjourned.]