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6 STRENGTHENING OUR HEALTH CARE

7 SYSTEM: LEGISLATION TO LOWER CONSUMER COSTS

8 AND EXPAND ACCESS

9 WEDNESDAY, MARCH 6, 2019

10 House of Representatives

11 Subcommittee on Health

12 Committee on Energy and Commerce

13 Washington, D.C.

14

15

16

17 The subcommittee met, pursuant to call, at 10:01 a.m., in

18 Room 2123 Rayburn House Office Building, Hon. Anna G. Eshoo

19 [chairwoman of the subcommittee] presiding.

20 Members present: Representatives Eshoo, Butterfield,

21 Matsui, Castor, Lujan, Kennedy, Cardenas, Schrader, Ruiz,

22 Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Rush, Pallone

23 (ex officio), Burgess, Upton, Shimkus, Guthrie, Griffith,

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24 Bilirakis, Long, Bucshon, Brooks, Carter, Gianforte, and Walden
25 (ex officio).
26 Staff present: Jacquelyn Bolen, Professional Staff; Jeff
27 Carroll, Staff Director; Tiffany Guarascio, Deputy Staff
28 Director; Zach Kahan, Outreach and Member Service Coordinator;
29 Saha Khaterzai, Professional Staff Member; Una Lee, Senior Health
30 Counsel; Samantha Satchell, Professional Staff Member; Andrew
31 Souvall, Director of Communications, Outreach and Member
32 Services; Sydney Terry, Policy Coordinator; C.J. Young, Press
33 Secretary; Mike Bloomquist, Minority Staff Director; Adam
34 Buckalew, Minority Director of Coalitions and Deputy Chief
35 Counsel, Health; Margaret Tucker Fogarty, Minority Staff
36 Assistant; and James Paluskiewicz, Minority Chief Counsel,
37 Health.

38 Ms. Eshoo. Good morning, everyone. Welcome to the
39 witnesses. The chair now recognizes herself for 5 minutes for
40 an opening statement.
41 Today is the second legislative hearing of the Health
42 Subcommittee in the 116th Congress. We are going to examine
43 legislation today to drive down costs and increase options in
44 the private insurance markets created by the Affordable Care Act.
45 Democrats made a promise to the American people to lower
46 their healthcare costs and undo the Trump administration sabotage
47 of the ACA. Today we are continuing to deliver on that promise
48 by examining legislation that creates a reinsurance program for
49 all states, funds states that did not initially set up state-based
50 insurance marketplaces to set up these state-run private
51 exchanges, and restore funding for patient navigators.
52 If an individual is not enrolled in Medicare or Medicaid,
53 does not get their insurance through their employer, or is a small
54 business owner or self-employed, the legislation we are
55 considering today will help bring down the cost of health
56 insurance. The bill gives states the funding and flexibility
57 to improve the private marketplaces created by the ACA and
58 increase choices for Americans who purchase their health
59 insurance from these exchanges.
60 Representatives Angie Craig and Scott Peters have written

61 a bill which provides funding for state-based reinsurance
62 programs and establish a federal reinsurance program similar to
63 the one established in the Affordable Care Act that expired in
64 2016, so all Americans can benefit from lower premiums in the
65 individual marketplace. Reinsurance programs add money to the
66 health insurance market created by the ACA to cover the costs
67 of patients with high medical costs such as those with
68 pre-existing conditions.
69 This will drive down costs for middle class Americans who
70 don't receive the ACA tax credit. By providing payments that
71 enroll high cost patients, many of whom have pre-existing
72 conditions, reinsurance protects against premium increases and
73 will bring down the cost of health insurance coverage for those
74 who buy their insurance from ACA exchanges. For anyone who cannot
75 afford health insurance on the private market today, this bill
76 will bring premiums down next year and help individuals afford
77 high quality, comprehensive coverage.
78 We will also examine the bipartisan SAVE Act introduced by
79 Representatives Andy Kim and Brian Fitzpatrick which provides
80 funding to states to set up state-based insurance marketplaces
81 like the original ACA did. I am very proud of Covered California
82 that is California's state-based insurance market. I think it
83 is the gold standard for these programs and currently has enrolled

84 one and a half million Californians. That is a lot of human beings
85 that have coverage today that never had coverage before. If a
86 state originally chose not to establish their own state-based
87 marketplace when the ACA became law, this bill gives those states
88 the funding they need to establish a marketplace that meets their
89 needs while maintaining the minimum benefits established by the
90 ACA.
91 Lastly, we will consider Representative Castor's ENROLL Act.
92 It provides funding for navigators who assist small businesses
93 or self-employed individuals with guidance and information to
94 determine the best health insurance option for their needs.
95 I promised that I would yield a minute of my time to
96 Congressman Ben Ray Lujan. Is Ben Ray here? Yes, he is. So
97 I am happy to yield to the gentleman from New Mexico for the
98 remaining time.
99 Mr. Lujan. Thank you, Madam Chair. Democrats made a
100 commitment to the American people that we would lower their
101 healthcare costs, and with their support we are now in the
102 majority. It is the expectation of the American people that we
103 move forward in a bipartisan way to address this major issue.
104 Ms. Craig's and Mr. Peters' bill is strong. In fact, the bill
105 is modeled after the reinsurance program that made its debut in
106 the Republican repeal effort.

107 Now what I am concerned about is what we will hear today
108 is that congressional Republicans are more focused on
109 interjecting an abortion fight into an unrelated debate, that
110 they are making sure families can't see their doctors. I do not
111 understand that, but what I do know is the Democrats are going
112 to forge ahead in our goal to lower healthcare costs for the
113 American people.
114 I am ready and willing to work with my colleagues across
115 the aisle when they want to join forward in this progress. I
116 thank the chair and I yield back. Ms. Eshoo. I thank the
117 gentleman.
118 The chair now recognizes Dr. Burgess, the ranking member
119 of the subcommittee for 5 minutes for his opening statement.
120 Mr. Burgess. Well, thank you for the recognition and thanks
121 to our witnesses. Today we are convened to discuss, according
122 to the title of this hearing, Legislation to Lower Consumer Costs
123 and Expand Access to health care. Legislation that my friends
124 on the other side of the dais have put forth today is once again
125 disappointing. I do believe there are some areas where we could
126 have worked together, particularly on the area of reinsurance,
127 but there was no effort to work in a bipartisan way on that issue.
128 Republicans have supported reinsurance when coupled with
129 additional structural reforms to improve healthcare markets and

130 have led efforts to establish a patient and state stability fund
131 to provide states with the funding and the flexibility that they
132 need to successfully set up and implement cost reduction programs.
133 While I see that much of this language may be similar to
134 that which we have supported before, there are some critical
135 provisions that are missing from the text. The benefits of a
136 smart and thorough reinsurance policy would allow states to repair
137 markets damaged by the Affordable Care Act while honoring
138 federalism. Unfortunately, the bill before us today is
139 particularly restrictive and does not provide states with
140 adequate flexibility to use those funds. It also fails to include
141 critical and longstanding Hyde protections.
142 I have introduced H.R. 1510. It includes a responsible
143 reinsurance policy that enables states to use funds for a wide
144 variety of initiatives from helping high-risk individuals to
145 enrolling in coverage to promoting access to preventive services,
146 providing maternity coverage and newborn care. It is important
147 to mention that this bill would also provide Hyde protections.
148 Next, I would like to turn to the issue of navigators. As
149 a physician, as a member of Congress, and just your average simple
150 country doctor, I like to base my decisions on evidence-based
151 research. I found it interesting as I read the Democrats' memo
152 that they are trying to sell us this legislation to increase

153 funding for navigators without outlining the impact that
154 navigators have had in enrolling individuals.
155 Navigators are not a new phenomenon. We have sufficient
156 data to show that they have been only minimally effective,
157 spending 36 million in 2018, prior to that 63 million, all to
158 enroll less than one percent of the fee-for-service market.
159 However, CMS data shows that agents and brokers have helped 42
160 percent of fee-for-service enrollment plan for 2018,
161 substantially more cost effective than navigators. The agents
162 and brokers cost $2.40 per enrollee.
163 The final bill before us today would provide $200 million
164 to create state exchanges, which is another effort that has proven
165 to be astonishingly efficient in wasting taxpayer dollars.
166 Seventeen states have spent a total of four and a half billion
167 dollars to establish exchanges, many of which have failed. The
168 Subcommittee on Oversight under Chairman Upton found that the
169 CMS was not confident that the remaining state-based exchanges
170 would be sustainable in the long term. Additionally, it found
171 that only one state had complied with the Affordable Care Act's
172 requirement that all state-based exchanges publicly publish costs
173 related to its operations.
174 Again it is disappointing that not only none of these bills
175 adequately address the affordability of health insurance, I am

176 disappointed that there was only a minimal attempt to work on
177 the reinsurance and no attempt to even discuss the other two bills.
178 Bipartisanship means asking for my input, not just my vote.
179 If you had asked for my input I would have suggested that
180 we look at language like I have introduced in H.R. 1510, a bill
181 that includes reinsurance coupled with structural reforms to the
182 Affordable Care Act, gives states more choice on how to repair
183 their markets that have been damaged by Obamacare, and the
184 legislation is, in fact, fully offset by stopping bad actors from
185 gaming the system, and includes language that affirms the
186 longstanding consensus that taxpayers should not foot the bill
187 for abortions.
188 I thank the gentlelady for the time and I yield back.
189 Ms. Eshoo. I thank the ranking member.
190 Now it is my pleasure to recognize the chairman of the full
191 committee, Mr. Pallone, for 5 minutes.
192 The Chairman. Thank you, Madam Chair. The bills we are
193 considering today reflect Democrats' continued commitment to
194 deliver on our promise to make health care more affordable and
195 accessible to all Americans and to reverse the Trump
196 administration's sabotage of the Affordable Care Act. This
197 legislative hearing comes several weeks after we held another
198 legislative hearing on bills that were important first steps in

199 lowering healthcare costs and protecting consumers with
200 pre-existing conditions.
201 Today we will be discussing three more bills that will reduce
202 consumers' costs and improve access to care. And one way to
203 ensure that people have access to health care is to provide them
204 the support and information they need to make the right decision.
205 So we will be discussing a bill introduced by Ms. Castor that
206 would reverse the Trump administration's harmful cuts to the
207 navigator program.
208 The Trump administration has gutted funding for the
209 navigator program by over 80 percent, leaving huge swathes of
210 the country without access to fair and unbiased enrollment help.
211 We should restore this critical funding and ensure that
212 navigators can provide fair and impartial information on people's
213 enrollment and financial assistance options.
214 We also have to look at providing states another round of
215 funding to establish state-based marketplaces. The SAVE Act was
216 introduced by Representatives Andy Kim and Brian Fitzpatrick.
217 As you may recall, some state legislatures who wanted to
218 establish state-based marketplaces were unable to do so due to
219 the opposition of the Republican governors. In my state of New
220 Jersey, former Governor Chris Christie, in 2012, vetoed a bill
221 to establish a state-based marketplace for the residents of New

222 Jersey.

223 While all states have been negatively affected by the Trump
224 administration's sabotage of the ACA, state-based marketplaces
225 have been better able to weather these storms. In 2018, premiums
226 in these marketplaces were 17 percent lower than in the
227 federally-facilitated marketplace, and enrollment in these
228 states has outpaced enrollment in the federally-facilitated
229 marketplace states. The state-based exchanges framework also
230 gives states the opportunity to tailor the program to meet the
231 needs of their state residents and the bill provides us another
232 opportunity to make health care more affordable.

233 And, finally, we will consider a bill introduced by Ms. Craig
234 and Mr. Peters to provide 10 billion in reinsurance funding for
235 states that set up their own reinsurance programs. States may
236 also use this funding to provide financial assistance to help
237 lower premiums and out-of-pocket costs for consumers and beyond
238 the ACA's subsidies. Reinsurance pays for the costs of people
239 with serious medical conditions whose healthcare costs are
240 significantly higher than the average person. This support helps
241 reduce premiums through the individual market, making health care
242 more affordable.

243 Seven states have successfully implemented state-based
244 reinsurance programs through the 1332 waiver program, including

245 my state of New Jersey. These programs have significantly
246 lowered premiums and have had widespread bipartisan support.
247 Now the bill that we are considering today would build upon the
248 success of these programs, but the funding would come from the
249 federal government.
250 I believe that that is the right approach. A sustained
251 federal commitment is needed in order to lower costs for all 50
252 states and the District of Columbia. Like with the Part D
253 program, reinsurance should be a permanent part of the individual
254 market and it should be a federally financed responsibility.
255 Now the bills that Ms. Craig and Mr. Peters have introduced
256 are modeled after the reinsurance program that all the Republicans
257 on this committee supported in the repeal bill of last year.
258 We all agree that Congress must take action to reduce costs for
259 middle class consumers and we all agree that reinsurance is a
260 good thing. And that is why I was disappointed that we were unable
261 to get to bipartisan agreement on reinsurance.
262 My colleagues on the other side of the aisle have made it
263 clear that they will not support any reinsurance bill without
264 Hyde language. There is no reason, in my opinion, to drag
265 Republicans' anti-choice politics into this discussion. There
266 is bipartisan consensus that reinsurance is effective in bringing
267 down costs for middle class consumers. A number of states under

268 Republican leadership such as Maine, Maryland, and Wisconsin,
269 happily took federal money for reinsurance without raising the
270 issue of Hyde and we should take this opportunity to allow states
271 to make health care more affordable for their residents.
272 So I want to yield now, the minute or so left, to Mr. Peters,
273 if I could, Madam Chair.
274 Mr. Peters. Thank you, Mr. Chairman or Chairman Pallone
275 for yielding me time and thanks to Chairwoman Eshoo and Ranking
276 Member Burgess for holding this hearing today.
277 I am grateful to the committee for their consideration of
278 H.R. 1425, the State Health Care Premium Reduction Act, a bill
279 that I recently introduced with Representative Angie Craig. I
280 would also like to thank Reps Schrader, Underwood and Kuster for
281 their early support of the bill.
282 Let's be honest. Stabilizing the individual marketplace
283 may not be a bipartisan priority, but lowering healthcare
284 insurance premiums and reducing out-of-pocket costs for working
285 Americans certainly is. And it is widely acknowledged by both
286 Republicans and Democrats that one of the best ways to lower
287 premiums is to provide adequate federal funding to create state
288 reinsurance programs.
289 H.R. 1425 creates a dedicated stability fund that states
290 can use to lower premiums and out-of-pocket costs for all

291 individuals by defraying the costs of high-cost enrollees. Our
292 bill is expected to lower premiums for individuals by
293 approximately ten percent. So Representative Craig and I look
294 forward to working with both our Republican and Democratic
295 colleagues to provide millions of Americans with swift relief
296 from the rising costs of health care, and I thank you for the
297 time.
298 Ms. Eshoo. I think I would now like to introduce the
299 witnesses that are here today and welcome them and thank them
300 for being willing to share their expertise with us.
301 First, Mr. Peter Lee. I am going to move off of script and
302 say to everyone that Mr. Lee comes from one of the most
303 distinguished families in California and our country. I am going
304 to go way back many, many years. I think it was your -- was it
305 your grandfather that founded -- he was Dr. Lee -- founded the
306 Palo Alto Medical Clinic. He had five sons, all M.D.s, at least
307 -- and a daughter -- well, you are ahead of me -- a daughter that
308 was also a doctor.
309 And out of those five sons, one served in two administrations
310 in the healthcare arena. So Mr. Lee comes to us not only with
311 great genes, but with having implemented the ACA in California.
312 We are really honored to have you here today and thank you for
313 your commitment, unswerving commitment that has traveled through

314 more than one generation of your family. You are a gift to the
315 country.
316 Mr. Wieske, welcome to you. He is the Vice President for
317 State Affairs at the Council for Affordable Health Coverage.
318 Ms. Audrey Morse Gasteier, who is the Chief of Policy and
319 Strategy for the Massachusetts Health Connector, again, thank
320 you.
321 I am going to recognize each witness for 5 minutes for their
322 opening statement. There is a lighting system. The light will
323 be green when it first comes on, then it will be followed by yellow,
324 then you will have 1 minute remaining, so we ask you to stay within
325 the 5 minutes.
326 So I am going to begin with the distinguished Mr. Lee.

327 STATEMENTS OF PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA;
328 J.P. WIESKE, VICE PRESIDENT, STATE AFFAIRS, COUNCIL FOR
329 AFFORDABLE HEALTH COVERAGE; AND, AUDREY MORSE GASTEIER, CHIEF
330 OF POLICY, MASSACHUSETTS HEALTH CONNECTOR
331
332 STATEMENT OF PETER LEE
333 Mr. Lee. Good morning, Chairwoman Eshoo, Ranking Member
334 Burgess, and distinguished members of the subcommittee. I do
335 want to note that as you see I am Mr. Lee, not Doctor, so clearly
336 the gene pool dilutes over time, but I want to very much appreciate
337 your remarks about my family. I serve as the executive director
338 of Covered California and am honored to participate in this
339 hearing to help inform your deliberations.
340 Remarkable progress has been made throughout the country
341 with the Affordable Care Act, but recent federal policy actions
342 are having significant negative effects on millions of Americans.
343 I welcome the fact that today's hearing is about building out
344 and improving the Affordable Care Act which is what we need to
345 focus on.
346 Well, Covered California, for 6 years, has effectively used
347 all the tools of the Affordable Care Act to improve affordability
348 for coverage, promote competition, give choice to consumers, and
349 drive improvements in the delivery system. We have made

350 investments in marketing, in outreach, in navigators, and the
351 results show that we have a 20 percent healthier enrolled
352 population which means our premiums are 20 percent healthier than
353 in the federal marketplace would have if they had our risk mix.
354 We made remarkable progress in California and across the
355 nation, but recent federal policy actions are posing challenges
356 such as the federal elimination of the individual mandate penalty,
357 promotion of limited benefit plans, and significant reductions
358 in marketing and outreach that don't affect California, but affect
359 39 states relying on the federal marketplace. These policies
360 are having the direct effect of raising premiums and pricing
361 millions of Americans out of coverage.
362 Today, California, Massachusetts, and Washington exchanges
363 released an analysis showing a very different story of what
364 happens in states like ours that lean in to support consumers,
365 compared, sadly, to what has happened in consumers served by the
366 federal marketplace. The findings in that report are stark.
367 Since 2014, federal marketplace states have had a cumulative
368 premium increase of over 85 percent. In our three states the
369 increase has been less than half of that. This means that if
370 the federal government had spent roughly -- because of that the
371 federal government spent roughly $35 billion -- $35 billion more
372 in premium tax credits than it would have if their premium

373 increases had matched ours. But the biggest impact has been felt
374 by millions of middle class Americans who get no financial help
375 who have been priced out of coverage.
376 This analysis shows the importance of the mandate penalty
377 also. California and Washington have leaned in to promote
378 insurance. We have good risk mixes. But this last year we saw
379 significant drops in new enrollment. The state of Massachusetts,
380 who you will hear from more today, saw a 31 percent increase in
381 their new enrollment. That is because they had a mandate that
382 predated the Affordable Care Act that is in place today. Their
383 consumers know about it. So while recent federal actions are
384 taking us backwards, I am encouraged that today's hearing focuses
385 on ways to move forward and build on the Affordable Care Act.
386 The first proposal relates to reinsurance to help stabilize
387 markets. Reinsurance can have a profound effect on coverage
388 affordability particularly for middle class Americans who don't
389 qualify for premium subsidies. It would directly benefit them
390 by lowering premiums and creating greater carrier participation
391 that provides market stability to encourage health plans to play.
392 We have 11 carriers in California. Many parts of America have
393 one or two. Reinsurance helps bring plans to the market.
394 Now I would note, state-based reinsurance programs may work
395 for some, but it is not a viable strategy for the vast majority

396 of states. Most states will not come up with state funds to invest
397 in the risk of uncertain federal pass-throughs. H.R. 1425 would
398 not only fund reinsurance but would allow states the option of
399 investing in targeted ways in their states to reduce costs for
400 their consumers. This proposal provides state flexibility,
401 state choice, and would lower premiums across the board.
402 H.R. 1385 would fund states that seek to establish their
403 own marketplaces. Now, Covered California benefited from
404 establishment funds. We got a lot of money to get started. We
405 have paid that off many times over by reducing premiums for
406 Californians. Other states need funds to get set up.
407 The final legislation is to support navigator funding. As
408 you consider this, I would look back at not only the dramatic
409 cuts that we have seen federally, but California has a robust
410 navigator program. That program we have funded at about $6.5
411 million for each of the last 4 years. But you need to consider
412 this program in concert with our broad, $100 million investments
413 in marketing and outreach and our support for over 12,000 licensed
414 insurance agents. All of those should be done. All of those
415 are necessary tools to keep robust enrollment, to keep premiums
416 down by having a healthy risk mix.
417 So I would close by noting that we really are at a pivotal
418 time in health care. To the extent federal policy discussions

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419 can now turn to building on, repairing, fixing, and having the
420 Affordable Care Act work better, we are at a good place for
421 California and for the nation. I look forward to your questions.
422 Thank you very much.
423 [The prepared statement of Mr. Lee follows:]
424
425 **********INSERT 1*********

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426 Ms. Eshoo. Thank you, Mr. Lee, excellent testimony.

427 Now I would like to recognize Mr. Wieske for his 5 minutes

428 of testimony. Welcome and thank you.

429 STATEMENT OF J.P. WIESKE

430

431 Mr. Wieske. Thank you, Chairman Eshoo and Ranking Member
432 Burgess, for the opportunity to testify on the issues surrounding
433 the Affordable Care Act and -- is this better? Sorry.
434 Thank you for the opportunity to testify on the issues
435 surrounding the Affordable Care Act and more specifically the
436 individual health insurance market through the proposed
437 legislation regarding exchanges, reinsurance, and navigators.
438 When I spoke before the committee in February of 2017, I
439 focused on the nature of the individual market. Since that time,
440 little has changed. It has remained a very small market, less
441 than five percent of almost every state's population, dwarfed
442 by employer coverage, Medicaid, and Medicare. In 2019, we have
443 seen a drop from the very sharp rate increases, but premium rates
444 remain too high. Of course the subsidized insurance market
445 consumers have largely been insulated from those rate increases.
446 In some cases, consumers even have the option of choosing no
447 premium Bronze plans due to the issue of Silver loading, a process
448 by which a state allows insurers to apply cost-sharing reduction
449 expenses exclusively to on-exchange plans.
450 The question before the committee is the same as it was in
451 2017. The ACA has done many good things for consumers, but it

452 has also created new problems. So how can we fix this market?
453 I think you can see from my written testimony that we support
454 the same goals. We need to stabilize the insurance market. We
455 need more outreach. We need more states' flexibility and state
456 ownership of the ACA.

457 Please allow me a brief aside. Last November I attended
458 an InsureTech conference. It was filled with innovators from
459 across the globe looking at insurance problems. And I was struck
460 by one --

461 Ms. Eshoo. Excuse me. What was that conference? I didn't
462 get --

463 Mr. Wieske. An InsureTech conference.

464 Ms. Eshoo. InsureTech?

465 Mr. Wieske. InsureTech conference, correct.

466 Ms. Eshoo. I see.

467 Mr. Wieske. InsureTech conference, and I was struck by one
468 presentation in particular. It was from an entrepreneur who had
469 figured out how to provide crop insurance to rural Africa through
470 their non-smart phones. What was fascinating about this is that
471 this innovator had found a way, is unlikely to make any effort
472 and make any money off his effort, but that wasn't the goal.
473 The goal was to provide financial stability to rural farmers in
474 Africa. A financially stable farmer is better able to provide

475 for his family and for his neighbors. The solution did not come
476 from government. It came from a private company looking to solve
477 a problem. Similarly, the goal of reinsurance, exchanges, and
478 navigators is not just to provide money for those programs, but
479 to stabilize the market, encourage consumers to make an informed
480 decision in purchasing health insurance coverage.

481 While I still hope you read my eight pages of testimony,
482 I can encapsulate it this way. CHC has long supported reinsurance
483 and ACA 1332 waivers to improve the markets, including
484 Collins-Nelson and Alexander-Murray efforts in the Senate who
485 recognize that reinsurance doesn't reduce costs directly, it
486 shifts who pays. We addressed the long, hard work of improving
487 risk pools and lowering costs in a letter we recently sent to
488 Senator Alexander which we would be happy to make available to
489 members of the committee.

490 Navigators, again our experience in Wisconsin was that
491 navigator approach didn't have a huge impact. In my written
492 statement I recommend both closer engagement with traditional
493 brokers and agents as well as new technologies to help consumers
494 find coverage. Finally, we recommend going beyond state
495 exchanges to allow private exchanges and web-based alternatives
496 and direct enrollment to connect people with coverage. Again
497 thank you for the opportunity to testify and I will be happy to

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498 answer any questions.

499 [The prepared statement of Mr. Wieske follows:]

500 **********INSERT 2**********

501 Ms. Eshoo. We thank you, especially for not attempting to
502 read eight pages of testimony into the record.
503 Now I would like to recognize Ms. Audrey Morse Gasteier.
504 Am I pronouncing your name correctly?
505 Ms. Gasteier. Gasteier, that is right.
506 Ms. Eshoo. Thank you very much for being here and you are
507 recognized for 5 minutes.

508 STATEMENT OF AUDREY MORSE GASTEIER

509

510 Ms. Gasteier. Thank you. Good morning, Chairwoman Eshoo
511 and Ranking Member Dr. Burgess, and members of the subcommittee.
512 My name is Audrey Gasteier and I serve as Chief of Policy and
513 Strategy at the Massachusetts Health Connector. Thank you for
514 the opportunity to testify today and share perspectives for
515 Massachusetts on expanding coverage and lowering costs.
516 Massachusetts has a unique history of bipartisan health
517 insurance expansion efforts spanning several decades. The
518 advantage of time has given us perspective on what health reform
519 and state marketplaces can look like when given stable regulatory
520 environments and tools to promote affordability and enrollment.
521 This historical view may be useful as the subcommittee builds
522 upon the initial years of ACA implementation.
523 Today Massachusetts enjoys a strong health insurance market
524 and the Health Connector is a high functioning and competitive
525 marketplace with nine carriers and 280,000 enrollees. Three key
526 building blocks have been critical to our market's success.
527 First, one of our most effective tools for promoting affordability
528 is our ConnectorCare program for individuals earning up to three
529 times the poverty level. ConnectorCare provides
530 additional state subsidies in addition to ACA subsidies.

531 Enrollees have access to zero or low-dollar premiums, zero or
532 low-dollar copays, and no deductibles. This level of
533 affordability assistance helps retain widespread enrollment
534 among a population that would otherwise be at higher risk of
535 uninsurance.
536 Second, for decades our market has featured the basic
537 protections consumers have come to expect following the ACA, such
538 as protections for people with pre-existing conditions,
539 guaranteed issue and renewability, community rating and strong
540 standards for minimum medical loss ratios. In addition, our
541 state has its own market rules and coverage standards and engages
542 in robust market monitoring which together results in little room
543 for noncompliant plans, keeping our risk pool stable and our
544 residents in coverage that is there for them when they need it.
545 Further, since 2007, the Commonwealth has had its own
546 individual mandate ensuring that people do not buy coverage only
547 when they expect to need it, driving up premiums for everyone
548 else. Third, the Health Connector has seen firsthand the
549 powerful role that outreach and consumer assistance play in
550 drawing residents into coverage. Outreach is an integral part
551 of successful coverage expansion and an essential component of
552 stable risk pools by drawing healthier risk into the marketplace,
553 improving affordability for all. The Health Connector runs a

554 robust navigator program partnering with 16 organizations with
555 longstanding, trusted presence in their communities. These
556 three building blocks of reform have resulted in a number of
557 successes for our residents. Specifically, Massachusetts has
558 achieved nearly universal coverage with 97 percent of our
559 residents now covered.

560 The Massachusetts Health Connector had the lowest average
561 premiums of any marketplace in the country in 2018 at $385 per
562 member per month before any subsidy was applied. We note for
563 the subcommittee that these lowest-in-the-nation premiums are
564 situated within a state market with robust benefit requirements
565 and protective cost-sharing limits, clarifying that cost savings
566 need not come at the expense of consumer protections.

567 Further, we note that Massachusetts' overall healthcare
568 system is one with relatively high medical costs, illuminating
569 that the marketplace model has the potential of bending the curve
570 for consumers even while the state and nation still have work
571 to do in bringing down the underlying healthcare costs that drive
572 premiums. We support this subcommittee's interest in ensuring
573 that states have resources and tools to foster stability and
574 affordability. We support the proposed state options for
575 further advancing affordability for consumers whether they are
576 low and moderate income, and affordability would be achieved

577 through a state wrap program designed to meet state and local
578 needs or a reinsurance program that could lower premiums across
579 the commercial market helping unsubsidized enrollees as well.
580 Each state's affordability challenges are likely to be unique
581 and it is important for states to have flexibility to address
582 the needs of their populations and market conditions above and
583 beyond the baseline protections of the ACA.
584 With respect to the navigator proposal, the Connector's
585 experience suggests that a robust navigator program is a vital
586 component of ensuring coverage for the populations that need the
587 most help getting insured and that the work they do contributes
588 to the overall stability of the commercial market risk pool.
589 Lastly, the Health Connector recognizes the subcommittee's
590 interest in supporting states that are interested in establishing
591 new state-based marketplaces. The successes Massachusetts has
592 experienced would simply not be possible without a state-based
593 marketplace. Working side by side, day in and day out with market
594 participants, state-based marketplaces can successfully bring
595 the promises of health reform and coverage expansion to life.
596 Thank you again for the opportunity to speak with you today
597 and your interest in hearing about our experiences in
598 Massachusetts. I look forward to working with you and welcome
599 your questions.

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

600 [The prepared statement of Ms. Gasteier follows:]

601

602 **********INSERT 3**********

603 Ms. Eshoo. Thank you very much.

604 Congratulations to each one of you. You did really well
605 with your allocation of 5 minutes.

606 My question of the three of you is we are considering the
607 three bills today, 1386, 1425, and the SAVE Act. Do you all
608 support the three bills? Do you think that they are going to
609 make a difference to reduce costs and allow for more choice and
610 more people being enrolled and being insured with good health
611 insurance policies?

612 Mr. Lee?

613 Mr. Lee. Covered California doesn't take positions on
614 legislation and so I am speaking more to the substance of what
615 is in the bills that may take different forms. I noted in my
616 testimony reinsurance is a valuable tool, reduces premiums and
617 also directly addresses the issue that the individual market will
618 always be more expensive than the rest of the market. Bringing
619 those costs down through reinsurance is a good vehicle.

620 I noted also that navigators provide a vital piece of a
621 broader whole for market --

622 Ms. Eshoo. I do. I think we all agree to that. Yeah.
623 I have learned that people know exactly what their premium costs,
624 but they don't know always what they are buying.

625 Mr. Lee. Right.

626 Ms. Eshoo. And so navigators are so important to assist
627 people and answer the questions that they have.
628 Mr. Wieske?
629 Mr. Wieske. I think I have some concerns with the navigator
630 piece. I mean I think we have seen some value.
631 Ms. Eshoo. Why?
632 Mr. Wieske. We have seen some limited value in the state
633 of Wisconsin related to navigators, so, you know, I think as a
634 program there is some value there. I think it has been much more
635 effective to use agents. I think our understanding is most of
636 the navigators, a lot of the navigators and certified application
637 counselors in the state of Wisconsin actually refer a lot of
638 clients to agents.
639 Ms. Eshoo. What about the rest of the country? You are
640 naming Wisconsin. What about the rest of the country?
641 Mr. Wieske. My impression from other states is that there
642 are some concerns with the navigator program in other states as
643 well.
644 Ms. Eshoo. But it is in and around whether they are licensed
645 agents. Is that what you are referring to?
646 Mr. Wieske. Correct, licensed insurance agents.
647 Ms. Eshoo. Thank you.
648 Ms. Morse Gasteier?

649 Ms. Gasteier. Like Mr. Lee, we don't take positions on
650 specific legislation, but the tools and the concepts I think
651 promoted here are ones that we recognize in our own experience
652 that the availability of navigators' in-person assistance, being
653 a state-based marketplace, and tools like reinsurance are very
654 powerful and evidence-based.
655 Ms. Eshoo. I want to just take a moment and recognize all
656 the white coats that are in the hearing room today. Welcome to
657 you and thank you for your professionalism and what you do for
658 people across the country. I don't know where you are from, but
659 I have no doubt that wherever you are from that you do magnificent
660 work, so thank you. We all want to thank you for that.
661 What of the three of you believe would be the most effective
662 tool in order to create affordability for those that are in the
663 private market and to afford a good health insurance policy?
664 What are the most effective tools? I know you don't want to take
665 a position on legislation, but just maybe spend a minute each
666 telling us what you think is the most effective tool.
667 Mr. Lee. So then I will start and --
668 Ms. Eshoo. The middle class has taken a hit. There is no
669 question in my mind about that. And that is not acceptable for
670 any of us.
671 Mr. Lee. I think that you are absolutely right, Chairwoman,

672 that middle class people who make more than 400 percent of poverty,
673 but that doesn't mean they are rich, have been hit hardest. They
674 don't get federal subsidies. So the two things that could be
675 done, well, there is three things, I think, could be done. Number
676 one is reinsurance. That lowers premiums for everybody. It
677 saves the federal government money, but it saves money for people
678 that over 400 percent of poverty. Second, targeted subsidies.
679 Governor Newsom in California has proposed providing state
680 subsidies and tell the federal government act to get rid of the
681 cliff for people that make from four to six hundred percent of
682 poverty.
683 Ms. Eshoo. Thank you.
684 Mr. Lee. We have people in northern California in your
685 district who are being forced to spend 30 percent of their income
686 to afford insurance. They can't afford it. So directed subsidy
687 -- and the third thing is market and outreach. Health insurance
688 must be sold. You need to remind people, cajole, nudge, those
689 three elements are needed; would make a vital difference.
690 Ms. Eshoo. Mr. Wieske?
691 Thank you, Mr. Lee.
692 Mr. Wieske. I would just add onto the discussion that I
693 think there needs to be some movement to fundamentally improve
694 the risk pool. I think California has indicated they have a good

695 risk pool, Wisconsin on the other hand does not. The average
696 age is much higher than the average ages across the --
697 Ms. Eshoo. Are you from Wisconsin?
698 Mr. Wieske. I am from Wisconsin, yes.
699 Ms. Eshoo. I see.
700 Mr. Wieske. So that is --
701 Ms. Eshoo. What was my first clue? All right.
702 Mr. Wieske. So, and across the country it varies state to
703 state, but it can be very expensive. So changing the dynamics
704 of that risk pool to get more younger folks in is a sort of key.
705 Ms. Eshoo. Healthy people, good mix.
706 Ms. Morse Gasteier?
707 Ms. Gasteier. Thank you. I would agree on reinsurance and
708 keeping risk pools stable and broad and not allowing for the
709 proliferation of plans that will siphon healthier people out of
710 the risk pool. And I think the flip side of that is outreach
711 to the people who because they are price-sensitive and maybe
712 younger, people who don't anticipate having health needs, whether
713 you have tools that promote continuous enrollment or whether you
714 are doing very proactive outreach to those populations to bring
715 them in, I think those can be very powerful tools.
716 In Massachusetts we have also found that applying additional
717 subsidies to lower income individuals can, in fact, incentivize

718 very competitive dynamics for carriers that also bring down costs
719 for unsubsidized enrollees as well, although there is more work
720 to do there.
721 Ms. Eshoo. Thank you very much.
722 The chair now recognizes the ranking member, Dr. Burgess,
723 for his 5 minutes of questioning.
724 Mr. Burgess. Thank you, Chairwoman.
725 And I would also just like to make a general statement to
726 all of the physicians who are in the audience. This is the
727 committee who brought you Cures for the 21st Century, so those
728 tools that you are going to have at your disposal that no
729 generation of doctors has ever known, this is the committee that
730 helped you achieve that goal. This is also the committee that
731 brought you the Affordable Care Act, so there is obviously some
732 good along with the bad. But you all are smart and young and
733 you have got good computers, and I trust that you will help us
734 figure this out.
735 Mr. Lee, let me just ask you on the individual mandates since
736 you referenced it, we had another panel of witnesses here earlier
737 that Mr. Tom Miller from AEI who suggested that zeroing out the
738 penalty for the individual mandate was as a practical matter no
739 significance because no one really paid the penalty in the
740 individual mandate.

741 Do you have a sense of the number of people who paid the
742 individual mandate penalty in California and what the dollars
743 collected were?
744 Mr. Lee. In California, because of the removal of the
745 penalty, we think we have dropped coverage by about 300,000.
746 Mr. Burgess. Prior to the --
747 Mr. Lee. The penalty, paid penalty in the last year we know
748 was about $500 million. So there were people that paid it that
749 did not take insurance, but also it provided that economic nudge
750 to about 300,000 people that the market has dropped and because
751 of that I note last year our premiums went up about nine percent.
752 Half of that increase was health plans pricing for a sicker
753 population because of the drop of people because of the mandate.
754 Mr. Burgess. $500 million and they still have no money to
755 put to their health care and they still get stuck with Silver
756 loading.
757 Mr. Wieske, you have -- and it is really a shame you couldn't
758 read the entirety of your statement into the record. I may just
759 take the time to do that myself. But there is one line here that
760 really caught my attention. And in your discussion of navigators
761 you talk about a number of factors that have contributed including
762 a robust economy, very low unemployment, which should lead to
763 higher rates of employer-based insurance coverage.

764 In the last 2 years we have seen a significant increase in
765 the number of people employed, people coming out of the ranks
766 of long-term unemployed to perhaps having the availability of
767 employer-sponsored insurance. I have not gotten, been able to
768 get the Congressional Budget Office to give us coverage numbers
769 for what would be the result of that increase in employment.
770 Do you have a sense of that?
771 Mr. Wieske. So I don't. Unfortunately there is a
772 significant lag in looking at coverage issues, and with the time
773 and the CBO it is usually about a two-year lag, so it will take
774 some time to figure out.
775 Mr. Burgess. So as if -- and I have a number of questions
776 and I will have to ask for written responses. Also in your written
777 responses, if you have an inclination as to where we might look
778 for that information outside of the CBO if there is any outside
779 group that might have looked at that, I think that would be helpful
780 information for the committee to consider.
781 Let me, because I am going to run out of time, let me ask
782 you, Mr. Wieske -- and I appreciate your testimony here in February
783 of 2017. Many people forget that we actually had hearings before
784 we did our healthcare bill and your testimony on the experience
785 you had on risk pools in Wisconsin was very helpful in crafting
786 that part of the bill that dealt with reinsurance, that plus the

787 Health Affairs article that dealt with the hybrid plans in the
788 state of Maine, the risk pools reinsurance hybrid that came about
789 in that state.
790 So yesterday -- this phenomenon of Silver loading, I mean
791 I get more complaints. Yeah, I get people who are concerned about
792 pre-existing conditions, but the overwhelming number of
793 complaints I get in my office are people who are outside the
794 subsidy window. Phenomenon of Silver loading that affects them,
795 a teacher and a policeman with two children are both in the
796 individual market because of the way insurance is structured in
797 our state for those professions and they don't get any help.
798 They get no subsidy. So the cost of the benchmark Silver plan
799 increases -- what, me worry -- I have a subsidy so my premium
800 didn't go up, but that teacher and policeman now are really, really
801 strapped.
802 So are there ways that this Congress and this administration
803 can increase the options for those Americans?
804 Mr. Wieske. So the Silver loading issue is caused by the
805 cautionary reduction subsidy. It is not paying the cautionary
806 reduction subsidy. There is no budget, federal budget number
807 that was attached, no appropriation, and so that would affect
808 the Silver loading from that standpoint that states, if that were
809 funded then states would not be required to do Silver loading.

810 Mr. Burgess. Let me just ask unanimous consent to include
811 for the record the article from the Kaiser Family Foundation and
812 yesterday's Washington Post, the Daily 202, which referenced how
813 risk pools and reinsurance may actually help this situation, and
814 again urge members to look at H.R. 1510 as a vehicle to achieve
815 that and I will yield back.
816 Ms. Eshoo. I thank the ranking member.
817 Is Mr. Pallone -- no, not here.
818 I now have the pleasure of recognizing the gentlewoman from
819 California, Ms. Matsui.
820 Ms. Matsui. Thank you very much, Chairwoman Eshoo and
821 Ranking Member Burgess, for holding this important hearing, and
822 to our three witnesses for being here with us today. And I am
823 particularly happy to welcome Mr. Lee who is from my home state
824 of California and who I see an awful lot in Sacramento.
825 I was struck by a few things that all our witnesses agree
826 upon. We all agree that the ACA has resulted in numerous positive
827 changes for Americans, consumer protections, expanded access to
828 coverage, and historic lows in the number of uninsured Americans.
829 We also agree there is an opportunity to build on the law, the
830 remaining gaps in coverage, affordability challenges for
831 consumers, and market challenges for insurers.
832 As we heard from Mr. Lee, California has made a significant

833 investment in marketing outreach and enrollment assistance for
834 consumers. A key component of this investment was funding the
835 California's navigators program, which plays an important role
836 in enrolling populations especially underserved populations in
837 health insurance. A new law taking effect this year in California
838 bans the sale of short-term, limited duration insurance in the
839 state. Last month our committee held a hearing on these types
840 of junk insurance plans and learned how consumers can be duped
841 into buying these products without knowing they don't cover
842 pre-existing conditions or certain essential health benefits.
843 Mr. Lee, does California's navigator program help
844 Californians enroll in these types of junk insurance plans?
845 Mr. Lee. Thank you for the question. Absolutely it does
846 not. They cannot. The short-term plans, actually, in
847 California are not allowed as a matter of law and we make sure
848 that our navigators and our certified agents are promoting
849 policies that actually provide good essential benefits.
850 Ms. Matsui. So you don't at all advocate, great.
851 Like California, we have heard about the success of
852 Massachusetts at achieving nearly universal coverage. As we
853 heard from Ms. Morse Gasteier --
854 Ms. Gasteier. Gasteier.
855 Ms. Matsui. -- this happened through strategic

856 investments, outreach, and policy. Ms. Morse Gasteier, in your
857 testimony you note that the Massachusetts Health Connector uses
858 data to better understand and reach individuals without coverage
859 and communities at greater risk of uninsurance. Can you
860 elaborate on how you reach these populations and help them enroll
861 in affordable coverage?
862 Ms. Gasteier. Thank you for the question. We do, we use
863 both national U.S. Census Bureau and local sources of data to
864 understand population and demographic dynamics around
865 populations that have a higher risk of uninsurance and then we
866 use that data to actually select our navigators that we include
867 in our program. We work with 16 navigators and they are
868 strategically selected to help us make inroads in those particular
869 populations. Not just because of their physical presence and
870 their sort of trusted role in the community, but because they
871 have particular tools to overcome the barriers that we think
872 people in those specific populations may be facing, whether it
873 is language barriers or accessibility to in-person assistance.
874 Ms. Matsui. That is wonderful. I am pleased that Covered
875 California -- and we have Mr. Lee here joining us to share in
876 the state's success story. As we heard today, Covered California
877 has been on the front lines of implementing the ACA, serving over
878 3.4 million Californians since 2014, lowering our eligible

879 uninsured rate to three percent, and working to keep our premiums
880 about 20 percent lower than the national average.
881 Mr. Lee, what are the unique characteristics of Covered
882 California that allowed you to steadily increase enrollment and
883 keep costs low and maintain competition?
884 Mr. Lee. Well, first I would note we aren't unique. We
885 were thrilled to do this report jointly with the state of
886 Washington, the state of Massachusetts, other states that have
887 leaned in, have used all the tools --
888 Ms. Matsui. Right.
889 Mr. Lee. -- specific to their state. But I would note
890 it has been number one, focusing on market and outreach. Number
891 two, having common patient-centered benefit designs that when
892 people sign up for our plans whether they pick Kaiser, Blue Shield,
893 or Anthem, they have the same knowledge that when they go to see
894 a doctor there won't be a deductible they need to pay before they
895 see the doctor. That means consumers see the value of insurance.
896 That, and finally I would note we actually focus on the
897 underlying cost of care. We have contractual requirements with
898 our 11 health plans to have them look at the delivery system making
899 sure people get the right care at the right time. Those factors
900 together we think are part of our formula for building what we
901 hope will be success for over the long term.

902 Ms. Matsui. Thank you.

903 Ms. Morse Gasteier, your state has also taken a proactive
904 approach going back to before the ACA. What lessons can you
905 continue to apply from Massachusetts to the federal marketplace?

906 Ms. Gasteier. So I would say that we focused again on trying
907 to bring in healthy, low-risk people into the marketplace by doing
908 data-driven outreach to them and also really work to have a very
909 stable regulatory environment where we keep our eyes on the road
910 in terms of keeping the markets stable. We work really closely
911 with our carriers which is something that we are able to do as
912 a state-based marketplace in being in very close contact with
913 them.

914 And I would just say more broadly in Massachusetts we have
915 had sort of a bipartisan cross-stakeholder support for our health
916 reform and that has continued through the 13-year experience of
917 our coverage expansion efforts which has been critical.

918 Ms. Matsui. Well, thank you very much and --

919 Ms. Eshoo. I thank the gentlewoman. I now would like to
920 recognize the gentleman from Michigan, and a gentleman he is.
921 He is a former chairman of the full committee, Fred Upton.

922 Mr. Upton. Well, thank you, Madam Chair. It is a delight
923 to be here obviously and I appreciate the testimony from our
924 witnesses.

925 Mr. Wieske, I would like to go back to your very beginning
926 of your statement talking about how states could have more
927 flexibility, and to date I would note that 14 states have submitted
928 waivers under section 1332. Eight of the states have active
929 waivers, seven of which are for state reinsurance programs. And
930 I would have to say that it is my understanding that these waivers
931 are budget-neutral to the federal government. Is that correct?
932 Mr. Wieske. That is correct, sir. It is a requirement of
933 the 1332.
934 Mr. Upton. And it is also true that states have demonstrated
935 that they can take steps under section 1332 to stabilize their
936 markets without new federal money? In fact, the pass-through
937 funding or savings generated from those market stabilization
938 programs can be reinvested onto the program further reducing
939 premiums. Is that correct as well?
940 Mr. Wieske. Correct. We use the program in the state of
941 Wisconsin to do exactly that.
942 Mr. Upton. Yeah. Now, Dr. Burgess -- I am sorry he left,
943 but I know he is coming back -- yesterday introduced legislation
944 that would provide additional federal resources for states to
945 establish market stabilization programs. And it is my
946 understanding that that would then incentivize additional premium
947 reductions across the country; is that right?

948 Mr. Wieske. Yeah. I think coming from Wisconsin and seeing
949 it on the front lines, I think states need a lot of flexibility
950 and having a one-size-fits-all program has never sort of worked.
951 Mr. Upton. I would note that CBO previously projected that
952 one of the most effective ways to stretch premium reductions is
953 to have a state option with a federal fallback, which is in a
954 sense what Dr. Burgess said does, or a federal default allowing
955 for states to innovate as they see fit. Would you agree
956 that states should be given choice instead of control when it
957 comes to repairing their markets' damage?
958 Mr. Wieske. Yeah. I think in my experience in Wisconsin
959 as deputy commissioner there, I think it was important for us
960 to have a lot of flexibility and I think a lot of the problems
961 that we face in the ACA would have been made better if we would
962 have had more flexibility in how we implemented it.
963 Mr. Upton. In your experience in Wisconsin, what other
964 states would you highlight are on that same path?
965 Mr. Wieske. So our reinsurance program was copied from
966 Minnesota's almost whole cloth. We made some changes which was
967 moved off of Alaska's. So I think in a lot of cases states are
968 talking to each other. And we talked when I was there, still
969 there, we talked to a number of states about our program as we
970 were going through the development.

971 So I think through the NAIC, National Association of
972 Insurance Commissioners, and other pieces, there is a lot of
973 discussion among states to sort of get commonality and to figure
974 out what the best approaches are and the best approaches are not
975 necessarily the same state to state.
976 Mr. Upton. Great.
977 Yield back, thank you. Thank you, Madam Chair.
978 Ms. Eshoo. I thank the gentleman. I now would like to
979 recognize the gentlewoman from Florida, Ms. Castor.
980 Ms. Castor. Thank you, Chairwoman Eshoo, for scheduling
981 this hearing on how we lower healthcare costs for our neighbors
982 and provide meaningful coverage for American families.
983 I want to start by thanking our hardworking, nonprofit
984 partners who have fought with us for affordable health care over
985 the years and to ensure that independent, unbiased navigators
986 are available to American families, especially Rob Restuccia,
987 the longtime executive director of Community Catalyst, who died
988 over the weekend from pancreatic cancer. Rob was a champion of
989 empowering consumers to fight for better health care and he will
990 be missed.
991 And I want to thank the witnesses. After reading your
992 testimony I was really struck by how difficult it has been for
993 American families to keep up. The Trump administration has

994 really socked it to them. We were making such good progress on
995 lowering the uninsured rate and lowering healthcare costs and
996 now, you know, it is like death by a thousand cuts.
997 Removing the individual mandate and promoting junk insurance
998 plans, a tax on the insurance pool, whittling away the protections
999 for pre-existing conditions just have really socked it to
1000 consumers in their wallet and we want to get back to doing
1001 everything we can to lower healthcare costs for them. The Trump
1002 administration also has slashed funding for our independent,
1003 unbiased navigators who are very effective. Yes, they work in
1004 concert with agents and brokers, but you need them both on the
1005 field. There is just no substitute for that independent,
1006 unbiased advice.
1007 So my bill, H.R. 1386, Expand Navigators' Resources for
1008 Outreach, Learning, and Longevity, the ENROLL Act, will secure
1009 vital services for navigators so that they can continue serving
1010 our neighbors. And I want to thank my colleague Congresswoman
1011 Blunt Rochester along with Representatives Wilson, Crist, and
1012 Murphy for being original cosponsors on this important bill.
1013 Families across the country have been aided by unbiased
1014 navigators to help them determine the best health insurance option
1015 for them. Unfortunately, the Trump administration attacked this
1016 crucial initiative by slashing it by over 80 percent since 2016,

1017 as well as big cuts to outreach and advertising efforts.

1018 So my ENROLL Act will guarantee that navigators remain on
1019 task to ensure that our neighbors understand the financial
1020 assistance and coverage options available to them.
1021 Specifically, the ENROLL Act will fund the navigator initiative
1022 in the federal ACA marketplace at $100 million per year. It will
1023 require HHS to ensure that grants are awarded to organizations
1024 with demonstrated capacity to carry out the duties of a navigator.
1025 It would reinstate the requirement that there be at least two
1026 entities at each state; that they have a physical presence in
1027 the state. Oftentimes, navigators determine that the more
1028 appropriate and affordable option might be the Children's Health
1029 Insurance Program or it might be Medicaid, so it would clarify
1030 that navigators can provide that advice on enrollment.

1031 In Florida we are very fortunate that the University of South
1032 Florida has been the lead navigator and has worked with other
1033 nonprofit partners all across the state and their efforts have
1034 paid great dividends to families across my state. We continue
1035 to lead in the number of enrollees in the healthcare marketplace.

1036 But they have told me this year that those dramatic cuts
1037 had a very serious impact. That they were not able to get out
1038 especially into rural areas to make sure that families understood
1039 what their options were and had the ability to sign up. This

1040 directly impacts affordability for everyone.

1041 And, Ms. Gasteier, could you speak to the importance of a
1042 broad-based insurance pool to lowering costs and the role that
1043 navigators play in that?

1044 Ms. Gasteier. Thank you for the question. We believe in
1045 Massachusetts that we all do better when everybody is in the same
1046 market and the same risk pool with strong comprehensive standards
1047 sort of holding up that market so that people know that the
1048 coverage they have they can count on. And we see outreach as
1049 an effective, proven method for drawing in people who might
1050 otherwise think that they can go out without coverage who may
1051 tend to be younger people.

1052 And so we have found that those efforts are very important
1053 both for those people so they are protected, even though they
1054 may not expect something to happen to them and that we think that
1055 that has been part of why we have been able to keep our premiums
1056 so stable in Massachusetts.

1057 Ms. Castor. And, Mr. Lee, do you agree with that?

1058 Mr. Lee. Very strongly and including in particular your
1059 note that it is not just navigators, it is navigators with agents.
1060 Twelve thousand agents in California, but we have 100 nonprofit
1061 groups we directly fund to fill in the gaps. We target them to
1062 serve areas that are not well served by agents.

1063 Ms. Castor. And that investment helps everyone by lowering
1064 costs; is that correct?
1065 Mr. Lee. Absolutely. We have lower costs in California
1066 because of the effective outreach, and again we use navigators
1067 to target where agents aren't effectively reaching. So it is
1068 not an either-or, agents in California get paid $130 million in
1069 commission payments. It is a lot of money. We pay our navigator
1070 program about 6.5 million. And so, yes, they enroll fewer than
1071 agents, great, but we target them to outreach to Spanish-speaking
1072 communities, African American communities, LGBTQ communities,
1073 rural communities. So that is the role that navigators -- to
1074 pick up the gaps that agents and other outreach isn't addressing
1075 effectively otherwise.
1076 Ms. Castor. Thank you very much. I yield back.
1077 Ms. Eshoo. We thank the gentlewoman for her legislation.
1078 I now would like to recognize Mr. Shimkus, the gentleman
1079 from Illinois and a good friend and my E911 partner and --
1080 Mr. Shimkus. Yes, ma'am.
1081 Ms. Eshoo. -- away we go.
1082 Mr. Shimkus. Thank you, Madam Chairman. This is a great
1083 hearing and I appreciate you all being here.
1084 Mr. Lee, I want to -- and the way I like to do it, I like
1085 to breeze through the testimony, but I like to hear the questions

1086 and answers and I scribble a lot of notes and questions taken
1087 off of -- so you mentioned that because the individual mandate
1088 was not enforced, 300,000 -- is that the right -- 300,000 dropped
1089 off.
1090 And then I think I heard through the other questions is that
1091 California, and I think my colleague Ms. Matsui mentioned
1092 California has a law that says you can't have other than the
1093 standard ACA-type plans. So these 300,000 have no option then,
1094 is that -- I am trying to figure where they -- are they covered
1095 somewhat?
1096 I mean a lot of states have options. I have been through
1097 the whole debate. I was here when we passed. A lot of folks
1098 liked the plan they had, the Congress and the President decided
1099 to change that. So then they got thrown into plans that they
1100 didn't like that was so too costly and the premiums were high
1101 and the deductibles were ridiculously high. And they just begged
1102 for me -- and I have four from just recently in October and November
1103 and December -- to just go back to the plan they had in the past,
1104 a lot of my constituents.
1105 So I am trying to figure out where is the -- does these 300,000
1106 have no coverage?
1107 Mr. Lee. Our understanding is the vast majority go to be
1108 what we call bare. They go without insurance. And again, this

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

1109 happens also in the employer market. About 20 percent of the
1110 people who --
1111 Mr. Shimkus. Yeah, I got that. But wouldn't something be
1112 better than nothing?
1113 Mr. Lee. In many cases not, because the issue about that
1114 something, often that something, a short-term plan may mean that
1115 if they get cancer it is not covered. So often it is faux
1116 coverage. The point of encouraging people to sign up for coverage
1117 that matters is to encourage people to get coverage that will
1118 be there for them when they get sick.
1119 Mr. Shimkus. Right. And we had a hearing earlier as was
1120 identified and I brought up associated health plans as an option
1121 with either associations -- I mean California is a big state,
1122 Illinois still a relatively big state. If our farm bureau decides
1123 to either state-wise to develop a covered pool in associated
1124 health plans that has the same requirements as outlined under
1125 the ACA, does California support association-type health plans?
1126 Mr. Lee. Again I don't speak for the state of California.
1127 What we have done in California as a state though is try to make
1128 sure that the insurance offerings will be there when people need
1129 them. And so examples of, there are products today in California
1130 that are under sharing ministries that mean you buy it and there
1131 is a $250,000 lifetime cap per incident.

1132 Mr. Shimkus. Right, okay. Fine, I got that.

1133 Mr. Lee. And so that is part of the --

1134 Mr. Shimkus. I want to get to another couple questions,
1135 but I would just from my experience in my district is many people
1136 lost insurance that they liked and was thrown into insurance that
1137 they couldn't afford and they couldn't use. And I want to go
1138 to Morse Gasteier for a second, because you mentioned how
1139 Massachusetts really changed the Affordable Care Act in one
1140 interesting provision.

1141 When we had this debate in the legislation, what was mandated
1142 was if you get sick you can immediately buy. And I think I heard
1143 either in your testimony or in response to a question you said
1144 we have changed that. How have you changed that and what did
1145 you do?

1146 Ms. Gasteier. Thank you for the question. I am not sure
1147 we have changed anything. We had our own individual mandate
1148 already in Massachusetts prior to the Affordable Care Act so there
1149 was --

1150 Mr. Shimkus. Can people -- I think one of the problems was
1151 people were if they got sick today they could go buy insurance,
1152 which when you are talking about pools and people buying in that
1153 escalates costs.

1154 Ms. Gasteier. It does. So we have always used open

1155 enrollment periods to try to make sure that people are not sort
1156 of, quote unquote, jumping and dumping and coming in and out of
1157 coverage just when they get sick or think they may need an expense.
1158 And we have found that having tools like that in the market where
1159 there is sort of an expectation that everybody is always in the
1160 pool has helped keep --
1161 Mr. Shimkus. So I may have misunderstood that response to
1162 your question.
1163 Ms. Gasteier. That is fine.
1164 Mr. Shimkus. So then I apologize. That is what I wanted
1165 to ask.
1166 Mr. Wieske, this Silver loading -- no. I don't want to ask
1167 that question. I want to ask, do you have empirical data on the
1168 benefits or the lack of benefits that you have seen in that
1169 navigator population? I am a big dealer and broker, folks. I
1170 understand spreading it out. But, really, the question is
1171 cost-benefit analysis and are they really delivering for what
1172 versus kind of what we hear?
1173 Mr. Wieske. There may be a difference between states that
1174 have an exchange and can control their navigator programs and
1175 states that don't. What we saw as a problem in Wisconsin is we
1176 never knew what was going on with navigators despite requirements
1177 for licenses, despite requirements for CAC licenses and

1178 registration of assisters.

1179 We had numerous occasions where we had to investigate
1180 navigators who we later found out in some cases were and in other
1181 cases were not navigators, were holding this out. So it was a
1182 little bit confusing for us despite the fact that we had some
1183 regulatory authority.

1184 Mr. Shimkus. Thank you, Madam Chairman, appreciate the
1185 time.

1186 Ms. Eshoo. Thank you, Mr. Shimkus.

1187 I have to excuse myself from the hearing for a bit, but
1188 certainly all the doctors in the audience will be pleased to know
1189 that we have M.D.s on both sides of the aisle. And so Dr. Raul
1190 Ruiz is going to take this chair.

1191 Mr. Ruiz. [Presiding.] And with that I would like to
1192 recognize Congressman Schrader from Oregon for 5 minutes.

1193 Mr. Schrader. Thank you very much, Mr. Chairman. I
1194 appreciate the hearing today. It is a great hearing, actually,
1195 indicative of hopefully where this Congress is going to go in
1196 terms of fixing some of the problems, a few of the problems with
1197 the ACA and recognize that it serves a great deal of value for
1198 a lot of folks.

1199 And I am a proud cosponsor of 1425. It is probably the single
1200 most important thing we can do to help stabilize the individual

1201 marketplace which, based on the Republicans' work in the last
1202 Congress, would be a goal of theirs as well as a goal of Democrats,
1203 so a nice area of bipartisanship.
1204 I wanted to also note that earlier this week I led a letter
1205 with 76 other of my colleagues from the New Democrat Coalition
1206 -- Chairman Pallone, Chairman Scott, and Chairman Neal -- making
1207 it a priority for this Congress to bring down costs and make sure
1208 that health care is affordable to everybody through the Affordable
1209 Care Act, which as I said went a long way to getting us there.
1210 So I would like to ask consent, unanimous consent that we
1211 can enter that letter into the record.
1212 Mr. Ruiz. So ordered.
1213 [The information follows:]
1214
1215 **********COMMITTEE INSERT 4**********

1216 Mr. Schrader. Okay. Thank you, Mr. Ruiz, Dr. Ruiz.

1217 I would also like to note for the record that Blue Cross
1218 Blue Shield is also a big supporter of 1425 because they recognize
1219 the value of reinsurance also.

1220 I guess a basic question for Mr. Lee, a number of states
1221 pointed out by the ranking member and others have established
1222 their own reinsurance programs through the 1332 waivers, which
1223 I think is a great thing, everyone has testified, and I think
1224 everyone here acknowledges is a great opportunity for states to
1225 innovate, you know, not a one-size-fits-all.

1226 But there are probably some limitations and some
1227 opportunities that a federal reinsurance program or high risk
1228 pool type of thing could offer. Could you talk a little bit about
1229 how that might relate to what some of the states who are already
1230 doing some reinsurance programs and how it might help them?

1231 Mr. Lee. Yeah, I would be happy to, thank you. So first,
1232 as you note, seven states have done the state-based reinsurance,
1233 but they range in what the federal government has matched to a
1234 low of 30 percent, meaning the state had to come up with 70 percent
1235 of the dollars, other states got a hundred percent, others 70.
1236 And most states are struggling with their own state budgets,
1237 so that is one uncertainty. The other thing I would flag is
1238 the 1332 provisions, as was noted earlier must be deficit-neutral.

1239 Now I understand the importance of deficit neutrality, but that
1240 actually means a state that uses a program and enrolls more people
1241 is hit because enrolling more people will affect the deficit.
1242 The goal of the Affordable Care Act should be to get more people
1243 covered.
1244 And that is one of the reforms I think that isn't on the
1245 table, but in thinking about to use a 1332 waiver mechanism that
1246 in essence punishes a state for getting more people insured is
1247 a bad mechanism. So those are two problems.
1248 The other is -- and I want to really appreciate the
1249 thoughtfulness in your legislation -- is some states will say
1250 reinsurance, reinsurance if we use California by the formulas
1251 in your bill would reduce premiums by about seven percent. That
1252 is a lot. But it might be better invested to target those people
1253 just from four to six hundred and your allowing a state the
1254 flexibility to do that I think gives state flexibility, which
1255 is exactly what many states like California would look to do.
1256 Mr. Schrader. Thank you very much for the response and I
1257 agree. I mean there is a nice synergy here between the federal
1258 government supporting some of these programs in a thoughtful way
1259 and enabling the states to use it in a flexible manner that best
1260 serves their needs. That was the genesis of the work that the
1261 New Democrats did with their solutions over politics in the last

1262 Congress. It is the genesis of the bipartisan legislation came
1263 out of the Problem Solvers Caucus. It included reinsurance, had
1264 the cost sharing subsidies, and expanded exactly what you are
1265 talking about, the 1332 waivers.
1266 But it kept the essential benefits package that you guys
1267 have also acknowledged is critical so that consumers aren't being
1268 deceived. And the more people you get into the marketplace, the
1269 more the risk is shared, the less cost shifting that goes onto
1270 these individual marketplace people that are suffering, if you
1271 will, under these premium/deductible increases while other people
1272 are benefiting.
1273 The last comment I would make real quick is to the Hyde
1274 language. I mean I really hope that my colleagues on the other
1275 side of the aisle are willing to move past that. I would point
1276 out that in our previous legislation, whether it was the ACA or
1277 the Problem Solvers one, we did not try and get rid of the Hyde
1278 Amendment, you know, that has been a longstanding agreement, or
1279 by both sides of the aisle. We recognize people have different
1280 faith-based concepts and support that.
1281 I think it is a little unfortunate that some of our colleagues
1282 on the other side of the aisle are trying to, you know, prevent
1283 states from using their own funds or nonprofits' funds or
1284 individuals' funds in the arena of family choice. That is unfair.

1285 That is an expansion of the Hyde Amendment that I think makes
1286 fixing the Affordable Care Act and fixing the marketplace, getting
1287 at the pre-existing condition thing a real problem. And I yield
1288 back. Thank you.
1289 Mr. Ruiz. Next is Congressman Guthrie.
1290 Mr. Guthrie. Thank you very much. Thanks, Chairman, for
1291 yielding. I appreciate the opportunity and all of you to be here
1292 today.
1293 I want to focus on the background of the state-based
1294 marketplaces. The state-based marketplace grants were awarded
1295 between 2010 and 2015 in compliance with the law. No planning
1296 or establishment grants could be awarded after December 31st,
1297 2014. I think we all agree with that. In all, CMS awarded over
1298 five and a half billion to 49 states, the District of Columbia,
1299 and four territories for the purpose of planning and establishing
1300 health insurance exchanges.
1301 The available money was unlimited, the amount of money was
1302 unlimited, and in definite authorization and appropriation the
1303 five and a half billion included grants for exchange planning,
1304 exchange establishment, early innovators and administrative
1305 supplements to any of these grants. Every state except Alaska
1306 applied for these grants.
1307 Florida and Louisiana were awarded planning grants but later

1308 returned their entire grants. Other states returned some of the
1309 money they received but kept some. For 2018 planning year, 34
1310 states had federally-facilitated marketplaces, 12 states had
1311 state-based marketplaces, and 5 states had state-based
1312 marketplaces using the federal platform.
1313 So in all, 17 states have 12 based marketplaces or
1314 state-based marketplace that uses the federal platform. Those
1315 17 states accounted for roughly 4.5 billion of the five and a
1316 half billion, but only 12 states had their own state-based
1317 marketplace. So in summary, of the five and a half billion
1318 dollars awarded in grants, 12 states have exchanges. So, Mr.
1319 Wieske, when you with Wisconsin's insurance department -- and
1320 this gets -- I think you talked about some innovative things you
1321 wanted to do when Congressman Upton asked you questions. But
1322 my question is, when you were with Wisconsin's insurance
1323 department, if you were given a slice, your slice of the 5.5
1324 billion without all the mandates that came with it, what creative
1325 and efficient ways would you choose to utilize federal dollars?
1326 Mr. Wieske. We actually started going down that path at
1327 one point and we actually are one of the states that returned
1328 the money. What we found was there was some lack of flexibility
1329 in the ability for us to design the exchange and it was going
1330 to be very expensive. And let me be more specific. We were

1331 looking for a single-door entry into both our Medicaid and our
1332 state system. We were looking a variety of other pieces to make
1333 it easier for consumers. Unfortunately, the requirements that
1334 the federal government had in place made it impossible for us
1335 to continue and we ended up dropping off of that.
1336 So I think at that time we were looking at a single-door
1337 entry, I just didn't think we under the federal rules think it
1338 was possible. On top of that, the cost of doing it for a smaller
1339 population in a state like Wisconsin where there is about 200,000
1340 people enrolled in the exchange, if you look at $20 million a
1341 year to spend that is $100 a person, $100 a person to be able
1342 to afford the exchange. That is a very expensive fee on top of
1343 what the overall costs were. So the risks were very high for
1344 us as well.
1345 Mr. Guthrie. Thanks. When we were debating the Affordable
1346 Care Act and repeal and replacement of it, Wisconsin came to the
1347 forefront in pre-existing condition coverage and a lot of debate
1348 here was talked about what Wisconsin did and how people who had,
1349 particularly cancer survivors and so forth, had better coverage
1350 under the Wisconsin pre-ACA model than after the mandate, after
1351 the ACA. Would you kind of talk about what you guys did for
1352 pre-existing conditions?
1353 Mr. Wieske. Yeah. I think the important message here, I

1354 think, from a state perspective is that states have an interest
1355 in insuring their residents as well. I think both, you know,
1356 everybody here at the table understands that and believes that.
1357 And Wisconsin actually had a very comprehensive high-risk pool.
1358 You could see any doctor in the state. We subsidized that
1359 high-risk pool. It was expensive, make no mistake. It was more
1360 expensive than standard coverage because we didn't subsidize it,
1361 so there should have been pieces that -- there were pieces that
1362 could have been improved upon.

1363 But I think we still have some folks who have an interest
1364 in going back to that. However, moving forward, you know, it
1365 is clear that the ACA has provided some subsidies for folks who
1366 had affordability issues in that market as well. So, you know,
1367 Wisconsin could have done a bit more if they had more flexibility.

1368 Mr. Guthrie. Thank you.

1369 And, Ms. Morse Gasteier, you talked about continuous
1370 coverage and tools for ensuring continuous coverage. I
1371 understand the open enrollment gives an incentive. Is there
1372 other tools that you would suggest? I mean just in open
1373 enrollment if I have guaranteed issue and I don't sign up and
1374 then I get sick, then I can buy health insurance coverage when
1375 open enrollment comes again. I get you are in it for the interim.
1376 Is there other tools that you would suggest to be able to do?

1377 Ms. Gasteier. Thank you for the question. I think we take
1378 the allure of affordability very seriously in Massachusetts and
1379 have tried to construct a very competitive marketplace that in
1380 addition to those tools incentivizing people to keep continuous
1381 coverage we see as drawing people into the ranks of the insured
1382 through our exchange which covers 280,000 people now. And I have
1383 noted some of the policy features of the way we have approached
1384 our subsidized program also has benefits for unsubsidized
1385 individuals as well who also have access to these lowest in the
1386 nation premiums.
1387 So we see all those tools as working together, those
1388 incentives through our individual mandate to incentivize coverage
1389 as well as making sure affordability is of paramount significance
1390 and presence for people in our market.
1391 Mr. Guthrie. Well, thank you. My time has expired and I
1392 yield back.
1393 Mr. Ruiz. Thank you.
1394 Representative Kuster, you have 5 minutes.
1395 Ms. Kuster. Thank you very much. And thank you to our panel
1396 for being with us. I want to start by associating myself with
1397 the remarks of Representative Schrader. I think we do have
1398 options to shore up the Affordable Care Act and they are bipartisan
1399 and we should work together to get that done. I am very concerned

1400 about the efforts of this administration to sabotage the
1401 Affordable Care Act, and I do agree that some of our colleagues
1402 on the other side of the aisle are trying to throw, really, a
1403 monkey wrench in terms of the status quo of the Hyde Amendment
1404 and trying to disrupt our ability to provide health insurance
1405 for all Americans.
1406 I want to talk about H.R. 1425, the reinsurance bill, and
1407 I am a proud supporter cosponsor with my colleagues Angie Craig
1408 and Scott Peters. Why would a state, and I will direct this,
1409 Mr. Lee, at you, why would a state seek to develop its own
1410 reinsurance program if there was a federal reinsurance? That
1411 is a place to start.
1412 Mr. Lee. A really good question, I think, that a state
1413 wouldn't. If the mechanism was reinsurance they would probably
1414 go with a federal administration. The issue is if
1415 proportionately a state could get the same amount of funds that
1416 would have been used for reinsurance and instead target it in
1417 a different way, states might do that.
1418 I gave the example of our Governor Newsom has said we want
1419 to bring back a penalty and expand subsidies, targeting people
1420 right above the cliff. We have working middle class Americans;
1421 I am sure, in New Hampshire as well in California that really
1422 need help. Reinsurance lowers costs for everybody, saves the

1423 federal government a lot of money, but it may make a state, for
1424 a particular state to say we want to target particular
1425 populations, but it would not make sense to me. I can't imagine
1426 a state that would take the money and just do reinsurance.
1427 Ms. Kuster. And I agree with you we want to target that.
1428 I was visiting with a hospital the other day that has dropped
1429 the uninsured population showing up at their hospital from nine
1430 percent down to three percent, but it is how to get at that three
1431 percent, the working low-income people and younger people,
1432 honestly.
1433 You mentioned the increased riskiness of the individual
1434 market making reinsurance a tool to control costs. Is there a
1435 point at which the market becomes too risky for even reinsurance
1436 to work -- and again back to the sabotage by this administration
1437 -- making these markets unstable?
1438 Mr. Lee. I think there is. I am not sure what it is, but
1439 you look at it again -- Massachusetts, California, Washington,
1440 other states with state-based marketplaces -- we have maintained
1441 enrollment over the last years. Federal marketplace states have
1442 seen mammoth drops in new enrollment. Many of those states have
1443 seen premiums rise so high that people without subsidies are
1444 largely only sick people because healthy people have been priced
1445 out entirely.

1446 Reinsurance would help. I don't think in many of those
1447 states it would help enough. A seven percent reduction in
1448 premiums when those states have seen an 85 percent premium
1449 increase in the last 5 years is good, but is it enough, probably
1450 not. And so I think one of the challenges, it is reinsurance
1451 is a tool, but it needs to be part of a broader issue of doing
1452 outreach, doing outreach, a whole range of things that in much
1453 of the nation is not currently happening.

1454 Ms. Kuster. And I want to get out the sabotage again because
1455 they have created a catch-22. This administration is sabotaging
1456 the Affordable Care Act and then turning around and saying rates
1457 have gone up. But you mentioned the proliferation of junk health
1458 plans and other efforts by the Trump administration to sabotage.

1459 Are you concerned that the efforts of this administration
1460 over the last year may push these markets past a tipping point,
1461 and again tying into your comment about how reinsurance can be
1462 helpful?

1463 Mr. Lee. Well, I think absolutely encouraging healthy
1464 people to buy products that look cheap but might not be there
1465 for them when they get sick both is risky for those individuals
1466 that buy the products and damages the risk pool, raises costs
1467 for everybody. I do think -- I am not sure what a tipping point
1468 is, because while we continue to have the subsidies people that

1469 get subsidies will always have a market. The only problem is
1470 without doing marketing they won't even know it is there.
1471 Ms. Kuster. And I do have legislation around the 1332
1472 waivers that to try to keep us from reaching that point.
1473 Ms. Morse Gasteier, as a New Hampshire neighbor to
1474 Massachusetts I am especially interested, why didn't
1475 Massachusetts seek a 1332 waiver for reinsurance?
1476 Ms. Gasteier. It is something we have looked at.
1477 Massachusetts, you know, looks at different options for
1478 flexibility and if we find opportunities that can help our market
1479 in terms of affordability and stability, you know, we are
1480 interested in those so long as they don't, you know, deteriorate
1481 any of the important market conditions or consumer protections
1482 that we have long held as critically important.
1483 Our market right now is largely stable. We will continue
1484 to look at opportunities for reinsurance. But as Mr. Lee noted,
1485 it does require at present a lot of state resources to invest
1486 in these 1332 waivers. So it is something we will continue to
1487 look at, but to date hasn't struck us as compelling for our market.
1488 Ms. Kuster. Well, and hopefully if we can get this
1489 bipartisan legislation passed you will have that option, so thank
1490 you.
1491 I yield back, Mr. Chair.

1492 Mr. Ruiz. Thank you.

1493 Now Representative Griffith, you have 5 minutes.

1494 Mr. Griffith. Thank you very much, Mr. Chairman. I do
1495 appreciate it. This committee had significant concerns about
1496 and accordingly extensively studied the navigators program in
1497 the previous administration. And I would like to introduce into
1498 the record the following letters sent by the committee in 2013:
1499 an April 12, 2013 letter to Secretary of HHS Kathleen Sebelius;
1500 a June 28, 2013 letter to then-Secretary of HHS Kathleen Sebelius;
1501 an August 29, 2013 letter sent to 51 grant recipients in 11 states
1502 that received 61 percent of navigator dollars at the time and
1503 a list of those grant recipients who received the letter; and
1504 a September 20th, 2013 letter to then-Deputy Administrator and
1505 Director of the Center for Consumer Information and Insurance
1506 Oversight, CCIIO, at CMS, Gary Cohen.

1507 May that be admitted, without objection?

1508 Mr. Ruiz. So ordered.

1509 [The information follows:]

1510

1511 **********COMMITTEE INSERT 5**********

1512 Mr. Griffith. During plan year 2017, navigators received
1513 more than $62 million in grants and enrolled only 81,426
1514 individuals, less than one percent of the total enrollees but
1515 at a cost of over $750 per person. By contrast, agents and brokers
1516 assisted with 42 percent of federally-facilitated exchange
1517 enrollment for the plan year 2018, which cost the FFE only $2.40
1518 per person or per enrollee to provide technical and training
1519 assistance.
1520 So, Mr. Wieske, I have questions about whether we should,
1521 you know, be putting more good money after bad results. H.R.
1522 1386 would redirect a hundred million annually to the failed
1523 navigator program. Based on your experience in Wisconsin, can
1524 you speak to whether the navigator program was a good investment
1525 for taxpayers there?
1526 Mr. Wieske. Look, what we saw in the state is if you look
1527 at the other lines of insurance they have moved away from sort
1528 of the face-to-face. They have moved into different methods to
1529 get customers. And while navigators have some value, certainly,
1530 in certain populations, I don't think we had a feeling that they
1531 had a strong presence in our rural communities that were also
1532 largely uninsured and in other spots. So, you know, we felt that
1533 agents were much more effective and that there were other methods
1534 to encourage enrollment.

1535 Mr. Griffith. Thank you. During your time as deputy
1536 insurance commissioner of Wisconsin, did Wisconsin experience
1537 any fraud, waste, or abuse within the navigator program?
1538 Mr. Wieske. So we had a number of cases that we had to
1539 investigate. Mostly people who were posing as navigators who
1540 were not, in fact, navigators, that had problems. We didn't
1541 actually have any problems, we had a --
1542 Mr. Griffith. So you didn't have any problems with the real
1543 navigators, it was with the fake navigators.
1544 Mr. Wieske. Real navigators. We had problems with fake
1545 navigators, correct.
1546 Mr. Griffith. All right. And based on your experience with
1547 the navigator program, do you believe that redirecting a hundred
1548 million annually to the navigator program as H.R. 1386 intends
1549 to do would be a wise investment for the taxpayer?
1550 Mr. Wieske. I think we are hoping to encourage more
1551 flexibility in the way consumers can sign up for coverage, should
1552 get them where they actually buy coverage today.
1553 Mr. Griffith. All right, I appreciate that. I did think
1554 it was interesting to note that several of my colleagues have
1555 talked about the cost of the insurance. Mr. Lee spoke about 85
1556 percent in most of the federal markets, the price has gone up
1557 in the states that have their own markets that is less than half

1558 of that about 39 percent, in his written testimony, and that this
1559 really affects the middle class family, the average family that
1560 are above that 400 percent of poverty level rate.
1561 What is interesting about that is that when this plan was
1562 being discussed, and it is one of the things that we have to look
1563 at when we are looking at the new promises to lower rates, people
1564 of my district were promised -- that the President came to the
1565 district when he was campaigning and said he was going to reduce
1566 the average cost of health care for the average family by $2,500
1567 a year.
1568 And now we are talking about if we pass new bills we might
1569 get a seven percent reduction in an 85 percent increase. Clearly
1570 we are not anywhere near the goals that this plan promised and
1571 we are experiencing -- and my constituents complain all the time.
1572 And so I appreciate you mentioning that, Mr. Lee. You know,
1573 their copays have gone up, their out-of-pockets have gone up,
1574 and their insurance premiums have gone up and they have just been
1575 hit hard and it is a whole lot more expensive than what they were
1576 facing before Obamacare.
1577 Hopefully we can find some bipartisan resolutions to bring
1578 down these costs, but I don't think that it can ever get to that
1579 point where the families actually see, average American family
1580 sees a reduction under Obamacare, as he promised at Virginia High

1581 School in my district, a $2,500 decrease. I yield back.

1582 Mr. Ruiz. Ms. Kelly, you have 5 minutes.

1583 Ms. Kelly. Thank you, Mr. Chair, and thank you all for your

1584 testimony today. Since the Affordable Care Act's passage,

1585 approximately 20 million Americans have gained health coverage

1586 through the laws' various coverage protections. An additional

1587 nine million low and moderate income Americans receive health

1588 insurance subsidies that help them pay for health care. In 2019,

1589 more than 7 in 10 consumers on the ACA marketplaces can get

1590 coverage for $75 or less per month after tax credits. These tax

1591 credits make health care affordable for millions of Americans.

1592 Ms. Morse Gasteier, thank you for your testimony today.

1593 You discussed Massachusetts' subsidy program known as

1594 ConnectorCare which supplements ACA subsidies and helps your

1595 state's residents pay for health care. You briefly mentioned

1596 how the program benefits consumers who are not eligible for

1597 subsidies. Can you describe how the program helps lower premiums

1598 for all enrollees in your state?

1599 Ms. Gasteier. Absolutely. Thank you for the question.

1600 So our program ConnectorCare provides subsidies, extra state

1601 subsidies on top of Affordable Care Act subsidies and further

1602 brings down the cost of premiums and cost sharing for individuals

1603 up to 300 percent of the federal poverty level. And those

1604 products that become available through that program are built
1605 on top of a commercial Silver market tier plan. And what the
1606 structure of the program does is it strongly incentivizes
1607 participating carriers to lower premiums to compete to be in that
1608 program because they show up to as the lowest cost plan and they
1609 get a lot of enrollment by being very cost-competitive. The
1610 benefit for unsubsidized individuals is those low base Silver
1611 plans then become available to unsubsidized enrollees as well.
1612 And in Massachusetts we also have small businesses in the
1613 same risk pool, so small businesses also benefit from those lower
1614 premiums that carriers are competing to get the attention of price
1615 competitive shoppers with. So that is one of the ways the program
1616 itself is helpful both to those low income enrollees who are
1617 enrolled in the program as well as middle class unsubsidized
1618 enrollees as well and small businesses too.
1619 Ms. Kelly. Thank you. For other states that are looking
1620 at this what are some of the challenges that they might face?
1621 Ms. Gasteier. So of course coming up with the funding to
1622 create those state wrap dollars is critical, so I would think
1623 if another state were pursuing something like this that would
1624 be sort of priority one for them to determine how to finance that.
1625 We, I think are very advantaged by being a state-based
1626 marketplace. In administering something like this we are able

1627 to aggregate all the different funding streams, the federal
1628 subsidies, the state subsidies, the enrollee contributions and
1629 we are able to do that by doing premium aggregation which is a
1630 benefit of being a state-based exchange.

1631 And so states that are pursuing things like this would need
1632 to think about the mechanics of how it all works together and
1633 we would certainly be happy to provide technical assistance to
1634 any state interested in that. But I would say resources are the
1635 top order issue for a state pursuing something like this.

1636 Ms. Kelly. And just share how you did come up with the
1637 resources and just -- okay.

1638 Ms. Gasteier. Absolutely. So it was a number of different
1639 funding sources that the state identified and this was all a part
1640 of our original state reform effort back in 2006. So we worked
1641 with our Medicaid program and federal partnership with CMS.
1642 There are a number of state-based revenue streams that come into
1643 a trust fund that our Connector administers. And so that has
1644 kind of gone back to 2006 and then we restructured the program
1645 in 2014 to complement the Affordable Care Act.

1646 Ms. Kelly. Thank you. And I want to thank you and I commend
1647 you for all the work you are doing to help make health care
1648 affordable for your state's residences. A lack of funding is
1649 certainly challenging for states which are interested in setting

1650 up similar programs, but hopefully you will get some phone calls.

1651 Ms. Gasteier. Thank you.

1652 Ms. Kelly. Thank you and I yield back.

1653 Mr. Ruiz. Thank you.

1654 Mrs. Brooks, you are up for 5 minutes.

1655 Mrs. Brooks. Thank you, Mr. Chairman.

1656 Mr. Wieske, in your testimony you mentioned that many
1657 insurers who were offered coverage in the individual market just
1658 a few years ago have left. Can you discuss further why, from
1659 your studies, why these insurers are finding business in the
1660 individual market untenable?

1661 Mr. Wieske. Yeah, I think in the state of Wisconsin they
1662 lost roughly $500 million in the individual market and that made
1663 it absolutely unaffordable for them to provide coverage. I think
1664 we saw a market that just became -- it was interesting. In my
1665 home city of Green Bay, the second least cost Silver went up 105
1666 percent from 2016 and 2017. And that became -- 2017 to 2018 --
1667 that became an untenable sort of solution. And the concern I
1668 think that the insurers had was that the market had deteriorated
1669 so far that they didn't want all of the risk even in a given region.
1670 So it was just unaffordable for them to continue to maintain
1671 coverage.

1672 Mrs. Brooks. Can you elaborate on ways in which the section

1673 1332 waivers have actually increased access to care that have
1674 those approved waivers?
1675 Mr. Wieske. And I will say, you know, in my home state,
1676 since I worked on it directly in my former role, so we had a $200
1677 million reinsurance program that we went through in a bipartisan
1678 effort through the legislature and got it passed. That reduced
1679 the premiums by 11 percent over where they would otherwise have
1680 been, a net five percent decrease year over year, so not just
1681 a decrease of the increase, but an actual decrease year over year
1682 on average. And we believe that that expanded coverage in the
1683 state of Wisconsin from where it otherwise would have been.
1684 Mrs. Brooks. Can you talk a little bit about what else the
1685 federal government might be able to do to increase enrollment
1686 in health insurance aside from spending more money on marketing
1687 and navigators? How else can we be bringing people into --
1688 because we all want people to have access to health insurance
1689 and understand their options, but what else might we be doing?
1690 Mr. Wieske. Sure. And in my prior role I think, you know,
1691 we dealt with life insurers and health and P&C insurers. And
1692 if you look at those other lines of insurance they are becoming
1693 increasingly active in other spaces to provide coverage and
1694 becoming increasingly active in their consumer's life to provide
1695 broader opportunities. There are even groups that are having

1696 individuals in shopping malls to download apps in order to buy
1697 coverage. And people are purchasing their entire coverage on
1698 an app, through their phone, and getting everything delivered.
1699 That seems to be, you know, while there is some availability,
1700 and there is some availability in the health space, that doesn't
1701 seem to be as much widely available in the individual market as
1702 it is in other lines of insurance and in employer coverage. So
1703 I think a lot more flexibility on the state level for states to
1704 be able to do some different things and to have different options,
1705 because states operate very differently and look very
1706 differently. Massachusetts is very different than Wisconsin and
1707 California is very different than Wisconsin as well.
1708 Mrs. Brooks. I am curious, Mr. Lee, excuse me. Do you have
1709 any other ideas of how we might be increasing enrollment in health
1710 care?
1711 Mr. Lee. Yeah. First, I would note that we in California
1712 have 11 carriers, have had since day 1. Massachusetts, I believe,
1713 eight; Washington nine. So the experience of many states that
1714 have not done marketing things that have worse risk pool is
1715 unstable for plans. We want a market that works for consumers
1716 which means plans competing, so that is number one, competition
1717 works.
1718 Number two, I would note, and I mentioned it earlier in my

1719 testimony having patient-centered benefit designs. In
1720 California, our standard benefit designs mean there isn't a $2,000
1721 deductible between patients and their primary care doctor. That
1722 means even healthier people don't say it is not worth me having
1723 insurance. They see value.
1724 The third thing I would note is subsidies. Health care as
1725 many of us have noted is too expensive in America. And even at
1726 what Massachusetts has done, below 400 expanding subsidies, above
1727 400 percent subsidies -- California, we issued a report to our
1728 legislature on how to improve affordability. A lot of it is
1729 subsidies, it is reinsurance with a penalty, but it is too
1730 expensive. People need financial help and I would encourage the
1731 committee to look at this report as options.
1732 Mrs. Brooks. Thank you. I yield back.
1733 Mr. Ruiz. Thank you. The chair now recognizes himself for
1734 5 minutes.
1735 Thank you all for your testimony. Since day 1 the Trump
1736 administration has taken actions that have increased premiums
1737 and out-of-pocket costs for Americans. I am just going to list
1738 a few here since there has been so many administrative actions
1739 to change, repeal, and sabotage the ACA.
1740 In 2017, the Trump administration stopped the cost-sharing
1741 payments that helped reduce out-of-pocket costs for low and middle

1742 income Americans. This act alone increased premiums by 20
1743 percent. Health insurance companies and CEOs said that it would,
1744 the action was taken, and they did. While subsidized consumers
1745 are largely protected from these premium increases, unfortunately
1746 many unsubsidized middle class consumers bear the brunt of this
1747 and have of these premium increases.
1748 Last year, the administration expanded these junk plans,
1749 harming Americans who need comprehensive coverage and get their
1750 health insurance through the ACA. They offer these very
1751 inexpensive premiums, relatively speaking, but they don't cover
1752 much so deductibles are very high and a lot of out-of-pocket costs
1753 are incurred by the patients. In states that opt not to regulate
1754 these plans, consumers will see their premiums increase and their
1755 options dwindle.
1756 The administration issued new 1332 guidance that would allow
1757 states to raise healthcare costs for individuals with
1758 pre-existing conditions and undermine the consumer protections
1759 for people with pre-existing conditions. The administration
1760 sabotages raising the cost of health care for hardworking
1761 Americans.
1762 Mr. Lee, I understand that 2018 premiums in California
1763 increased by double what it would have otherwise been because
1764 the Trump administration terminated these cost-sharing payments.

1765 Is that correct and can you elaborate?

1766 Mr. Lee. Absolutely, it is correct. But I think it is
1767 really important to note that stopping direct cost-sharing
1768 payments meant that states across the nation did what is called
1769 Silver loading, but it is actually a CSR surcharge. Plans have
1770 to pay for that benefit. What we did in California is direct
1771 our plans to not put that surcharge on the off-exchange product.
1772 So in California and many states, unsubsidized individuals did
1773 not have to pay that 12 percent surcharge that plans had to put
1774 on to cover their costs of that program which is required.

1775 Mr. Ruiz. Did other states that couldn't do that were those
1776 costs then given to the consumers?

1777 Mr. Lee. In many states they had policies to protect
1778 off-exchange individuals, other states did not. Some of the
1779 concerns that we have with the potential of federal policy to
1780 ban Silver loading is it would shift the cost of paying for a
1781 required program on unsubsidized Americans and lower coverage,
1782 raise costs for everybody.

1783 Mr. Ruiz. Can you discuss how these actions by the Trump
1784 administration has impacted access to affordable health care
1785 particularly for Americans who are not eligible for the ACA
1786 subsidies?

1787 Mr. Lee. Well, again the --

1788 Mr. Ruiz. Do you have any numbers in terms of people who
1789 --
1790 Mr. Lee. I don't have numbers, and again there is a number
1791 of policies that have had big effects, the CSR rollback and caused
1792 confusion, many states have worked around that. Bigger issues
1793 in federal marketplace states are not doing marketing and
1794 promoting plans that don't offer coverage that encourage healthy
1795 people to buy a product that they think is a good deal that isn't.
1796 Mr. Ruiz. Yeah.
1797 Mr. Lee. It is going to cost them later. It costs all of
1798 us in the near term.
1799 Mr. Ruiz. Ms. Gasteier, can you describe the impact of the
1800 Trump administration's termination of these cost-sharing
1801 payments on your state's residents' access to affordable
1802 coverage?
1803 Ms. Gasteier. Yes. So similar to California, we did
1804 everything we could to try to avoid that outcome where the Trump
1805 administration stopped making those CSR payments which they
1806 announced right before the beginning of open enrollment 2018.
1807 But we had worked with our Division of Insurance to prepare for
1808 a plan B in the event that they did that. Similar to other states,
1809 we permitted carriers to add that load of CSR value onto the Silver
1810 tier plans only on exchange and then we worked with the population

1811 of impacted, unsubsidized people to make sure they understood
1812 they had other options.
1813 But it was incredibly disruptive to our market, of course,
1814 and Massachusetts actually stepped in to cover the cost exposure
1815 of our carriers in the last quarter of 2017.
1816 Mr. Ruiz. One of the things that I want to make clear is
1817 that oftentimes these cost-sharing reduction payments get
1818 characterized as industry bailouts. They are not industry
1819 bailouts because they are point of care only when needed by people
1820 who only meet certain criteria to help them pay for their care.
1821 So it is not a health insurance bailout especially when health
1822 insurance companies are making record profits during this entire
1823 time.
1824 I yield back the time and next speaker is Mr. Carter from
1825 Georgia.
1826 Mr. Carter. Thank you, Mr. Chairman. And thank all of you
1827 for being here, we appreciate your attendance.
1828 Mr. Wieske, I am going to start with you. You testified
1829 before this committee, I believe, before the subcommittee in
1830 February of 2017 and talked about how states could improve our
1831 healthcare system and the role that they could play in improving
1832 it. Beyond reinsurance, what are some ways that you think we
1833 could use stability funds to help patients in the exchange

1834 marketplace?

1835 Mr. Wieske. Yeah, I think from the perspective that I came

1836 from then and the perspective that I come from now, I think there

1837 are ways to design more affordable benefit options for consumers

1838 to add some flexibility. I think there are ways to provide some

1839 risk sharing. I think if you look at some of the issues that

1840 we have seen with younger folks who are not signing up for

1841 coverage, you know, we may have 13 carriers in the state of

1842 Wisconsin, but they are regional and in some cases we are seeing

1843 no younger folks signing up because of value propositions.

1844 Redesigning those sort of subsidies, I think re-looking at

1845 the way we, you know, the cost-sharing reduction subsidy issue

1846 related to whether or not you use, you know, payments or whether

1847 or not you use an account-based solution that would provide some

1848 value to consumer, I think there are ways to sort of, you know,

1849 for states to become laboratories of democracy and experiment

1850 and find out what the best solution would be similar to the way

1851 Massachusetts started.

1852 Mr. Carter. Okay. Well, thank you for that. Let's move

1853 on to the state-based exchanges bill, the one that we are

1854 discussing here. And correct me if I am wrong, but I believe

1855 that you of the 12 state-based exchanges that you said that only

1856 half of them received, that over half of them received a D or

1857 an F grade; is that correct?

1858 Mr. Wieske. Yeah. I think we had some issues with the level

1859 of information that is available through the exchanges. And this

1860 is part of the reason why we support looking at some private

1861 competitive versions in the state and new ways to enroll. That,

1862 you know, what we are looking at now is different than what we

1863 looked at in 2014 and time has moved on for a lot of the ways

1864 consumers shop.

1865 Mr. Carter. And I believe you said that almost

1866 three-fourths of them were worse, or scored worse than the federal

1867 exchanges.

1868 Mr. Wieske. Yeah. And we are seeing that you know, states

1869 are certainly making efforts to improve, but it is a very expensive

1870 process and it is very intensive. And the people who are bearing

1871 the cost of those in a lot of cases, either the state through

1872 general tax revenue or more likely it is through the consumers

1873 who are purchasing coverage through the exchange for access to

1874 that website.

1875 Mr. Carter. Okay. All right, let's move on to talk about

1876 the navigators. In 2017, we spent sixty two and a half million

1877 dollars on navigator grants and it yielded us only a one percent

1878 increase in ACA enrollment out of those grants? That doesn't

1879 seem like it is a very efficient use of money to me.

1880 Mr. Wieske. Again what we have seen in other lines of
1881 insurance and in other places that there are different ways for
1882 people to get access to coverage, so it is not just that. So
1883 I think navigators are important, a small important piece of that
1884 to do outreach for underserved consumers, but consumers are buying
1885 their coverage in different ways. And a 22 year old, 27 year
1886 old is not going to go into a navigator in the same way other
1887 folks are.

1888 Mr. Carter. Right. And the same thing in rural areas; am
1889 I correct?

1890 Mr. Wieske. Correct. Correct.

1891 Mr. Carter. So that is really something we need to be
1892 concentrating on, younger people as well as our rural areas.

1893 Mr. Wieske. Mm-hmm.

1894 Mr. Carter. Well, thank you for that. I appreciate it.

1895 Mr. Chairman, and I realize you are sitting in for the
1896 chairman, so but I do have to get this on record. And that is
1897 here we are in our third hearing in the subcommittee that has
1898 the broadest jurisdiction over health care of any subcommittee
1899 in Congress, and yet already the Oversight and Reform Committee
1900 has had a drug pricing hearing. The Ways and Means Committee
1901 has had a drug pricing hearing and they are on their second one
1902 this week. The Senate Finance Committee has had two hearings.

1903 And this week, the Senate Committee on Aging is having two
1904 hearings on drug pricing. Now this committee, the Energy and
1905 Commerce Committee, has a record of working in a bipartisan
1906 fashion. We have come up with Cures. We have come up with 21st
1907 Century Cures. We have come up with a number of different things
1908 in a bipartisan fashion. Can you give me an idea or at least
1909 relate to the chairman an idea of when we are going to start talking
1910 about drug pricing that impacts all --
1911 Mr. Ruiz. Yes, sir. Yes, sir.
1912 Mr. Carter. -- Americans and it is a bipartisan issue?
1913 Mr. Ruiz. Yes, sir. Yes, sir. And I recognize you are
1914 the one pharmacist in our committee.
1915 Mr. Carter. Yes, sir.
1916 Mr. Ruiz. So I appreciate your concern. It reminds me of
1917 a scene in the Karate Kid where the Master told the Karate Kid,
1918 patience, Daniel-San, patience.
1919 Drug pricing will be a priority in this committee. In fact,
1920 the first hearing is going to be next week and we are going to
1921 tackle this issue straight on and you are going to be gleaming
1922 with happiness when we do.
1923 Mr. Carter. Thank you, Mr. Chairman. I yield back,
1924 Daniel-San.
1925 Mr. Ruiz. Great.

1926 Next, Ms. Blunt Rochester, please.

1927 Ms. Blunt Rochester. Thank you, Mr. Chairman, and thank
1928 you to the panel.

1929 Over the past 2 years, the Trump administration's funding
1930 cuts have prevented marketplace navigators from providing counsel
1931 to consumers looking to enroll in health insurance plans that
1932 work best for them. In Delaware, only one navigator organization
1933 received federal funding for 2019 open enrollment, making it even
1934 harder for Delaware families to sign up for coverage. Navigators
1935 help communities in my state learn about their coverage options
1936 and enroll in affordable health care.

1937 According to the Kaiser Family Foundation study, 40 percent
1938 of uninsured Americans are unaware of the marketplaces and over
1939 75 percent of consumers sought help from navigators because they
1940 either lacked confidence to apply on their own or needed help
1941 understanding their plan choices. For many of the 24,000
1942 Delawareans participating in the individual marketplace,
1943 enrollment specialists are a trusted source they can rely on when
1944 making deeply personal decisions about their health insurance
1945 plan.

1946 Ms. Gasteier, I understand that uninsured Americans are less
1947 likely to be aware of the availability of coverage or even that
1948 subsidies can help them pay for coverage. Is that true?

1949 Ms. Gasteier. That is correct. We found that in
1950 Massachusetts and we work with our navigators to make sure that
1951 we have in-person resources available to educate people about
1952 how affordable options can be for them and people are often
1953 surprised when they find out what they qualify for.
1954 Ms. Blunt Rochester. And can you describe how gutting this
1955 funding for the program, the navigator program, impacts
1956 enrollment, because we just heard from Mr. Carter that it was
1957 only a one percent increase in enrollment. Can you talk a little
1958 bit about that?
1959 Ms. Gasteier. Absolutely. So that doesn't square with
1960 what our experience has been in Massachusetts where our navigators
1961 provide immense in-person support in the communities that need
1962 the most help getting into coverage. So just as an example,
1963 our navigators this past open enrollment period held 400
1964 informational events around the state educating people about
1965 their options, and we find that the uninsured population even
1966 in a well-covered state like Massachusetts is always churning.
1967 It is a new group of people that need assistance and so their
1968 in-person presence in those communities where they are sort of
1969 trusted leaders for many other services are really key.
1970 I would also like to note that navigators do more than just
1971 get people into coverage once and then walk away. They provide

1972 year-round support to people who need to make updates to their
1973 income information, add a baby, had a life change, and we find
1974 that that assistance for particularly low income populations is
1975 key to not just getting into coverage but staying covered as well.
1976 Ms. Blunt Rochester. You know, I was going to ask you, you
1977 brought up the term "churning," and I saw that in your testimony
1978 and was going to ask you if you could expand a little bit on the
1979 concept of churning, the population churning.
1980 Ms. Gasteier. Absolutely. So we find in Massachusetts,
1981 again even with a less than three percent uninsurance rate, the
1982 uninsured population is a mix of some people who are chronically
1983 uninsured, but also people who have gaps of 6 months, 12 months
1984 in between other kinds of coverage who kind of fall through the
1985 cracks. And that could be because somebody loses a job and loses
1986 job-based coverage, somebody who moves to Massachusetts from
1987 another state and doesn't really know kind of where to go for
1988 help.
1989 And so we try to kind of catch people, you know, people who
1990 may be weighing a COBRA option if they are leaving a job, or people
1991 who may be in between some other kind of life circumstance, getting
1992 a divorce, et cetera. And we find that that kind of active
1993 presence to make sure that the new people coming into the ranks
1994 of the uninsured we are there to catch them right away.

1995 Ms. Blunt Rochester. Excellent. And my last question was
1996 really another thing I noticed in your testimony was about the
1997 diversity of your state, but also all of the players that are
1998 involved in helping to do the outreach. You mentioned everything
1999 from focusing on 21 different languages to the different
2000 community-based organizations, 16 of which -- can you talk a
2001 little bit about that as well?

2002 Ms. Gasteier. Absolutely. So like most states,
2003 Massachusetts is diverse and we have very dense urban population
2004 areas as well as rural areas in the western part of our state
2005 and our navigators are spread out to be present in places where
2006 we know there is a higher risk of uninsurance. And, for example,
2007 in urban areas we find language access and awareness about
2008 affordability programs is a key thing for those navigators to
2009 work on. In our rural areas we will work with navigators to make
2010 sure they are sending people out into the community.

2011 So in our more rural Greenfield area, for example, the
2012 Franklin County Community Health Center will send their folks
2013 out to drive 20, 30 minutes to meet people at food pantries and
2014 farms and make sure they are providing the kind of assistance
2015 people in those less populated areas need.

2016 Ms. Blunt Rochester. Thank you so much. I yield back.

2017 And well, before I yield back I did want to say I am a proud

2018 cosponsor of this bill and thank Ms. Castor for that and also
2019 the support on the MORE Health Education Act. Thank you.
2020 Mr. Ruiz. Thank you.
2021 Now, Mr. Long, you have 5 minutes.
2022 Mr. Long. Thank you, Mr. Chairman. I appreciate also my
2023 friend Larry Bucshon, here, next to me who yielded his place in
2024 order. I was a little late and missed the gavel. I was actually
2025 cleaning up a spill out in the hallway and somebody said did you
2026 spill something? And I said no, but I am cleaning it up so
2027 somebody else doesn't fall. So, you know, no good deed goes
2028 unpunished, so I was late for the gavel.
2029 Mr. Wieske, if memory serves, when we were talking about
2030 implementing the Affordable Care Act and talking about
2031 navigators, it is in the back of mind it seems like navigators
2032 were not allowed to be navigators if they had any background in
2033 the insurance field. And to me that would be kind of like taking
2034 your car to a mechanic, but oh, you have to pick a mechanic that
2035 has never worked on a car before.
2036 So that being said, you said that the loss of agents in the
2037 individual health insurance market has created many problems and
2038 that navigators are just not a substitute for driving enrollment.
2039 Could you talk about the differences in how agents and brokers
2040 operate compared to navigators both before and after consumers

2041 purchase their insurance and why are not navigators a substitute
2042 for agents?

2043 Mr. Wieske. Yeah. When we looked at creating our own
2044 navigator program, which by the way in Wisconsin we are going
2045 to call badgigators, we saw the same issue that you saw that there
2046 was some limited ability for folks with ongoing industry
2047 background to be able to be a navigator, so that created a concern.

2048 I think in the individual market we have seen insurers stop
2049 paying commissions to a lot of agents in Wisconsin. Again that
2050 reflects at $500 million of lost revenue as they have exited the
2051 market. We may have 13 carriers but they are regional in nature.
2052 They are all small carriers, so those expenses are very high.
2053 That makes it difficult for the folks in the community to be
2054 able to access sort of coverage and expertise. And the expertise
2055 that we require a navigator to have in Wisconsin in their license
2056 is nowhere near what we require what an agent is required to have.

2057 Mr. Long. You also note that the federal navigator program
2058 operates largely outside of the current healthcare system and
2059 in many cases the navigator program is centered around large
2060 population centers which we kind of talked about earlier in not
2061 serving the rural areas. What effect does this have for those
2062 rural communities and how important is the role of agents and
2063 brokers in advising consumers out in these rural areas? I

2064 represent a lot of rural areas in Missouri.

2065 Mr. Wieske. We had two sort of issues. We had navigators

2066 come in who were under a navigator grant that we had no idea existed

2067 and were papering a local community with, papering a local

2068 community and we were never told, they were never registered.

2069 They turned out to be licensed through a different entity so

2070 they were okay, we had some concerns with that.

2071 I think rurally, I think in places like Rhinelander,

2072 Wisconsin where my wife is from, there is just not as much

2073 availability. There is just not as many people. They have to

2074 drive hours just to get to a dermatologist, let alone anything

2075 else. But that is an issue in those reasons that they are

2076 primarily served by their local insurance agents.

2077 Mr. Long. And could you talk about how the medical loss

2078 ratio is affecting agents and brokers? Is it inhibiting agents'

2079 and brokers' ability to operate?

2080 Mr. Wieske. Yeah. I think again in Wisconsin prior to us

2081 doing the $200 million reinsurance program, our insurers had loss

2082 ratios in excess of a hundred percent after the various government

2083 programs provided reinsurance back to them. That means that you

2084 know, the medical loss ratio, those losses made it unaffordable

2085 for them. They had to cut expenses somewhere and largely they

2086 have cut it out of agents.

2087 And I think in other states where you are cutting it closer
2088 to the 80 percent, we have seen agents, you know, the loss of
2089 agents serving individual consumers, you know, across the
2090 country.
2091 Mr. Long. And do you think that instead of focusing solely
2092 on navigators, which enroll less than one percent of the total
2093 enrollees for the plan in the year 2017, we should be considering
2094 amending the medical loss ratio provisions to ensure greater
2095 access to agents and brokers in order to drive enrollment?
2096 Mr. Wieske. Yeah, I think that would, you know, from our
2097 perspective I think that would provide some value. And I think
2098 on top of it, I think allowing some flexibility in enhanced direct
2099 enrollment and some private exchanges, some other folks who are
2100 incentivized to find people who are uncovered and have some
2101 incentives to get there.
2102 It is certainly, you know, different approaches work in
2103 different states so what works in California and Massachusetts
2104 may not work in Wisconsin. But I think incentivizing states to
2105 have a different approach would make some sense.
2106 Mr. Long. Okay, thank you. And once again I would like
2107 to thank my friend Larry Bucshon for giving me his slot here.
2108 And, Mr. Chairman, I yield back.
2109 Mr. Ruiz. Thank you.

2110 Mr. Cardenas, you have 5 minutes.

2111 Mr. Cardenas. Thank you very much, Mr. Chairman. I would
2112 like to thank all of you for testifying today and thank you for
2113 bringing your expertise and your perspectives on this very
2114 important issue. Since the ACA's passage I would like to remind
2115 America that 20 million Americans have gained coverage that
2116 otherwise didn't have it before then. The uninsured rate fell
2117 from a high of 18 percent in this country to 11 percent at the
2118 end of 2016.

2119 What is unfortunate is that this Trump administration has
2120 been actively undermining the law and attacking Americans' access
2121 to health care. For example, the administration cut their
2122 advertising enrollment budget from $100 million to $10 million,
2123 then they gutted funding for the navigator program by 80 percent.
2124 This program helps American families learn about the coverage
2125 options that are available to them.

2126 As anyone can tell you, understanding different healthcare
2127 plans can be difficult and, thankfully, under the Affordable Care
2128 Act we have these navigators, these medical professionals who
2129 can guide people over the phone on the different options they
2130 have to protect their families is very important. This program
2131 is critical for people who might have difficulty understanding
2132 the difficult options or who might be short on time, for example,

2133 single patients working multiple jobs, families already
2134 struggling with their finances, and Americans who don't speak
2135 English as their first language.
2136 English was not my first language but English is now my most
2137 dominant language. I have gone to college, I have an electrical
2138 engineering degree. But going through the coverages before the
2139 Affordable Care Act when I used to provide health care for my
2140 employees was always complicated and difficult. Now that I have
2141 my own coverage as a public servant, it is still very difficult
2142 to navigate through that. So let me make that very, very
2143 clear. The Affordable Care Act did not make health care
2144 complicated in America, it was already complicated. The good
2145 thing about it is, it is still complicated. However, 20 more
2146 million Americans now have health care that otherwise didn't have
2147 it.
2148 I grew up when I was born under health care when my father
2149 was a union worker. Later on he became a self-employed gardener.
2150 I was number 11, child number 11, and shortly thereafter he went
2151 off to be a private business owner and that is when healthcare
2152 coverage was unaffordable to them. Now people in my district
2153 like my father who are gardeners now have access to health care
2154 and these navigators are very, very important.
2155 So with that, Mr. Lee, can you describe how navigators help

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2156 Californians access affordable coverage? Can you give us a good
2157 example that is working well in California?
2158 Mr. Lee. I absolutely can. I think that -- I want to note
2159 that we use agents, licensed agents, 12,000. They cost a lot,
2160 1.7 percent of premium goes to paying agents. That is a lot.
2161 It is over $130 million. We have a $6.7 million navigator
2162 program where we target communities that don't have as many agents
2163 serving them, in particular Spanish-speaking communities.
2164 We do a lot of studies and looking at the fact that agents
2165 are less apt to be serving Spanish-speaking people, so we
2166 specifically contract with entities that serve Spanish-speaking
2167 communities. Similarly, we have seen agents are less apt to serve
2168 African Americans. We target grants to navigators anchored in
2169 the Crenshaw district, anchored in parts of the community that
2170 are otherwise underserved.
2171 So it is very much a complement to a broad program and it
2172 is not just to be scored by enrollment, scored by doing outreach.
2173 The outreach function as you heard from Ms. Morse Gasteier is
2174 part of getting the word out that is particularly important in
2175 federal marketplace states that as you noted have abandoned doing
2176 marketing. We in California spend $60 million on marketing and
2177 advertising. The federal government now spends 10 for 39 states.
2178 That money means people know to find navigators, know to find

2179 agents, so it is a complementary program.

2180 Mr. Cardenas. So basically navigators are helping people

2181 potentially save money, also end up getting coverage that is more

2182 applicable to their situation and their family, and then on top

2183 of that does it translate into Americans having better access

2184 to health care when a navigator helps an individual get to that

2185 point?

2186 Mr. Lee. So we study this closely, people that use

2187 navigators or agents make better decisions. They are more apt

2188 to choose a health plan that is right for them than those that

2189 do online only. Whether a web broker or whether other, getting

2190 help means they make a better choice. It also means more people

2191 enroll, they are healthier which lowers costs for everybody.

2192 So it really is one of those things, investing and helping people

2193 understand insurance and get insurance and use insurance means

2194 they get access to care when they need it, better, and lowers

2195 costs for everybody.

2196 Mr. Cardenas. Are navigators needed in rural areas?

2197 Mr. Lee. Absolutely.

2198 Mr. Cardenas. Are navigators, when available, are they

2199 utilized at high rates in rural areas?

2200 Mr. Lee. By high rates -- we actually are going to be, we

2201 are re-upping our navigator program in California to fund more

2202 navigators. In some rural areas we don't have enough. So it
2203 is one of the issues we do that we base on analysis and target
2204 where the needs are.
2205 Mr. Cardenas. Thank you very much, Mr. Chairman. I yield
2206 back my time.
2207 Ms. Eshoo. I thank the gentleman from California, excellent
2208 questioning. And it really, I think, brings together a highly
2209 diverse state and one that may not be diverse, and how navigators
2210 work it is instructive.
2211 I now would like to recognize 5 minutes for questioning,
2212 the gentleman from Indiana, Mr. Bucshon.
2213 Mr. Bucshon. Thank you.
2214 Mr. Wieske, H.R. 1386 seeks to significantly increase the
2215 funding for the navigator program. In the 2016 and 2017
2216 enrollment year in Indiana, the total amount of grant funds for
2217 navigators was $1,635,961. Three entities in the state were
2218 awarded grants. The total estimate for the number of individuals
2219 who would be enrolled in the ACA the estimate was 3,314, but in
2220 reality only 606 people were enrolled for a cost of nearly $2,700;
2221 to be exact, $2,699.61 per enrollee. If the grant recipients
2222 had met their goals, the per enrollee cost would have been $493.65.
2223 So do you know of any requirements that grant recipients
2224 attain their enrollment goals or penalties for nonattainment?

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2225 Mr. Wieske. I am not aware of any.

2226 Mr. Bucshon. Okay, neither am I. Do you think there should
2227 be a per enrollee cap and that assuming we have navigators and
2228 that any unspent funds should be returned to the government?

2229 Mr. Wieske. So, you know, I think the funds, to be honest,
2230 are spent at the time that they are granted. The awards come
2231 very, very late. It is very difficult for the navigator entities
2232 to be able to plan ahead based on when they have received those
2233 grants. And so there have been issues and this goes back, all
2234 the way back to 2014. So, you know, if they are not spending
2235 the money, yes, they should. But I think, by and large,
2236 they are almost required to spend it the day they get it. And
2237 I think, you know, in Wisconsin we had less than 50 navigators
2238 registered, I think, year to year in any given year.

2239 Mr. Bucshon. Yeah, I mean I have strong concerns that it
2240 seems like there is really an incentive to enroll fewer people
2241 because there is no penalty and the legislation doesn't seem to,
2242 this legislation doesn't seem to address the problem. I mean
2243 it seems to me that $2,700 per enrollee is quite a lot when you
2244 were expected to be less than $500 per enrollee. And it seems
2245 like we need to maybe have some guardrails in that program.

2246 Mr. Wieske. I think what we hope as an organization is that
2247 there are more opportunities for other entities to be able to

2248 enroll, that some of them are much more effective especially with
2249 distinct populations.
2250 Mr. Bucshon. Okay.
2251 Mr. Wieske. And so we are hoping for more enhanced direct
2252 enrollment and more private exchanges, more other options, more
2253 flexibility for the individual plans to be able to sign people
2254 up and make it easier from a path perspective instead of making
2255 it harder, especially through the federal exchange.
2256 Mr. Bucshon. Thank you.
2257 Mr. Lee, California has spent roughly a hundred million
2258 dollars every year for the last 3 years, I think it was 99; that
2259 I mean this year it is estimated at 111.5 million on advertising.
2260 3 years ago, how many people were in Obamacare, enrolled in
2261 Obamacare in California?
2262 Mr. Lee. In the individual market about 2.4 million.
2263 Mr. Bucshon. Okay. And how about after 3 years of a hundred
2264 million in marketing, what is the number?
2265 Mr. Lee. About the same because 40 percent of the people
2266 leave our market every year. So we have to market with a hundred
2267 million because people leave job-based coverage and you have got
2268 to bring them in. So this is like any product, if we stop
2269 marketing we would dwindle away. And by staying constant we have
2270 kept that risk pool which again is 20 percent healthier than the

2271 federal marketplace which translates directly into 20 percent
2272 lower cost, so our one percent of premium goes to marketing.
2273 Mr. Bucshon. Okay, so I get that.
2274 Mr. Lee. Okay.
2275 Mr. Bucshon. So, but the national experience hasn't been
2276 the same with a large amount of marketing. It really didn't
2277 change the overall enrollment nationally, which is your
2278 experience in California. 3 years, a hundred million dollars,
2279 and you have the same number of people. They may not be the same
2280 people, I get that. But that seems like a lot of money. That
2281 is your decision, I am fine with that. Do you think there
2282 is anyone in America that doesn't know that they have an option
2283 to get health care on the exchanges, on Obamacare?
2284 Mr. Lee. Sadly, yes. I know that even in California where
2285 with our advertising the average Californian sees or hears us
2286 59 times during open enrollment, even in California.
2287 Mr. Bucshon. Well, the question was is do you think there
2288 is anyone in the United States that doesn't know that if they
2289 don't have health care they can't get it on the exchange under
2290 the ACA?
2291 Mr. Lee. Yep. There are absolutely many Americans in
2292 California and across the nation that don't know that, that are
2293 --

2294 Mr. Bucshon. Yeah, I would be interested in you submitting
2295 that estimate to the committee, because I would argue that I don't
2296 know anyone that I come across that doesn't know that after all
2297 the years and the debate on the national level about Obamacare
2298 both pro and con that doesn't know that if they don't have health
2299 coverage -- you know, it is one of those things where, you know,
2300 it is not like McDonald's.
2301 You drive by McDonald's and you say, hey, I am hungry. I
2302 am going to stop and get something, right? It seems like health
2303 care is more of a destination restaurant where you decide, hey,
2304 I am hungry and I am going to go to this restaurant specifically,
2305 you are not driving by. And I think to many, in many respects
2306 that maybe you don't agree with that that, you know, people
2307 understand that they can get health care through the exchanges
2308 and it is a decision they are making not to or to do it. I just
2309 --
2310 Mr. Lee. I would be happy to --
2311 Mr. Bucshon. That is why I want to say at the national level
2312 I just don't see it is justified to spend millions and millions
2313 of dollars marketing something that everybody knows about.
2314 Thank you, I yield back.
2315 Ms. Eshoo. I thank the gentleman.
2316 Just as an aside, there are millions of people in the country

2317 that don't know that the ACA and Obamacare are one and the same.
2318 So, hard to believe, but it is still the case. I now would
2319 like to recognize the chairman of the full committee, Mr. Pallone,
2320 for 5 minutes of questioning.
2321 The Chairman. Thank you, Madam Chair. In his testimony,
2322 Mr. Wieske recommends that we dismantle the federal and the
2323 state-based marketplaces where of course millions of Americans
2324 receive health coverage. So I wanted to get a response to that
2325 from Mr. Lee and Ms. Gasteier.
2326 Mr. Lee, can you comment on Mr. Wieske's recommendations
2327 that we shut down the marketplaces and privatize it instead, and
2328 then I am going to ask Ms. Gasteier to answer the same question.
2329 Mr. Lee. Certainly. So Covered California partners
2330 closely with hundreds of licensed agents, many of which are
2331 web-based entities, web-based brokers. We believe there is a
2332 vital role for them in the private sector. But we are also deeply
2333 concerned that private entities have one purpose, to earn money
2334 based on commissions paid differentially by different insurance
2335 companies and different insurance products.
2336 We in the public sector have one purpose, to lower health
2337 costs for Americans or specifically to California. Web-based
2338 brokers are -- I have known them well -- are good, bad, and ugly.
2339 There are some great ones. There are some really lousy ones.

2340 And some of their tools are good, some are terrible. But they
2341 have a very different motivation. Our job in the public
2342 sector is to help millions of Americans get public dollars to
2343 lower healthcare costs and to make health care more affordable.
2344 Web-based brokers are seeking to get a best return, and I will
2345 note some agents might get 20 percent for one product, two percent
2346 for another. I would be quite nervous about what is going to
2347 happen to consumers. We put them first all the time.
2348 The Chairman. And, Ms. Gasteier?
2349 Ms. Gasteier. Similar. We find that having a publicly-run
2350 exchange is really critical for the integrity that people know
2351 they will find when they come and shop for products on our shelf.
2352 We offer a curated, competitive marketplace experience for
2353 people that people know when they come and get coverage from the
2354 Health Connector in Massachusetts or healthcare.gov they are
2355 getting safe, trustworthy coverage. And that they can make
2356 apples to apples comparisons, that is helpful for everybody in
2357 terms of affordability and understanding their options.
2358 I would also say part of the exchange's responsibility is
2359 to administer taxpayer dollars in the way of subsidies and so
2360 we think there is an important role for the public oversight
2361 component of being a public entity and doing that and ensuring
2362 that there is program integrity to these important functions.

2363 The Chairman. I appreciate that because I mean obviously,
2364 as you said, the federal and state-based marketplaces have to
2365 certify plans to ensure that only the products that offer
2366 comprehensive coverage are available for sale and the exchanges
2367 verify eligibility to ensure that low and moderate income
2368 Americans who qualify for financial assistance receive the ACA
2369 subsidies.
2370 But let me ask Mr. Lee kind of in the same vein, can you
2371 discuss the risk to consumers if the marketplaces are privatized?
2372 Mr. Lee. Well, first, we do look very closely at every
2373 health plan that wants to be in our marketplace. They have to
2374 be clear they have good networks, the right benefits and, sadly,
2375 health care is one of the areas that has actually failed consumers.
2376 Web-based brokers can sell not just qualified health plans, but
2377 in many states that offer skimpy benefits and they may get better
2378 commissions, those could be looking right next to products that
2379 are there and meaningful. Consumers don't know and may not know.
2380 And again the danger of the incentive for one agent or broker
2381 is very different than a group like ours which is publicly
2382 accountable. We bring together consumer advocates, doctors, and
2383 others to say what are the right benefit designs, how do we
2384 position plans so that consumers can choose right. I would be
2385 very concerned about many consumers being steered wrong if we

2386 just threw it to the market.

2387 The Chairman. I mean I agree, you know, many people, you

2388 know, from what I can see end up buying these junk plans and then

2389 have no idea of the lack of coverage.

2390 Ms. Gasteier, similarly, can you discuss the risk of shifting

2391 this responsibility to private insurance companies given billions

2392 of dollars, you know, in subsidies that are at stake?

2393 Ms. Gasteier. Sure. So I think again it comes back to

2394 exchanges play a really important role in being a source of

2395 trusted, comprehensive coverage where people know what they are

2396 getting is not going to be something that exposes them to costs

2397 if they get sick or that there is sort of tricks in the coverage

2398 itself in terms of what is sold to people. And so in having a

2399 place that is publicly accountable where we are engaging with

2400 carriers, consumer advocates, providers, and others to design

2401 products that are safe and trustworthy for people, there for them

2402 when they need it, is really a critical component of the public

2403 role for exchanges and we found that to be very effective in

2404 Massachusetts.

2405 And again similar to California, we have placed a real

2406 premium on standardizing benefits so that we can ensure that

2407 people when they shop and compare their options really understand

2408 what they are getting and what the differences may or may not

2409 be, but that everything there is safe and reliable.

2410 The Chairman. And I agree. I mean I am very concerned that,

2411 you know, we have billions of dollars in federal subsidies and,

2412 you know, they could be at risk from fraud, abuse, and waste.

2413 That is my concern.

2414 Thank you, Madam Chair.

2415 Ms. Eshoo. I thank the chairman.

2416 I now would like to recognize the gentleman from Montana,

2417 Mr. Gianforte.

2418 Mr. Gianforte. Thank you, Madam Chair, and thank you for

2419 the panel being here today. Time and time again I hear from

2420 Montanans about the rising cost of health care in our state.

2421 For many in Montana, Obamacare has been unaffordable. Watching

2422 their premiums and deductibles continue to grow, while their

2423 benefits shrink has been a frustrating and in some cases a

2424 devastating experience for them. Thankfully, the Trump

2425 administration has proposed real solutions to halt the rise in

2426 healthcare costs. Improving access to short-term, limited

2427 duration insurance plans, eliminating the individual mandate

2428 penalty, and expanding association healthcare plans is giving

2429 choice back in control to Montanans and putting them back in charge

2430 of their healthcare needs.

2431 Unfortunately, the ENROLL Act is not innovative and is a

2432 prime example of policies that misunderstand the needs of rural
2433 communities. Our rural hospitals in Montana are hurting. And
2434 across this country since 2010, 98 rural hospitals have been
2435 closed and almost 700 are vulnerable to closure. Our communities
2436 depend on these vital institutions. When a hospital closes in
2437 a rural community, not only do we lose access to care, but the
2438 community is less sustainable. The region loses jobs and
2439 financial viability.

2440 We need to be working to make sure that people not only have
2441 coverage but also have access to care. A navigator won't be
2442 around to help when a farmer needs emergency medical services
2443 and their local hospital has closed. We need to ensure that our
2444 rural providers are stable and available in case of emergencies
2445 and I look forward to working together to continue encouraging
2446 innovation, affordability, and access to care for all.

2447 Mr. Wieske, I would like to direct a couple of questions
2448 to you. In your testimony you say that navigators are typically
2449 centered around large population centers with limited
2450 availability in rural communities. Can you speak as to why the
2451 navigator program is less effective in rural areas and frontier
2452 communities like Montana?

2453 Mr. Wieske. I mean it is a matter of economics. I mean
2454 the population is not there and the ability to drive the number

2455 of people you can see in a given time frame in a rural community
2456 is, you know, the distances as you know are significant and so
2457 the effectiveness is an issue.
2458 Mr. Gianforte. Okay. In our business we are constantly
2459 looking for ways for continual improvement. When we found a
2460 program in our business that wasn't working we would stop focusing
2461 resources on that program and look to invest elsewhere.
2462 Mr. Wieske, do you believe that there should be a shift in
2463 our resources away from navigators to other areas that provide
2464 better outcomes for Americans?
2465 Mr. Wieske. I do think there are other ways that we can
2466 provide better access in rural communities in the same way that
2467 you are seeing other insurance lines, you are seeing medical care
2468 and other things delivered in different ways in those rural
2469 communities in order to give them access, so.
2470 Mr. Gianforte. So there might be better ways to use the
2471 money --
2472 Mr. Wieske. Yes.
2473 Mr. Gianforte. -- in rural areas in particular. Okay.
2474 And then, Mr. Wieske, you also talked in your testimony about
2475 transparency in the navigator program. And I constantly hear
2476 from Montanans that they want -- they are frustrated with the
2477 lack of transparency, generally, in our healthcare system. What

2478 changes could we make from your experience to make this program
2479 more transparent?
2480 Mr. Wieske. I think for, you know, I think one of the issues
2481 that we have seen is that this is something that states should
2482 be primarily responsible. I think California and Massachusetts
2483 certainly highlighted the way they deal with the navigator
2484 program. I think if states are responsible for the navigator
2485 program directly, I think that will make it a much more effective
2486 program because they understand how the state works, where the
2487 needs are, work with the Medicaid department, work with the
2488 insurance department in order to make that work better.
2489 Mr. Gianforte. So as we look at public policy, we should
2490 really have a design requirement around more local control at
2491 the state level; you would agree with that?
2492 Mr. Wieske. Yes.
2493 Mr. Gianforte. Okay. Thank you so much.
2494 And with that I yield back -- yes, I would.
2495 Mr. Burgess. You know, you have reminded me that one of
2496 the principal failures of the Affordable Care Act was when we
2497 allowed Speaker Boehner, Leader Reed, President Obama, to remove
2498 Members of Congress from being forced to go into the exchanges.
2499 That was a mistake.
2500 I did not accept the subsidies that all Members of Congress

2501 get for going in the D.C. exchange. I went through
2502 healthcare.gov, one of the most miserable experiences I have ever
2503 been through in my life, but it would be important for Members
2504 of Congress to experience what our constituents were feeling as
2505 they faced the very dire prospects of healthcare.gov not working
2506 on its rollout, and then of course the very expensive and
2507 unsubsidized premiums that we faced in the individual market.
2508 And I am just like anybody else, I bought on price. I bought
2509 a Bronze plan. I had a $6,800 deductible, never understood why
2510 I couldn't couple that with a Health Savings Account. It was
2511 difficult to do that. We could have made it easy and that would
2512 have been easier had we all been required to go through what we
2513 were putting our constituents through. I thank the
2514 gentleman for yielding and yield back to him.
2515 Mr. Gianforte. And, Madam Chair, I yield back.
2516 Ms. Eshoo. I thank the gentleman.
2517 I think, Dr. Burgess, you made a big mistake by not enrolling
2518 because it is terrific. It works beautifully for me. It has
2519 gone beyond my expectations because of its coverage.
2520 Mr. Burgess. But if I --
2521 Ms. Eshoo. No.
2522 Now I would like to recognize the gentleman from Florida.
2523 I did see him, where is he? There, way down there.

2524 Mr. Soto, you have 5 minutes to question.

2525 Mr. Soto. Thank you, Madam Chairwoman. And, first, I am
2526 from Florida, home of the largest federal exchange for the ACA
2527 in the nation with over 1.7 million Floridians. We had an
2528 increase this year. One of the big reasons that the ACA has been
2529 so successful in Florida is because we don't have a lot of folks
2530 with access to employer-based health insurance. So for large
2531 states like us, this was made to help. My wife and I are on the
2532 insurance plans from the D.C. exchange. She recently had surgery
2533 which was pretty much covered, so it has been a good experience
2534 for the Soto family.

2535 I want to go through each of the five ways that President
2536 Trump has sabotaged the Affordable Care Act and get an idea from
2537 our witnesses whether it increased or decreased access and what
2538 it would relate to costs. So starting just brief answers with
2539 each of our witnesses going through first the five ways, one is,
2540 it eliminated cost sharing; two, ending high-risk corridors;
2541 three, cutting enrollment dollars and marketing dollars in half;
2542 four, eliminating the individual mandate; and five, eliminating
2543 mandatory Medicaid expansion.

2544 So let's start with the first of these five plagues on
2545 Obamacare, the eliminating of the cost-share subsidies.

2546 Mr. Lee, did this increase access or decrease access by

2547 eliminating the subsidies?

2548 Mr. Lee. I think on the margins it decreased access. But

2549 the fact of Silver loading meant some consumers with subsidy

2550 actually had more money to work with so it is actually a trade-off.

2551 It definitely cost the federal government more money. It caused

2552 confusion that I think in many markets led health plans to pull

2553 out of their markets, so it is a market-by-market issue.

2554 Mr. Soto. So, but you would say overall it decreased access?

2555 Mr. Lee. Overall, decreased.

2556 Mr. Soto. Ms. Gasteier, did it increase or decrease access

2557 or costs?

2558 Ms. Gasteier. It reduced access for the unsubsidized middle

2559 class population.

2560 Mr. Soto. And, Mr. Wieske, did it increase or decrease?

2561 Mr. Wieske. It increased costs and created some

2562 instabilities.

2563 Mr. Soto. What about on ending the high-risk corridors,

2564 Mr. Lee? How did that affect access and costs?

2565 Mr. Lee. That I think also ended up having -- well, I am

2566 actually, I am not sure.

2567 Mr. Soto. Okay. You are not sure.

2568 Mr. Lee. So I will pass.

2569 Mr. Soto. What about Ms. Gasteier? How did it affect

2570 access or costs?

2571 Ms. Gasteier. I would say all of the reductions or

2572 disruption to any of the three Rs -- risk corridors, reinsurance,

2573 and risk adjustment -- have been, have reduced access and

2574 stability just in general to the extent that each of those programs

2575 have either been ended or they have hit turbulence in various

2576 ways.

2577 Mr. Soto. And, Mr. Wieske?

2578 Mr. Wieske. I think with the three Rs, I think the decision

2579 early on to federalize them and not to go state by state created

2580 significant issues in the market outside of it which predates

2581 most of the issues surrounding it.

2582 Mr. Soto. What about cutting marketing dollars and

2583 enrollment time, Mr. Lee? How did that affect access and costs?

2584 Mr. Lee. Dramatically reduced access, dramatically has

2585 increased premiums across much of the nation except for those

2586 states that have state-based marketplaces that continue to do

2587 marketing.

2588 Mr. Soto. And, Ms. Gasteier, how did that affect costs and

2589 access?

2590 Ms. Gasteier. I would presume elsewhere it has reduced

2591 access. Like California, Massachusetts has been able to stay

2592 level with respect to its investment in outreach and marketing

2593 so has stayed the same.

2594 Mr. Soto. Mr. Wieske?

2595 Mr. Wieske. We just didn't see that effect, that negative

2596 effect.

2597 Mr. Soto. Okay. What about eliminating the individual

2598 mandate? Mr. Lee, how did that affect access and cost?

2599 Mr. Lee. It has raised premiums across both California and

2600 the nation and decreased enrollment. Many fewer, hundreds of

2601 thousands of fewer Californians have insurance because of that.

2602 Mr. Soto. Ms. Gasteier?

2603 Ms. Gasteier. We have stayed insulated from those impacts

2604 in Massachusetts because we have our own individual mandate, but

2605 we imagine if we didn't have a tool like that either state or

2606 federally-based it would reduce access.

2607 Mr. Soto. Mr. Wieske?

2608 Mr. Wieske. Specifically in Wisconsin, our rates were so

2609 high that we are not convinced that it had a significant impact

2610 on enrollment.

2611 Mr. Soto. Okay. And, finally, not requiring Medicaid

2612 expansion, I realize the courts helped in that, how did that affect

2613 access and costs?

2614 Mr. Lee. Well, I think that in states like Florida, the

2615 reason you have a big exchange is you have many, many Floridians

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2616 who do not benefit from the Medicaid program, and I think
2617 Californians benefit. I think there are millions of Americans
2618 not benefiting from that coverage expansion.
2619 Mr. Soto. Ms. Gasteier?
2620 Ms. Gasteier. Similar, I think the Affordable Care Act put
2621 puzzle pieces in place with the assumption that Medicaid expansion
2622 would catch a particular population of people and ensure that
2623 they had guaranteed coverage, so obviously Massachusetts has
2624 taken advantage of that to great effect. And so I would expect
2625 that that has dramatically reduced coverage elsewhere where that
2626 has not been mandatory.
2627 Mr. Soto. Mr. Wieske?
2628 Mr. Wieske. And we haven't seen a negative impact from that
2629 in where I was in Wisconsin. We saw a positive impact.
2630 Mr. Soto. Thank you.
2631 Mr. Wieske. And we had a unique approach.
2632 Mr. Soto. Thank you. My time has expired.
2633 Ms. Eshoo. I thank the gentleman for his excellent
2634 questions.
2635 Now I have the pleasure of recognizing Mr. Bilirakis from
2636 Florida to question for 5 minutes. And I would like to note that
2637 for those that may not know, his father preceded him in Congress
2638 and was the chairman of this subcommittee, a wonderful chairman

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2639 and still a wonderful friend. So you have 5 minutes to question,
2640 Mr. Bilirakis.
2641 Mr. Bilirakis. Thank you. I appreciate that. Thank you
2642 so very much. It is an honor to serve on this committee and to
2643 serve under you as the chairwoman, and also the ranking member.
2644 I won't forget that.
2645 So anyway, thank you very much and thank you for your
2646 testimony. I appreciate it very much.
2647 Mr. Wieske, in your testimony you talked about how in
2648 Wisconsin the insurance markets were damaged by the exchanges.
2649 The number of insurance companies withdrew from the market and
2650 premiums kept moving up. That problem isn't isolated just to
2651 Wisconsin. In Florida we have less participation in the exchange
2652 today than 2014 and the majority of counties only have one
2653 insurance carrier. As a matter of fact, the county that I
2654 represent, I represent three counties, one of the counties only
2655 has one insurance and it is a carrier and it is -- I think the
2656 population is close to 500,000.
2657 Last year, Wisconsin received a 1332 state innovation waiver
2658 to reestablish a reinsurance program and other states have applied
2659 or received a waiver for reinsurance in other programs. Are 1332
2660 waivers still available for states to use? This is for again
2661 Mr. Wieske.

2662 Mr. Wieske. They are, yes.

2663 Mr. Bilirakis. They are. Okay, thank you.

2664 Does it make sense to move a standalone reinsurance bill
2665 by itself with no reforms in it, and wouldn't it be better to
2666 move legislation to reform the 1332 state innovation waiver to
2667 give greater flexibility to states to reform and repair their
2668 insurance markets? What do you think of that?

2669 Mr. Wieske. Yeah, I think given the issues surrounding the
2670 risk pool that we have all sort of talked about especially in
2671 states like Wisconsin, Iowa, and other states, I think it is
2672 important not to just look at reinsurance. Reinsurance shifts
2673 who pays, as I stated, but we need to find some new ways to sort
2674 of improve that risk pool. So I think a broader 1332 will have
2675 some value for states.

2676 Mr. Bilirakis. Okay. This question is regarding state
2677 exchanges again.

2678 Mr. Wieske, one of the bills under consideration today would
2679 spend $200 million for more state-based exchanges. Wouldn't it
2680 make more sense to have private entities running the exchanges
2681 rather than government entities? What do you think of that?

2682 Mr. Wieske. I think Wisconsin and a lot of other states
2683 like it could not afford with the 200 million to run its own
2684 exchange. So in order to have a first-class experience, I think

2685 looking at private entities to be able to offer additional options
2686 makes a lot of sense.
2687 Mr. Bilirakis. Okay. Wouldn't it make more sense again
2688 as you said to have the private entity running the exchanges rather
2689 than the government entities? Can we have businesses assume the
2690 financial risk of running an exchange rather than the federal
2691 government bankrolling the states? What are the barriers to
2692 having private exchanges provide this particular service?
2693 Mr. Wieske. I think one of the things to understand is that
2694 there is still a state regulatory process in place that reviews
2695 the plans, reviews the insurers, licenses the agent, licensing
2696 the insurers, checks their financial solvency, does everything
2697 soup to nuts, currently, in a number of states. And they can
2698 serve, continue to serve that role and it changes, functionally,
2699 a website and an outreach entity to be able to get consumers to
2700 sign up for coverage. They existed before the ACA. They exist
2701 now, after the ACA.
2702 And I think what our thought is, is that having a
2703 first-in-class experience and having an entity, entities offering
2704 with state oversight the in-exchange role makes a lot of sense
2705 financially. There is a lot less risk.
2706 Mr. Bilirakis. Thank you very much.
2707 Unless the ranking member would like the balance of my time,

2708 I yield back.

2709 Mr. Burgess. Well, thank you. In fact, I would like to
2710 take just a minute.

2711 Mr. Bilirakis. I figured you would.

2712 Mr. Burgess. It is not really the subject of what this
2713 subcommittee is considering today, but, Madam Chair, I just feel
2714 like this committee has had such a good relationship with Dr.
2715 Scott Gottlieb over the last 2 years and certainly I don't know
2716 what was involved in his decision to make his announcement
2717 yesterday, but I will just say he will be missed certainly by
2718 me personally and I believe by the subcommittee generally. And
2719 we certainly want to wish him well in whatever his future
2720 endeavors.

2721 I do not know that we have ever had a brighter witness here
2722 at the witness table than Dr. Gottlieb and he was never shy about
2723 telling us that also, but he will be missed. And I really
2724 appreciated the enthusiasm with which he took the job of
2725 administrator of the Food and Drug Administration and, really,
2726 under his leadership some very positive changes occurred at that
2727 agency.

2728 So that is all I wanted to say. I will yield back to the
2729 gentleman from Florida.

2730 Mr. Bilirakis. And I will yield back, Madam Chair. Thank

2731 you.

2732 Ms. Eshoo. Just to thank you, Mr. Bilirakis.

2733 I would like to add my voice to that of the ranking member.
2734 I think that our country has been fortunate to have had Dr.
2735 Gottlieb as the commissioner of the FDA. It is an agency that
2736 the American people, I believe, trust. They always want it to
2737 uphold the highest standards because it stands between them and
2738 God knows what if the wrong decisions are made.

2739 So I think that we have been more than fortunate to have
2740 him as FDA commissioner. I think that he has worked very well
2741 with the committee, both sides of the aisle. In his statement
2742 he said he was getting tired of commuting from Connecticut. And
2743 I thought I wished I had known that ahead of time because I would
2744 have called him and encouraged to keep commuting, because I make
2745 a much longer commute across the country every week to California,
2746 not to Connecticut.

2747 So I know that on behalf of this subcommittee that we wish
2748 him well and we thank him. We thank him for, I think, exemplary
2749 public service.

2750 So with that I will ask unanimous consent to enter into the
2751 record the following, and it is kind of a long list: a statement
2752 from the American Lung Association in support of H.R.1425; a
2753 statement from the American Lung Association in support of H.R.

2754 1386; a letter from the American Medical Association in support
2755 of H.R. 1386, 1385, and 1425; a statement for the record from
2756 the American Cancer Society Cancer Action in support of H.R. 1386,
2757 1385, and 1425; a letter from Blue Cross Blue Shield Association
2758 in support of 1386, 1385, and 1425; written from the Asian and
2759 Pacific Islander American Health Forum in support of H.R. 1386,
2760 1385, and 1425; a letter in support of H.R. 1386 from the Young
2761 Invincible; a report on Exploring the Impact of State and Federal
2762 Actions on Enrollment in the Individual Market; a comparison of
2763 the federal marketplace and California, Massachusetts, and
2764 Washington; a statement from the American Health Insurance Plans;
2765 and a letter from the Healthcare Leadership Council.
2766 So we ask that that -- I am asking unanimous consent that
2767 we enter all of what I just read into the record including what
2768 the ranking member had raised earlier.
2769 Do you have something that you would like to add?
2770 Mr. Burgess. Yes, if I could be recognized for additional
2771 unanimous consent.
2772 Ms. Eshoo. Certainly.
2773 Mr. Burgess. I would like to ask unanimous consent to insert
2774 into the record the text of the bill that I introduced, H.R. 1510,
2775 and I would like to introduce into the record a letter from Blue
2776 Cross Blue Shield Association in support of that Bill 1510.

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2777 Ms. Eshoo. So ordered.

2778 [The information follows:]

2779 **********COMMITTEE INSERT 6**********

2780 Ms. Eshoo. I want to thank again, I started out by thanking
2781 the witnesses, I want to close by thanking you. You know, it
2782 is not very often said around here that we are so dependent upon
2783 experts in our country. It never ceases to amaze me the knowledge
2784 that resides in experts on so many issues.
2785 And so when you come forward and answer our questions that
2786 all becomes part of the record and that stays there for a long
2787 time, but it also remains with us because we learn from you.
2788 No one can say to any of you, you don't know what you are talking
2789 about. You have lived it. You have done it. You have brought
2790 your expertise here, and we are, on behalf of all of our
2791 constituents and the American people, really very grateful to
2792 you for the time and the expertise that you have shared with us.
2793 So with that the subcommittee is adjourned. Thank you,
2794 everyone.
2795 Mr. Burgess. And we have 5 days.
2796 Ms. Eshoo. Oh, we have 5 days for members -- I said that
2797 at the beginning of the hearing.
2798 Mr. Burgess. Oh, okay.
2799 Ms. Eshoo. But I will say it again -- time for members to
2800 submit their comments for the record.
2801 [Whereupon, at 12:32 p.m., the subcommittee was adjourned.]