

# RISING HEALTH INSURANCE PREMIUMS UNDER OBAMACARE

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## HEARING BEFORE THE SUBCOMMITTEE ON OVERSIGHT OF THE COMMITTEE ON WAYS AND MEANS U.S. HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

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## **RISING HEALTH INSURANCE PREMIUMS UNDER OBAMACARE**

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**WEDNESDAY, JUNE 24, 2015**

U.S. HOUSE OF REPRESENTATIVES,  
COMMITTEE ON WAYS AND MEANS,  
SUBCOMMITTEE ON OVERSIGHT,  
*Washington, DC.*

The subcommittee met, pursuant to call, at 10:04 a.m., in Room 1100, Longworth House Office Building, the Honorable Peter Roskam [chairman of the subcommittee] presiding.

[The advisory announcing the hearing follows:]



**Chairman Roskam Announces Hearing on Rising Health Insurance Premiums Under Obamacare**

House Committee on Ways and Means Subcommittee on Oversight Chairman Peter J. Roskam (R-IL) today announced that the Committee on Ways and Means Subcommittee on Oversight will hold a hearing on the effects of the Affordable Care Act (ACA) on health insurance premiums. The hearing will take place on Wednesday, June 24, 2015 at 10:00 AM in Room 1100 of the Longworth House Office Building.

Oral testimony at the hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

**Details for Submission of Written Comments:**

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, July 8, 2015**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

**Formatting Requirements:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses

and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

3. Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

**Note:** All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>.



Chairman ROSKAM. The committee will come to order. Before we begin, I would like to take a point of personal privilege and acknowledge the ranking member, Mr. Lewis. You know, it is often said that people look at the United States Congress today and they can be pretty discouraged and pretty overwhelmed by what happens up here. And I began to reflect on that a little bit, and I have been, for the past several months, sitting next to a man who brings everything that is good about this process to the forefront, and that is John Lewis. And when I took over the gavel of this subcommittee, I knew he was the ranking member, and I knew he had an autobiography, and I read it, and I was fascinated by it. The part that fascinated me, oftentimes I put myself into the place of someone about whom I am reading in terms of time and place.

And I began to think and read about what John Lewis did in the summer of 1961, that is he took on an incredible physical and moral challenge to be one of the original Freedom Riders who was to integrate the interstate bus system and all of those things around it.

I was thinking, what was I doing in the summer of 1961? In the summer of 1961 I was comfortably in my mother's womb to be born later on in September of that year. And as I thought about it, and I had planned to do this before the events of Charleston, and now the events of Charleston have come upon us, and as I thought about it, I thought what a privilege to sit on a dais with somebody who worked so hard to improve the world for all of us, because we are all better off, every one of us, regardless of our racial background, we are all better off today because of the work and the tenacity and moral clarity and the courage in light of physical trauma that John Lewis, as a very young man, was willing to endure. And so, we have a copy for every member, *Walking With the Wind*, a memoir of the movement by John Lewis.

I would even go so far as to say I bet you if you give him eye contact and corner him, he will even sign the book for you. I really, recommend it to you, because it is a work that is an inspiration, it is a work that I think can guide us all. And it is an invitation basically to come with a sense of clarity to say look, we can take on these things. If John Lewis was able to be a part of taking on a very broken and dangerous system that was legal segregation in the United States and was able to persevere through that, then surely we can take on and deal with a number of the challenges that are here before us.

And so, I am so deeply appreciative of his leadership and his clarity, and I am very anxious for my colleagues to read this.

Now, since you don't get a copy of your own book, I have got a gift for you, and that is this, my wife Elizabeth is an oil painter, and she has painted a series of paintings, and this is has not yet been published or put out anywhere, but one the paintings she has done is called *Dreams of Freedom*, and *Dreams of Freedom* is a portrayal of Martin Luther King, Jr.'s speech in 1963, and I note Mr. Lewis was there, I know he was inextricably linked to that time that was so pivotal in our history, the march of 1963. And so I present this print to you of Elizabeth Roskam's oil painting, *Dreams of Freedom* for you. And I hope that you will accept it with the spirit with which it is presented to you today, Mr. Lewis.



[Applause.]

Mr. LEWIS. Mr. Chairman, thank you so much for those kind words. Thank you for making *Walking With the Wind* available to our colleagues. I thank you and your wife for this lovely, beautiful painting of freedom, portraying Dr. Martin Luther King, Jr. standing at the Lincoln Memorial delivering that speech. I was there, I was there, 23 years old, had all of my hair and a few pounds lighter. I spoke number six and Dr. King spoke number 10. And out of the 10 people who spoke that day, I am the only one still around. Thank you for your friendship, thank you for being you and I will cherish this. With debate, I will have an executive session with myself, whether put it in my office or take it to my house. Just thank you so much.

Chairman ROSKAM. Thank you, thank you. I should show the audience the print. How is that?

Mr. LEWIS. It is beautiful.

Chairman ROSKAM. There you go.

Well, let's get down to business, shall we? Today's hearing we are going to focus in on this discussion about big premium hikes that insurance companies are currently proposing for 2016 under the Affordable Care Act. For 5 years, the administration has insisted the law would reduce health care costs. The President said that we can cut the average family's premium by \$2,500 per year and yet the nonpartisan fact checker, PolitiFact, called that a broken promise. President Obama pledged that insurance premiums would go down, and yet The Washington Post fact checker rated that it as a three Pinocchios. In fact, we are 5 years in, the health insurance costs under ObamaCare are not going down, they are going up. Under the House rules the subcommittee's job is to evaluate the application, execution and effectiveness of the Federal laws. Today we are going to do that.

For the first time since the ACA became law, insurers are able to look at a full year's worth of data claims to calculate premium prices for the year ahead. That is an important distinction. So we have real data to talk about. The proposed premium hikes tell us a lot about how much healthcare costs last year and what insurers calculate healthcare costs are going to be next year. On June 1, CMS made public proposed premium hikes of 10 percent or more for the 2016 plan year, and many of the proposed increases are eye-poppingly huge.

In Maryland, Care First Blue Choice, which covers approximately 80 percent of the individual market has asked for an average increase of nearly 30 percent. In Missouri, Coventry Health has requested an increase of over 22 percent. In North Carolina, Blue Cross Blue Shield has asked for an increase of over 25 percent. In Tennessee, Blue Cross Blue Shield has asked for over 36 percent. In South Dakota one of the largest insurers, Wellmark has asked for premium hikes between 24 and 51 percent.

It is noteworthy in many States, the largest insurers are also the ones proposing the biggest increases, which is especially troubling if you think about it, because they have got the most data and are likely the most accurate. We could go on, but there are a number of these prices that have real consequences in the lives of real people. In other words, this isn't just about insurance commissioners

and scholars, this is about what people are actually paying, and they are paying this in the context of a false narrative, and the false narrative, in my opinion, was this is going to be great, your costs are going to come down and you are going to love it.

So here is a question, how many of Representative's Noem's constituents in South Dakota have gotten a 50 percent wage increase? I would venture very, very few in order to pay for those. Now, to be fair, these are just proposals, nothing has been finalized yet. In 36 States, State insurance authorities must approve the increases, and often after negotiating with the insurers, but there is a reason that the insurers are asking for such big rate hikes, the Affordable Care Act isn't working to lower costs, it is actually driving them up in many circumstances.

President Obama said that under the ACA more people will have health insurance so that the costly emergency care would diminish. But in order to keep costs down, these plans have relied on narrower provider networks, meaning fewer doctors and limited availability. Also, much of the new law's health insurance coverage came in the form of expanding Medicaid.

As many individuals can't get in to see their doctors and many doctors aren't taking Medicaid patients, the net result is that the ACA is ironically driving the number of emergency room visits up. Just the opposite of what President said and hoped would be achieved.

Are these effects of the ACA just growing pains? Hmm, I don't think so. The law created a number of temporary programs to bail out billions in taxpayer funds during the first few years to lower the costs seen by individuals and to protect the insurance carriers against financial losses, but those programs are beginning to phase out. As the government is slowly taking off the training wheels, the Affordable Care Act is looking pretty wobbly.

Even with the billions and billions of taxpayer dollars sent to reduce the sticker price of insurance for individuals to lower their out-of-pocket costs, to pump up big insurance companies, to establish and operate the insurance market places and more, all hidden and shifted costs paid by the taxpayer, even with all that, healthcare costs and health insurance premiums are still going up.

On its Web site, the Department of Health and Human Services says this: A new wave of powerful evidence points to one clear conclusion, the Affordable Care Act is working to make health care more affordable, accessible and of higher quality for families, seniors, businesses and taxpayers alike. But look at the facts, premiums are going up, emergency room use is rising, co-ops are failing and there is certainly a new wave of evidence, I would argue, and that is one that is pointing in a different direction, and that is, that the Affordable Care Act or Obama care is not working as promised.

We are going to have a robust discussion in a couple of minutes; we will introduce our witnesses. But for now I would like to recognize Mr. Lewis for his opening statement.

Mr. LEWIS. Good morning. Mr. Chairman, I want to thank you for holding today's hearing on the Affordable Care Act. I would also would like to thank our witnesses for being here. We are always pleased to discuss our landmark health law.

I will begin by saying that I have said at countless other hearings, the law works. The ACA is the law of the land. It was the right thing to do, it was the just thing to do, and it was long overdue.

I believe in my core that health care is a basic human right, it should not be reserved for a select few, for the rich or for the wealthy. Each and every one of us must do all we can to make this country better for the least among us, and for generations yet unborn. We have a duty to speak up and speak out on behalf of people who have no one to stand up for them. The Affordable Care Act responded to the desperation of countless Americans who have a need, a right to health care.

The law provides real benefits to American families. Today, over 16 million people who did not have coverage now do. More than 100 million people with existing health conditions can no longer be denied coverage. Millions of young people can now stay on their parents' insurance plan until age 26. And over 9 million hard-working Americans have received tax credits to make health insurance affordable, just as Congress intended.

During today's hearing, I would like to learn more about how premiums are being set for next year. Many have heard or read stories in the press, but these stories may overlook future rate cuts, and instead, focus on proposal and still must be reviewed under the law. Although these rates are not yet final, I look forward to hearing more from our witnesses about what they think the final rates would be.

Again, Mr. Chairman, I would like to thank you for holding today's hearing. Thank you very much and I yield back.

Chairman ROSKAM. Thank you, Mr. Lewis. We will hear from our four witnesses, two of whom I will introduce, and two of whom will be introduced by members of the panel. Our first witness is Al Redmer, Jr., who is the commissioner of Maryland Insurance Administration. He will testify about the cost of health plans within the State of Maryland and the experiences with Maryland's State-based exchange. Then we also have Seth Chandler, an insurance professor at the University of Houston who will testify about contributing factors regarding the premium spike.

And I would like to recognize Mrs. Black to make an introduction.

Mrs. BLACK. Thank you, Mr. Chairman. I want to thank you for allowing me to be here with you on committee as a noncommittee member. I am very proud today to introduce the commissioner of my State, Julie McPeak, and she is Commissioner of Tennessee's Department of Commerce and Insurance. She serves in this role under Governor Haslam, our current Governor. She has been doing so since 2011, and she brings 15 years of experience with her in the legal and administrative experience in State government.

I am also proud, extremely proud to tell you that she has been commissioner of commerce and insurance in two different States before coming to the State of Tennessee. She was the commissioner there in Kentucky and she is the first woman in the country who has had this title of being able to serve in two different States in this position.

I really appreciate her dedication to our State. She has done a great job. She is committed to the State, and we have the most robust competitive insurance market possible here under the current law. I look forward to hearing her testimony today as she talks about the impact of ACA, in particular, on my State's insurance marketplace, specifically on the premiums and also the laws and impact on our enrollees, so it is my pleasure to have her with us here today.

Chairman ROSKAM. Thank you. And Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. It is my pleasure to introduce my colleague Mike Kreidler. Mike before he got involved in politics was an optometrist, he could see clearly. He worked for 20 years for a group held cooperative in Washington State so he understands managed care and has been very deeply involved in that on a personal, professional level.

I got to know Mike when I was in the State legislature, he was there in the 1970s onward, and then came for a very short stay in the United States Congress. He was here 2 years and fate and the tides of war took him home again, but he kept up his public service by becoming the insurance commissioner of the State of Washington and has been such for—I have if forgotten how many years it has been—but it has got to be 15 by now, isn't it? He is a very knowledgeable man and I commend him to the committee. He knows about both on the doing side as well as the public policy side.

Chairman ROSKAM. Thank you. For our witnesses, your written statements are part of the record. You have got 5 minutes, so Mr. Chandler, we welcome the opportunity to hear from you. You get the joke on this, green, yellow, red, there is a light that will be fairly intuitive. And if I have to explain that to you, it is hopeless.

**STATEMENT OF SETH CHANDLER, INSURANCE LAW  
PROFESSOR, UNIVERSITY OF HOUSTON**

Mr. CHANDLER. Thank you very much. My name is Seth Chandler, I am a law professor at the University of Houston with specialization in insurance law and healthcare law. I do a lot of work using mathematics to enhance legal analysis. I am here today to testify on some of the anticipated premium increases and their sources on the exchanges for 2016 with an emphasis on two of the famous three Rs.

Point one, we need to be careful in looking at premium increases. There are many occasions on which the net premium increase actually seen by an insured, which I think is the most important thing, will be considerably higher than the gross premium increase. A fact likely to diminish individual choice, and induce policyholders to purchase lower cost, silver HMO policies.

Second, the phaseout of transitional reinsurance and the CR/Omnibus alteration of risk corridors is unlikely, in most cases, to play a large role for any particularly large premium increases for 2016.

Third, the major source of increases is likely to be higher than expected claims for insureds, particularly in the more generous platinum, and gold, and PPO plans.

Now for some details. Net premiums, the amount paid after lawful subsidies are taken into account, not the published gross pre-

miums are what matters to most people. And as I show in my technical appendix, it is a matter of indisputable mathematics that net premium increases under the ACA are not, not, not the same as gross premium increases. This fact can convert a 10 percent gross premium increase into a 15 percent net premium increase; it can convert a 10 percent gross into 12 percent net premium increase in a way that may impel the purchaser to experience a 50 percent increase in out-of-pocket costs.

People on both sides of the aisle take note. The poor bear the brunt of this math. The more heavily subsidized you are, the higher the percentage price increase if you want continuity of insurers or continuity of care.

Based on the actuarial value continuance tables created by CMS for its regulation of the Affordable Care Act, I have computed the reduction in net claims expenses created by the Transitional Reinsurance Programs for 2014, 2015, 2016. The TRP, as retroactively modified last week, reduced insurer's exchange expenses by 14 to 16 percent in 2014, depending on the metal level. By the way, prior to the change last week, the figures were 11 to 12 percent, meaning that insurers large and small just received a 3 percent cash back rebate from the Federal Government for 2014.

For 2015, the TRP should reduce insurers' net claims expenses by 3 to 4 percent, and for 2016, the figures are almost the same. Since the value of the subsidies have not declined substantially between 2015 and 2016, it is difficult to attribute a substantial part of the premium increases for 2016 to the phaseout.

Now, another source of premium increases for 2016, sometimes mentioned is the modification of the risk corridors program by the CR/Omnibus bill. I did some research and it looks like that is unlikely, again, to be a source of a significant change in premiums. Yes, it is true that insurers may only received 37 percent or so of what they had hoped to receive under CR/Omnibus, but many insurers hope that they will actually make a profit under the Affordable Care Act.

And, therefore, the big picture is, it is unlikely that when we are looking at particularly large increases, the source of those increases is the phaseout of the transitional reinsurance program or of the alteration of risk corridors. Instead, let's look at what is going on here. Standard & Poor's has suggested that most insurers lost money in 2014, and so it is natural to see them requesting a rate increase. But don't trust the insurers, look at the Obama administration's actuarial value calculator which it is used to regulate insurers to determine if they are providing value. If you look at that, it shows that the gross claims of insurers is going to go up by 13 to 14 percent in 2016, relative to 2017.

Let me just conclude by saying that the ACA focused mostly on insurance markets. And in the absence of better medical cost control, one should everything else hold equal, expect the Federal bills for subsidies to increase. Moreover, it is likely to cause an escalation of premiums, particularly for the more generation PPO plans and gold and platinum plans. And if so, we will see a diminishing choice of physicians, potentially less continuity of care, and increased cost sharing for many individuals.

Obviously, I am speaking here before *King v. Burwell* is decided. A decision adverse to the Obama administration would not change the concepts I am laying out, but it would change the numbers. In fact, one of the most interesting things is to think about what happens to the transitional reinsurance program if we have gridlock both at the Federal level and the States. But if *King v. Burwell* is decided adversely to the Obama administration, you folks have a lot more issues to discuss.

Thank you very much.

[The prepared statement of Mr. Chandler follows:]

## Sources of 2016 Premium Increases

Seth J. Chandler

Foundation Professor of Law

University of Houston Law Center

The views expressed herein do not necessarily represent those of the University of Houston.

### Introduction

My name is Seth Chandler and I am a law professor at the University of Houston with specialization in insurance law and health care law. I also do a lot of work using mathematics to enhance legal analysis. I am here to testify on some of the sources of anticipated premium increases on the Exchanges for 2016 with an emphasis on two of the "3 Rs."

Here is a summary of what I have to say:

- We need to be careful in looking at premium increases: there are many occasions on which the net premium percent increase seen by an insured, the important thing, will be considerably higher than the gross premium percent increase. This fact is likely to diminish individual choice and induce policyholders to purchase lower cost silver HMO policies. Sometimes the net premium increase will be less than the gross.
- Although they will contribute, the phase out of transitional reinsurance and the Cromnibus alteration of risk corridors are unlikely to be responsible for particularly large premium increases for 2016.
- The major source of increases is likely to be higher-than-expected claims from insureds, particularly in the more generous platinum and gold plans.

Because I have been obliged to write this before *King v. Burwell* is resolved, I am going to assume that the case is resolved favorably to the Obama administration's position. If that is not the case, the issues created thereby will not make what I say untrue in concept, but the numbers may well change and there will be an issue of greater magnitude to debate.

### Net premiums will often rise more than gross premiums, particularly for low income policyholders

The gross premium increases that may be coming are troubling to the stability of the ACA. What should be yet more worrisome, however, is the increase in *net* premiums chronically ill or lower income purchasers are likely to see. This is because gross premiums will not determine most consumer's behavior: net premiums, the amount paid after lawful subsidies are taken into account are what will matter. And, as I show in a technical appendix to my written testimony, the rate of net premium increases is not the same as the rate of gross premium increases. Rather, the rate of net premium increases are the

difference between the gross premium increases divided by the prior years net premium. As the denominator of that fraction decreases — as the person gets poorer — the net premium increase grows. I show in the appendix how this fact can easily convert a 10% gross premium increase into a 15% gross premium index. Or how it can convert a 10% gross premium increase into a 12% net premium increase in a way that may impel the purchaser to experience a 50% increase in out of pocket costs.

This is not some bug in the ACA. It is a feature. Baked right into the architecture. What it means, however, if higher metal level policy premiums rise faster than silver policies and or PPOs rise faster than HMOs, is that there will be more pressure than one might expect for purchasers to head for silver HMOs.

## The phasing out of transitional reinsurance should cause significant but not enormous increases in premiums for most insurers

Part of the Affordable Care Act was to provide insurers participating in the Exchanges for free with something they otherwise might have purchased: specific stop loss reinsurance. This "R" reduced risk a bit for smaller insurers but, more importantly, permitted insurers to offer lower gross premiums for all purchasers. Unlike the cost sharing subsidies and tax credits, Congress chose by this plan to make the reduction no greater for poorer purchasers than for the wealthier.

The estimates I am to provide are based on the Obama administration's "Actuarial Value Calculator" for 2014, 2015 and the current draft for 2016. These calculators have behind them estimates for the distribution of claims expenses called continuance tables for purchases of each of the four metal levels of policies. It is the method by which CMS determines whether a policy is really offering benefits equal to some specified percentage of claims expenses, 70% for silver, 80% for gold, etc. Thus, I would certainly hope it is accurate.

Using Excel to spot check and both the Wolfram and R computer languages to do the bulk of the computations, and based on the Actuarial Value Calculator continuance tables, I have computed the reduction in net claims expenses created by the transitional reinsurance program for 2014, 2015 and 2016. Using the just-increased reinsurance benefits for 2014, the TRP reduced insurers net claims expenses by 14-16% in 2014, depending on the metal level. (Prior to the change last week, the figures were 11-12%, meaning that insurers just received a 3% cash-back rebate from the federal government for 2014.) For 2015, the TRP, assuming its current parameters are not revised, should reduce insurers net claims expenses by 3-4%. And for 2016, the same figures are 3% for all metal levels. Of course, these are average figures. Insurers with unusually large claims expenses may get more benefit out of the TRP. Insurers with unusually low claims expenses may get less.

So, what does this mean. First, since the value of the subsidies has not declined substantially between 2015 and 2016, it is difficult to attribute a substantial part of premium increases to this anticipated change in the subsidy. And even if insurers anticipate some retroactive modification in the generosity of the 2015 program, as has occurred in 2014, I do not see how, in most cases, the 2015-16 phase out of transitional reinsurance would lead to increases on the order of 10% or more. Second, most of the reduction in the TRP occurred between 2014 and 2015. So, the final elimination of the TRP for 2017 should not itself result in enormous increases, though, combined with further increases in claims expenses, might well cast the program deeper into an adverse selection cycle.

A footnote: There has been an implication that the ability of CMS to increase TRP payments for 2014 is a sign that the ACA is working. This is not correct. The main reason TRP payments could increase is



that they are proportional to the number of people enrolled. And because this was at least 14% less than what was estimated at the time the original TRP parameters were developed, it is not surprising that, even with higher than expected claims expenses, there could be some extra money to increase the subsidy rate.

## The modification of the Risk Corridors program will usually not be responsible for major increases in gross premiums

Another potential source of premium increases for 2016 is the modification of the Risk Corridors program by the Omnibus bill. This is a program that offers a free derivative -- and I mean that in the securities sense -- to insurers participating in the Exchanges. If they make money -- calculated the Obama administration's way -- they pay into Risk Corridors, sometimes a substantial amount. If they lose money, they get paid by Risk Corridors, again, sometimes a substantial amount. There was no guarantee under the prior program that payments in would equal payments out and work by Standard & Poors indicates that, as some, including me, had earlier predicted, payments out would indeed be greater than payments in. The Omnibus bill changes this by making Risk Corridors somewhat akin to bankruptcy. If obligations out are greater than payments due, the payments out are reduced pro rata until payments out and payments in equilibrate.

So, the question is, to what extent is this change in the law responsible for premium increases that may well be down the pike for 2016. It is my best estimate that, as a result of Omnibus, insurers essentially losing money will receive about 37% of what they would have received had the federal government not required a balanced budget for the program. Of all the things I am testifying about here today, this one, I believe is the one in which there could be significant error bars around my estimate. There is a lot of information we do not yet know.

I further attempted to estimate how much this increase in downside risk would mean to most insurers. The answer is, it depends. If, of course, the insurer was pretty confident that it would make money -- something we might ordinarily expect -- then the increase in downside risk does them little harm. Risk corridors only kicks in when you lose money -- or at least are treated as having lost money by the complex formula implemented by CMS. On the other hand, if the insurer thought it would lose money using that formula or it was very uncertain as to what its financial position would be, then the increase in downside risk is somewhat significant. I therefore estimated that reasonable bounds on the incremental cost to insurers created by Omnibus ranged from 0 for insurers who expected profitability, 0.5 percent for insurers that thought they would break even and were confident within 95% that their Risk Corridors ratio would range from 0.92 to 1.08, and up to 5% for an insurer that thought it would lose money but had high uncertainty as to its financial position. I should emphasize that I am looking at the Omnibus-induced change in Risk Corridors, not at the effect of Risk Corridors as a whole.

The bottom line is, however, when we are looking at gross premium increases over 5% and certainly over 10%, it is unlikely that most of that is the result of the Omnibus modification of risk corridors.

## The main cause of gross premium increases is likely to be adverse claim experience

This is a conclusion reached partly by a process of elimination. If it's not the diminution of transitional reinsurance and it is not the Omnibus modification of Risk Corridors that is responsible for large

premium increases, what is it? While there could conceivably be other factors such as state regulatory developments or interest rate changes, the most obvious candidate is adverse claims experience. This is particularly so since interest rates have remained relatively stable and the past few years have not been a fertile time for major state regulatory reforms in health insurance. Certainly many of the filings published thus far by insurers seeking gross premium increases in excess of 10% have so stated and work by Standard and Poors strongly indicates that there will far more insurers losing money this year than gaining money.

Before we explore more exotic hypotheses, we should realize that data from the Actuarial Value Calculator that the Obama administration uses to regulated insurers reinforces the belief that adverse claims experience is significantly driving higher premiums. If one simply looks at the data, the expected claims of an insurer offering a silver policy is 14% higher under that calculator for 2016 than it is for 2015. The other metals have results of 13%. This data would not factor in either the Transitional Reinsurance Program or the Risk Corridors program. And lest anyone think there must be something wrong with the data in the Calculator, here is CMS's description of it: "The AV Calculator represents an empirical estimate of the AV calculated in a manner that provides a close approximation to the actual average spending by a wide range of consumers in a standard population." (<https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-av-calculator-methodology.pdf>)

Footnote : I also attempted to see whether there was any difference in the rate of increase between medical claims and pharmaceutical claims. I found no significant difference. This is either because, in fact, there is no difference or because CMS has not yet differentiated in its 2016 drafts of its actuarial value calculator.

## Technical Appendix I

### Gross premiums v. Net premiums

In this material, I use the following notation.

- ◆ sg1 is the gross premium for the second lowest silver policy in year 1.
- ◆ sg2 is the gross premium for the second lowest silver policy in year 2.
- ◆ y1 is the subsidy in year 1.
- ◆ y2 is the subsidy in year 2.
- ◆ rs is the percent increase in the premium for the second lowest silver policy between year 1 and year 2.
- ◆ g1 is the gross premium for the policy actually purchased by the insured in year 1.
- ◆ rg is the percent increase in the premium for the policy actually purchased by the insured between year 1 and year 2.

If we assume the income of the purchaser remains relatively constant and that the income of the purchaser bounds the most that it can pay for the second lowest silver policy then the subsidy in the second year for the second lowest premium has to be enough so that the net premium remains the same. The algebra below computes a formula for the second year subsidy using this invariance.

```
netPremiumEquivalenceRule = First[Solve[sg1 - y1 == sg2 - y2, y2]] /. sg2 -> sg1 (1 + rs)
(y2 -> -sg1 + (1 + rs) sg1 + y1)
```

We can now calculate the rate of increase in the net premium if the insured decides to keep its policy (and probably its doctors).

$$\text{netPremiumIncrease} = \frac{g1 (1 + rg) - y2}{g1 - y1} - 1;$$

We can simplify this expression using the net premium equivalence rule derived above.

```
simplifiedNetPremiumIncrease =
Simplify[netPremiumIncrease /. netPremiumEquivalenceRule]

$$\frac{g1 rg - rs sg1}{g1 - y1}$$

```

If we stare at this expression for a bit, we can see that it is the difference in the increases in gross premiums divided by the net premium for the policy actually purchased in the prior year.

We can turn this into a function as follows:

```
snpi[g1_, rg_, sg1_, rs_, y1_] := 
$$\frac{g1 rg - rs sg1}{g1 - y1}$$

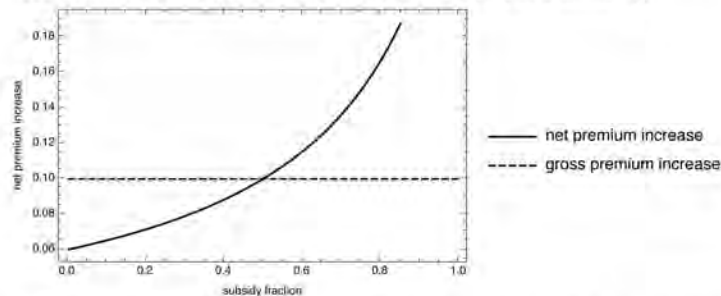
```

We can test this on various scenarios. Here is one in which the gross premium in year 1 for the policy chosen is 1000, the rate of gross premium increase in that policy is 10%, the second lowest silver policy has a gross premium of 800 with a rate of gross premium increase of 5%. And the initial subsidy is 600.

```
snpi[1000, 0.1, 800, 0.05, 600]
0.15
```

We can also evaluate the rate of net premium increase for the policy chosen as a function of the percentage of the premium subsidized, which is a proxy for income.

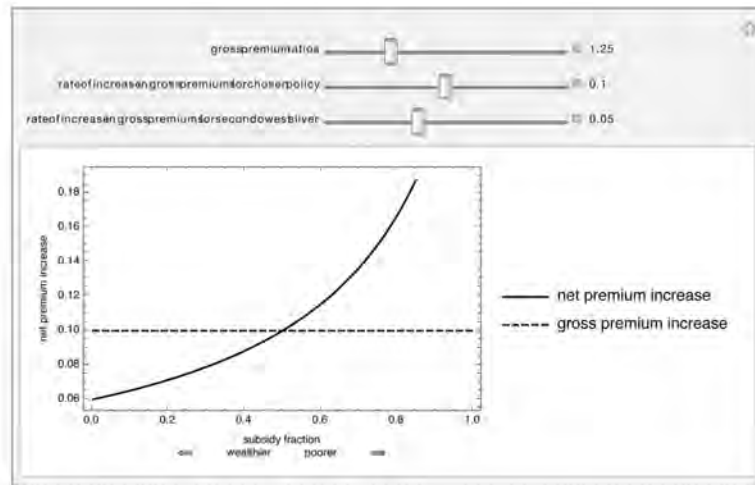
```
Plot[{snpi[1000, 0.1, 800, 0.05, 800 + subsidyFraction], 0.1},
{subsidyFraction, 0, 1}, Axes -> False, Frame -> True, FrameLabel ->
{"subsidy fraction", "net premium increase"}, PlotTheme -> "Monochrome",
PlotLegends -> {"net premium increase", "gross premium increase"}]
```



In the interactive version of this document, you can also see a plot such as the one above in which one is permitted to vary other variables such as the ratio of the gross premiums and the two rates of

increase.

```
Manipulate[Plot[(snpi[s * 800, rg, 800, rs, 800 * subsidyFraction], rg),
  {subsidyFraction, 0, 1}, Axes → False,
  Frame → True, FrameLabel → {Grid[{"subsidy fraction"},
    {Row[Riffle[{"="}, "wealthier", "poorer", "="], " "
      "net premium increase"}], PlotTheme → "Monochrome",
    PlotLegends → {"net premium increase", "gross premium increase"}],
  {{e, 1.25, "gross premium ratios"}, 1, 2, 0.01, Appearance → "Labeled"},
  {{rg, 0.1, "rate of increase in gross premiums for chosen policy"},
    -0.1, 0.3, 0.01, Appearance → "Labeled"},
  {{rs, 0.05, "rate of increase in gross premiums for second lowest silver"},
    -0.1, 0.3, Appearance → "Labeled"}],
  1
```



We can also now compute explicitly the circumstances under which the rate of increase in net premiums will exceed the rate of increase in gross premiums. Unfortunately, it is difficult to find a simple English language version of this complex formula.

```

Refine[Reduce[{y1 ≥ 0, g1 > 0,  $\frac{g1\,rg - rs\,sg1}{(g1 - y1)^2} > rg, g1 \geq y1, sg1 > 0$ }, rg, Reals], y1 ≥ 0]

$$\left( y1 < g1 < \frac{1}{2} (1 + 2\,y1) + \frac{1}{2} \sqrt{1 + 4\,y1} \ \&\& \ sg1 > 0 \ \&\& \ rg > -\frac{rs\,sg1}{-g1 + g1^2 - 2\,g1\,y1 + y1^2} \right) ||$$


$$\left( g1 = \frac{1}{2} (1 + 2\,y1) + \frac{1}{2} \sqrt{1 + 4\,y1} \ \&\& \ sg1 > 0 \ \&\& \ rs < 0 \right) ||$$


$$\left( g1 > \frac{1}{2} (1 + 2\,y1) + \frac{1}{2} \sqrt{1 + 4\,y1} \ \&\& \ sg1 > 0 \ \&\& \ rg < -\frac{rs\,sg1}{-g1 + g1^2 - 2\,g1\,y1 + y1^2} \right)$$


```

## Technical Appendix 2

# The effect of declining transitional reinsurance on insurer prices and exposure under the Affordable Care Act

## Read in data

We begin by reading in data from the 2014, 2015 and 2016 actuarial value calculators.

```

sheets14 = Import[
  "/Users/sethchandler/Dropbox/Scholarship/Amsterdam15/avcalculator2014.xlsm",
  "Sheets"]
{Sheet2, User Guide, Enrollment Restrictions, AV Calculator,
Variation Results, Platinum Cont. Table - Medical, Gold Cont. Table - Medical,
Silver Cont. Table - Medical, Bronze Cont. Table - Medical,
Platinum Cont. Table - Rx Only, Gold Cont. Table - Rx Only,
Silver Cont. Table - Rx Only, Bronze Cont. Table - Rx Only,
Platinum Cont. Table - Combined, Gold Cont. Table - Combined,
Silver Cont. Table - Combined, Bronze Cont. Table - Combined}

```

```

sheets15 = Import[
  "/Users/sethchandler/Dropbox/Scholarship/Amsterdam15/avcalculator2015.xlsm",
  "Sheets"]

(Sheet2, User Guide, Enrollment Restrictions, AV Calculator,
Variation Results, Platinum Cont. Table - Medical, Gold Cont. Table - Medical,
Silver Cont. Table - Medical, Bronze Cont. Table - Medical,
Platinum Cont. Table - Rx Only, Gold Cont. Table - Rx Only,
Silver Cont. Table - Rx Only, Bronze Cont. Table - Rx Only,
Platinum Cont. Table - Combined, Gold Cont. Table - Combined,
Silver Cont. Table - Combined, Bronze Cont. Table - Combined)

sheets16 = Import[
  "/Users/sethchandler/Dropbox/Scholarship/Amsterdam15/avcalculator2016.xlsm",
  "Sheets"]

(Sheet2, User Guide, AV Calculator,
Platinum Cont. Table - Medical, Gold Cont. Table - Medical,
Silver Cont. Table - Medical, Bronze Cont. Table - Medical,
Platinum Cont. Table - Rx Only, Gold Cont. Table - Rx Only,
Silver Cont. Table - Rx Only, Bronze Cont. Table - Rx Only,
Platinum Cont. Table - Combined, Gold Cont. Table - Combined,
Silver Cont. Table - Combined, Bronze Cont. Table - Combined)

```

### Determine relevant sheets

We now determine which sheets of these multi - sheet spreadsheets contain the data we want and are common to all sheets.

```

combinedSheets = Select[sheets14[] sheets15[] sheets16,
  StringMatchQ[#, RegularExpression[".+Cont\\.\\.\\.s+Table\\s+~\\.\\.s+Combined"]] &]

(Bronze Cont. Table - Combined, Gold Cont. Table - Combined,
Platinum Cont. Table - Combined, Silver Cont. Table - Combined)

rxSheets = Select[sheets14[] sheets15[] sheets16,
  StringMatchQ[#, RegularExpression[".+Rx.*"]] &]

(Bronze Cont. Table - Rx Only, Gold Cont. Table - Rx Only,
Platinum Cont. Table - Rx Only, Silver Cont. Table - Rx Only)

medicalSheets = Select[sheets14[] sheets15[] sheets16,
  StringMatchQ[#, RegularExpression[".+Medical.*"]] &]

(Bronze Cont. Table - Medical, Gold Cont. Table - Medical,
Platinum Cont. Table - Medical, Silver Cont. Table - Medical)

```

### Main functionality

This section develops the major functions used in the analysis.

```
combinedRegex = RegularExpression[".+Cont\\.\\.\\.s+Table\\s+~\\.\\.s+Combined"];
```

```

sheetProcess[xlsFileString_, regex_, yearString_] :=
Module[{s, sheets, sheetsAssoc, dsAssoc, totsAssoc, augAssoc},
s = Import[xlsFileString, "Sheets"];
sheets = Select[s, StringMatchQ[#, regex] &];
sheetsAssoc =
Association@Map[name -> {StringReplace[name, (RegularExpression["\\s+"] -> "",
RegularExpression["\\."] -> "", RegularExpression["-"] -> "")},
yearString) -> Import[xlsFileString,
{"Sheets", name}][[5 ;; 88, 1 ;; 4]], sheets];
dsAssoc = Map[sheet -> Dataset@Map[row -> AssociationThread[
{"bin", "count", "maxd", "binAverage"} -> row], sheet], sheetsAssoc];
augAssoc = Map[ds -> With[{tot = ds[All /* Total, "count"]}],
ds[All, Append[#, "normalizedCount" -> #count / tot] &]], dsAssoc]]

switchValue[value_, params : {attach_, max_, pct_}] := Position[
{#1[[1]] <= value < #1[[2]] &} /@ Partition[{0, attach, max, #}, 2, 1], True, 1, 1][[1, 1]]

f[avg_, params : {attach_, max_, pct_}] :=
avg[All /* Total, #normalizedCount Switch[switchValue[#binAverage, params],
1, #binAverage,
2, attach + (1 - pct) (#binAverage - attach),
3, attach + (1 - pct) (max - attach) + (#binAverage - max)] &]

delta[{x_, y_}, OptionsPattern[{"roundingValue" -> 0.01}]] :=
Round[ $\frac{x - y}{y}$ , OptionValue["roundingValue"]]

```

## Constants

We input the TRP parameters for each of the years. We use two parameters for 2014, the original ones and the revised ones.

```

TRPparameters["2014"] = {45 000, 250 000, 0.8};
TRPparameters["2014a"] = {45 000, 250 000, 1};
TRPparameters["2015"] = {70 000, 250 000, 0.5};
TRPparameters["2016"] = {90 000, 250 000, 0.5};
ignoreReinsurance = {0, 100 000 000, 0};

```

### Plans for 2014

We now process the sheets.

```

sh2014 = sheetProcess[
"/Users/sethchandler/Dropbox/Scholarship/Amsterdam15/avcalculator2014.xlsm",
combinedRegex, "2014"];

```

And get expected claims for each mental level, with no reinsurance, with the revised reinsurance and with the original reinsurance.

```
noReinsurance2014 = Function[d, f[d, ignoreReinsurance]] /@ sh2014
{ | {PlatinumContTableCombined, 2014} → 6153.63,
  | {GoldContTableCombined, 2014} → 4995.66, {SilverContTableCombined, 2014} → 4736.52,
  | {BronzeContTableCombined, 2014} → 4064.37 | }

withRevisedReinsurance2014 = Function[d, f[d, TRPparameters["2014a*"]]] /@ sh2014
{ | {PlatinumContTableCombined, 2014} → 5406.67,
  | {GoldContTableCombined, 2014} → 4337.27, {SilverContTableCombined, 2014} → 4095.71,
  | {BronzeContTableCombined, 2014} → 3522.06 | }

Merge[{noReinsurance2014, withRevisedReinsurance2014},
  delta[H1, "roundingValue" → 0.01] &]
{ | {PlatinumContTableCombined, 2014} → 0.14, {GoldContTableCombined, 2014} → 0.15,
  | {SilverContTableCombined, 2014} → 0.16, {BronzeContTableCombined, 2014} → 0.15 | }
```

#### Original Plans for 2014

```
withReinsurance2014 = Function[d, f[d, TRPparameters["2014*"]]] /@ sh2014
{ | {PlatinumContTableCombined, 2014} → 5556.06,
  | {GoldContTableCombined, 2014} → 4468.95, {SilverContTableCombined, 2014} → 4223.87,
  | {BronzeContTableCombined, 2014} → 3630.52 | }

Merge[{noReinsurance2014, withReinsurance2014}, delta[H1, "roundingValue" → 0.01] &]
{ | {PlatinumContTableCombined, 2014} → 0.11, {GoldContTableCombined, 2014} → 0.12,
  | {SilverContTableCombined, 2014} → 0.12, {BronzeContTableCombined, 2014} → 0.12 | }
```

#### Plans for 2015

We do the same thing for 2015 ...

```
sh2015 = sheetProcess[
  "/Users/sathchandler/Dropbox/Scholarship/Amsterdam15/avcalculator2015.xlsm",
  combinedRegex, "2015"];

noReinsurance2015 = Function[d, f[d, ignoreReinsurance]] /@ sh2015
{ | {PlatinumContTableCombined, 2015} → 6153.63,
  | {GoldContTableCombined, 2015} → 4995.66, {SilverContTableCombined, 2015} → 4736.52,
  | {BronzeContTableCombined, 2015} → 4064.37 | }

withReinsurance2015 = Function[d, f[d, TRPparameters["2015*"]]] /@ sh2015
{ | {PlatinumContTableCombined, 2015} → 5954.24,
  | {GoldContTableCombined, 2015} → 4812.54, {SilverContTableCombined, 2015} → 4556.69,
  | {BronzeContTableCombined, 2015} → 3911.76 | }
```



```
Merge[{noReinsurance2015, withReinsurance2015}, delta[#1, "roundingValue" -> 0.01] &]
<| {PlatinumContTableCombined, 2015} -> 0.03, {GoldContTableCombined, 2015} -> 0.04,
{SilverContTableCombined, 2015} -> 0.04, {BronzeContTableCombined, 2015} -> 0.04 |>
```

### Plans for 2016

And 2016.

```
sh2016 = sheetProcess[
  "/Users/sethchandler/Dropbox/Scholarship/Amsterdam15/avcalculator2016.xlsm",
  combinedRegex, "2016"];
```

What is the expected payment for 2016 if there were no reinsurance

```
noReinsurance2016 = Function[d, f[d, ignoreReinsurance]] /@ sh2016
<| {PlatinumContTableCombined, 2016} -> 6979.6,
{GoldContTableCombined, 2016} -> 5666.2, {SilverContTableCombined, 2016} -> 5384.88,
{BronzeContTableCombined, 2016} -> 4602.96 |>
```

```
withReinsurance2016 = Function[d, f[d, TRParameters["2016"]]] /@ sh2016
<| {PlatinumContTableCombined, 2016} -> 6780.57,
{GoldContTableCombined, 2016} -> 5483.53, {SilverContTableCombined, 2016} -> 5204.57,
{BronzeContTableCombined, 2016} -> 4451.09 |>
```

```
Merge[{noReinsurance2016, withReinsurance2016}, delta[#1, "roundingValue" -> 0.01] &]
<| {PlatinumContTableCombined, 2016} -> 0.03, {GoldContTableCombined, 2016} -> 0.03,
{SilverContTableCombined, 2016} -> 0.03, {BronzeContTableCombined, 2016} -> 0.03 |>
```

### What is the increase in gross expected payments from 2016 relative to 2015

```
Merge[{KeyMap[First, noReinsurance2016], KeyMap[First, noReinsurance2015]},
  delta[#1, "roundingValue" -> 0.01] &]
<| {PlatinumContTableCombined -> 0.13, GoldContTableCombined -> 0.13,
SilverContTableCombined -> 0.14, BronzeContTableCombined -> 0.13 |>

Merge[{KeyMap[First, noReinsurance2016],
  KeyMap[First, noReinsurance2015],  $\frac{\#1[[1]] - \#1[[2]]}{\#1[[2]]}$  &]
<| {PlatinumContTableCombined -> 0.134225, GoldContTableCombined -> 0.134225,
SilverContTableCombined -> 0.136886, BronzeContTableCombined -> 0.132514 |>
```

What is the expected payment today given 2016 reinsurance

```
withReinsurance2016 = Function[d, F[d, TRParameters["2016"]]] /@ sh2016
{ {PlatinumContTableCombined, 2016} -> 6780.57,
  {GoldContTableCombined, 2016} -> 5483.53, {SilverContTableCombined, 2016} -> 5204.57,
  {BronzeContTableCombined, 2016} -> 4451.09 }
```

Visualization

```
noReinsurance2016[All, {"binAverage", "normalizedCount"}]
Missing[KeyAbsent, All]
```

## Technical Appendix 3 : The Risk Corridor Computation

### Post - Cromnibus Risk Corridors

#### The original Risk Corridors Formula

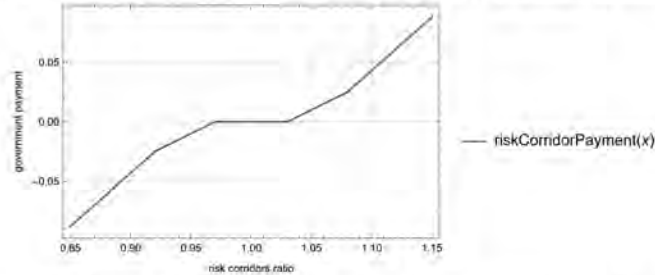
We start with the original risk corridors formula and develop a piecewise function that takes  $x$ , the risk corridor ratio, and calculates the fraction of that ratio that the government pays to the insurer. If the calculation produces a negative number, the value represents the fraction of that ratio that the insurer pays the government.

$$\text{riskCorridorPayment}[x_] := \text{Piecewise}\left[\left\{\left\{\frac{1}{2}\left(x - \frac{103}{100}\right), \frac{103}{100} < x \leq \frac{108}{100}\right\}, \right.\right. \\ \left.\left\{\frac{9}{10}\left(x - \frac{108}{100}\right) + \frac{1}{2}\left(\frac{108}{100} - \frac{103}{100}\right), x > \frac{108}{100}\right\}, \left\{-\frac{1}{2}\left(\frac{97}{100} - x\right), \frac{92}{100} \leq x < \frac{97}{100}\right\}, \right. \\ \left.\left\{-\frac{1}{10}\left(9\left(\frac{92}{100} - x\right)\right) - \frac{1}{2}\left(\frac{97}{100} - \frac{92}{100}\right), x < \frac{92}{100}\right\}, \left\{0, \frac{97}{100} < x < \frac{103}{100}\right\}\right\}\right]$$

```
SetAttributes[riskCorridorPayment, Listable]
```

The plot below maps the risk corridors ratio into the amount of money the government pays under the Risk Corridors program as a function of a particular insurer's risk corridors ratio.

```
Plot[riskCorridorPayment[x], {x, 0.85, 1.15}, PlotTheme -> "Detailed", Axes -> False,
Frame -> True, FrameLabel -> {"risk corridors ratio", "government payment"}]
```



If we assume the risk corridor ratio is normally distributed, which would appear to be a reasonable approximation, we can derive the distribution of risk corridor payments the government is likely to make as a function of  $m$  and  $s$ , which are respectively the mean of the risk corridor ratio and the standard deviation of the risk corridor ratio. We can write this as  $\tau$ .

```
 $\tau[m, s] :=$   
TransformedDistribution[riskCorridorPayment[x], x  $\approx$  NormalDistribution[m, s]]
```

## Computing the Cromnibus Fraction

```
Needs["Notation`"]
```

```
Quiet@Symbolize[ $\tau^+$ ]; Quiet@Symbolize[ $\tau^-$ ]
```

```
Symbolize::symbol: Warning: The boxstructure attempting to be symbolized as a  
similar or identical symbol already defined possibly overriding previous symbolized boxstructure =>
```

```
Symbolize::symbol: Warning: The boxstructure attempting to be symbolized as a  
similar or identical symbol already defined possibly overriding previous symbolized boxstructure =>
```

The distribution of positive payments can be written as a censored distribution,  $\tau^+$ , of  $\tau$  on the interval  $(0, \infty)$ . The distribution of negative payments can be written as a censored distribution  $\tau^-$  of  $\tau$  on the interval  $(-\infty, 0)$ .

```
 $\tau^+[m, s] :=$  CensoredDistribution[{0,  $\infty$ },  $\tau[m, s]$ ]
```

```
 $\tau^-[m, s] :=$  CensoredDistribution[{- $\infty$ , 0},  $\tau[m, s]$ ]
```

We can now calculate the ratio ("the Cromnibus fraction") of  $\tau^+$ , the amount the government receives, to  $\tau^-$ , the amount the government is obliged to pay out under Risk Corridors. If the Cromnibus fraction is greater than 1, then, under Cromnibus, all insurers get paid fully. If the Cromnibus fraction is less than 1, however, then, under Cromnibus, the payment the insurer receives is equal to the payment the insurer would have received prior to the Cromnibus bill multiplied by the Cromnibus fraction. It's conceptually not different from figuring out how much unsecured creditors get paid in a bankruptcy: you take the assets of the bankrupt and divide by the liabilities to get the fraction of their claim that each unsecured creditor receives.



```

α =
N[ToRules[Refine[Reduce[{m ∈ Reals, s ∈ Reals, CDF[NormalDistribution[m, s],  $\frac{97}{100}$ ] =
 $\frac{14}{100}$ , SurvivalFunction[NormalDistribution[m, s],  $\frac{103}{100}$ ] =  $\frac{30}{100}$ ],
(m, s), Reals], {Erfc[ $\frac{\frac{103}{100} - \frac{97 \text{ InverseErfc}[\frac{1}{2}] + 103 \text{ InverseErfc}[\frac{7}{25}]}{100 \text{ InverseErfc}[\frac{1}{2}] + 100 \text{ InverseErfc}[\frac{7}{25}]}$ ],  $\sqrt{2} s$ ]}]
Erfc[ $\frac{\frac{97 \text{ InverseErfc}[\frac{1}{2}] + 103 \text{ InverseErfc}[\frac{7}{25}]}{100 \text{ InverseErfc}[\frac{1}{2}] + 100 \text{ InverseErfc}[\frac{7}{25}]}$ ],  $\sqrt{2} s$ ]}] ∈ Reals]]]
(m → 1.01039, s → 0.0373897)

```

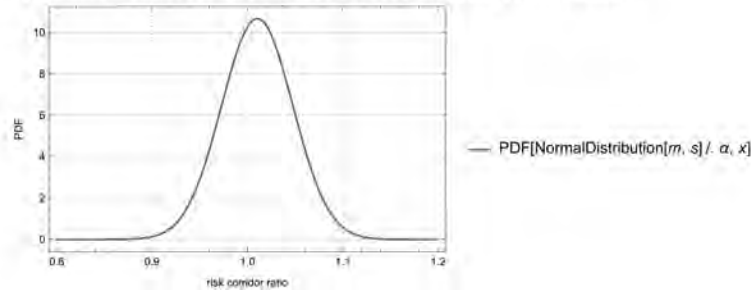
## Calculating the most likely "Cromnibus Fraction"

So, it turns out that the mean value of the distribution of risk corridors ratio that can derived from the Standard and Poors data is 1.01039 and the standard deviation of the distribution of the risk corridors ratio that can be similarly be derived is 0.0373897. The probability density function of the risk corridors ratio implied by the Standard and Poors data thus looks as follows.

```

Plot[PDF[NormalDistribution[m, s] /. α, x], {x, 0.8, 1.2},
PlotTheme → "Detailed", FrameLabel → {"risk corridor ratio", "PDF"}]

```



This calculation now allows us readily to determine the most probable Cromnibus Fraction.

```

φ /. α
0.366729

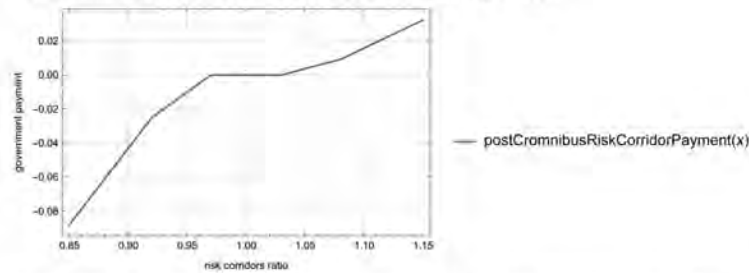
```

So, as a result of Cromnibus, insurers should expect to receive roughly 37 % of what they would have received prior to Cromnibus. And they should expect to pay the same amount as they did if they make money.

Here is now a revised graph of what the government will pay as a function of the risk corridors ratio.

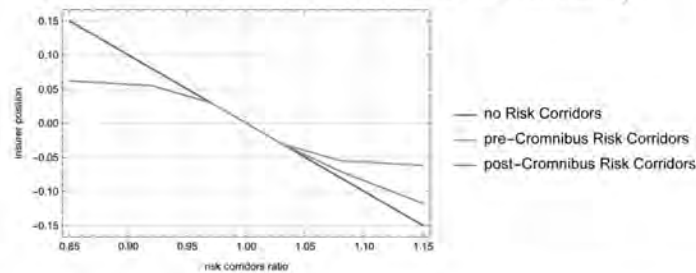
```
postCromnibusRiskCorridorPayment[x_] :=
  If[x < 1, riskCorridorPayment[x], (phi /. alpha) riskCorridorPayment[x]]

Plot[postCromnibusRiskCorridorPayment[x],
  {x, 0.85, 1.15}, PlotTheme -> "Detailed", Axes -> False, Frame -> True,
  FrameLabel -> {"risk corridors ratio", "government payment"}]
```



We can also compare the position of the insurer post-Cromnibus to what it would have been if there were no Risk Corridors at all and what it would have been if the government had paid what the statute said was owed prior to the passage of Cromnibus.

```
Plot[{1 - x, 1 - (x - riskCorridorPayment[x]),
  1 - (x - postCromnibusRiskCorridorPayment[x])},
  {x, 0.85, 1.15}, PlotTheme -> "Detailed", Axes -> False, Frame -> True,
  FrameLabel -> {"risk corridors ratio", "insurer position"},
  PlotLegends -> {"no Risk Corridors",
    "pre-Cromnibus Risk Corridors", "post-Cromnibus Risk Corridors"}]
```



## Valuing the greater risk to insurers post - Cromnibus

Suppose a given insurer believes its risk corridors ratio is distributed as a normal distribution with mean

1 and standard deviation 0.04.

```
NA = NormalDistribution[1., 0.04]
NormalDistribution[1., 0.04]
```

Without risk corridors the distribution of (roughly) profits is then

```
d0 = TransformedDistribution[1 - x, x ≈ NA]
NormalDistribution[0., 0.04]
```

We can now calculate the expected position of the insurer if they are risk averse.

```
p0 = Quiet[With[{e0 = SmoothKernelDistribution[Sort[RandomVariate[d0, 10 000]]]},
  NExpectation[Quantile[e0, q], q ≈ BetaDistribution[1, 2]]]
- 0.0224289
```

With original risk corridors, the distribution (again, roughly) of profits is ...

```
d1 = TransformedDistribution[1 - (x - riskCorridorPayment[x]), x ≈ NB]
TransformedDistribution[
  1 - x *  $\begin{pmatrix} \frac{1}{2} \left( -\frac{103}{100} + x \right) & \frac{103}{100} < x \leq \frac{27}{25} \\ \frac{1}{40} + \frac{9}{10} \left( -\frac{27}{25} + x \right) & x > \frac{27}{25} \\ \frac{1}{2} \left( -\frac{97}{100} + x \right) & \frac{23}{25} \leq x < \frac{27}{100} \\ -\frac{1}{40} - \frac{9}{10} \left( \frac{23}{25} - x \right) & x < \frac{23}{25} \\ 0 & \text{True} \end{pmatrix}, x \approx \text{NormalDistribution}[1.1, 0.08]]$ 
```

We can now calculate the expected position of the insurer if they are risk averse.

```
p1 = Quiet[With[{e1 = SmoothKernelDistribution[Sort[RandomVariate[d1, 10 000]]]},
  NExpectation[Quantile[e1, q], q ≈ BetaDistribution[1, 2]]]
- 0.0592451
```

With post-Cromnibus risk corridors, the distribution (again, roughly) of profits is ...

```
d2 = TransformedDistribution[1 - (x - postCromnibusRiskCorridorPayment[x]), x ≈ NA]
TransformedDistribution[
  1 - x * If[x < 1, riskCorridorPayment[x], (ψ / α) riskCorridorPayment[x]],
  x ≈ NormalDistribution[1., 0.04]]
```

Finally, we can calculate the expected position of the insurer if they are risk averse.

```
p2 = With[{e2 = SmoothKernelDistribution[Sort[RandomVariate[d2, 10 000]]]},
  NExpectation[Quantile[e2, q], q ≈ BetaDistribution[1, 2]]]
- 0.0216643

p0 - p2
- 0.000764594
```

What we can see is that if the insurer is moderately risk averse but expected to break even on plans sold on an Exchange, the original risk corridors saved them about 0.56% of their expenses. Note that

this is 0.56%, not 5.06%. The post-Cromnibus risk corridors will save them only 0.16% of their expenses. Thus the Cromnibus modification of risk corridors does not have in the average case what most would consider a large effect on probable insurer pricing.

There is an exception worth discussing. Consider the insurer who, because they wanted to bring people into their network was willing to price policies such that the distribution of the risk corridors ratio was as follows:

```
NB = NormalDistribution[1.1, 0.08]
NormalDistribution[1.1, 0.08]
```

This reflects higher expenses but also more uncertain expenses.

We can now rerun the computations under this assumption.

Without risk corridors the distribution (roughly) of profits is then

```
d0B = TransformedDistribution[1 - x, x ≈ NB]
NormalDistribution[-0.1, 0.08]
```

We can now calculate the expected position of the insurer if they are risk averse.

```
p0B = Quiet[With[{e0B = SmoothKernelDistribution[Sort[RandomVariate[d0B, 10 000]]]},
  NExpectation[Quantile[e0B, q], q ≈ BetaDistribution[1, 2]]]
0.145109
```

With original risk corridors, the distribution (again, roughly) of profits is ...

```
d1B = TransformedDistribution[1 - (x - riskCorridorPayment[x]), x ≈ NB]
TransformedDistribution[
```

$$1 - x \approx \left( \begin{array}{l} \frac{1}{2} \left( -\frac{103}{100} + x \right) \\ \frac{1}{40} + \frac{9}{10} \left( -\frac{27}{25} + x \right) \\ \frac{1}{2} \left( -\frac{97}{100} + x \right) \\ -\frac{1}{40} - \frac{9}{10} \left( \frac{21}{25} - x \right) \\ 0 \end{array} \right) \quad \begin{array}{l} \frac{103}{100} < x < \frac{27}{25} \\ x > \frac{27}{25} \\ \frac{21}{25} \leq x < \frac{97}{100} \\ x < \frac{21}{25} \\ \text{True} \end{array}, x \approx \text{NormalDistribution}[1.1, 0.08]$$

We can now calculate the expected position of the insurer if they are risk averse.

```
p1B = Quiet[With[{e1B = SmoothKernelDistribution[Sort[RandomVariate[d1B, 10 000]]]},
  NExpectation[Quantile[e1B, q], q ≈ BetaDistribution[1, 2]]]
-0.0589978
```

With post-Cromnibus risk corridors, the distribution (again, roughly) of profits is ...

```
d2B = TransformedDistribution[1 - (x - postCromnibusRiskCorridorPayment[x]), x ≈ NB]
TransformedDistribution[
  1 - x + If[x < 1, riskCorridorPayment[x], (ϕ / α) riskCorridorPayment[x]],
  x ≈ NormalDistribution[1.1, 0.08]
```

Finally, we can calculate the expected position of the insurer if they are risk averse.



```

ρ2B = With[{e2B = SmoothKernelDistribution[Sort[RandomVariate[d2B, 10 000]]]},
  NExpectation[Quantile[e2B, q], q ~ BetaDistribution[1, 2]]]
-0.114678

ρ0B - ρ1B
-0.0861109

ρ0B - ρ2B
-0.030431

```

In this scenario, the original risk corridors saved the insurer about 8.6 % of their expenses; the post-Cromnibus risk corridors program saved the insurer about 3.1% of their expenses. This would be a practical upper bound on the effect of risk corridors.

Chairman ROSKAM. Mr. Kreidler.

**STATEMENT OF MIKE KREIDLER, WASHINGTON STATE  
INSURANCE COMMISSIONER**

Mr. KREIDLER. Thank you, Mr. Chairman, for the privilege to be here, Ranking Member Lewis, Members of the Committee. My name is Mike Kreidler, I am the insurance Commissioner for the State of Washington, elected to that position. I am the longest serving insurance commissioner in the country. And as Mr. McDermott pointed out, I am also a former Member of Congress too. As a provider, as an elected policy maker, and also as a health administrator, I have enjoyed working on the issues around healthcare reform. And I can be no closer to it than to be insurance commissioner at a time like this.

As insurance commissioner for the last 14 years, I have heard many personal stories from individuals. One individual for the ACA, a woman from Kent, Washington, called my office complaining about a situation where she wanted to have a child, so she wanted to do the responsible thing, she got health insurance. Unfortunately, when she was expecting to deliver normally, and as scheduled to at the end of July, had to have an emergency C section. Because it was in the 9 months, this is pre ACA, within the 9 months, it was not covered. She complained to our office. We intervened with the health insurer and got some reduction in the bill that she had voluntarily by the health insurer. So she wound up with a very large medical bill, and that was through no fault of her own.

What we saw before the ACA was that we had almost 1 million people in State of Washington without insurance, that was 14 percent of the State's population. We had 11 insurers in the market, which was better than most States, and pretty good, but consumers still wanted more choices.

We carefully reviewed the rates that came before us, but we still frequently looked at double-digit rate increases that we had to approve pre ACA. Many of the health plans also did not cover maternity or prescription drugs. The system was not sustainable, the cost for continuing to rise precipitously, and we saw the uninsured rate continue to rise.

Now let's fast forward to today. The health care reform is working in the State of Washington. We have an uninsured rate coming down some 40 percent, down to 8.5 percent since the Affordable Care went into effect. We looked at the numbers going back, and that is the lowest numbers that we can have tracking that goes back to 1987 numbers that we are looking at, and it is the lowest we have seen.

Premiums are not soaring, the lowest rate request we have seen in decades—in fact, if you look at the plans inside the exchange now, if you paid the full cost with no subsidy, the average rate \$384 a month; if you receive a subsidy, it is \$174.

This year, insurers are requesting 5.4 percent, and 3 percent of that is actually going to the exchange, to fund the exchange, 3 percent of the 5.4. We had 11 insurers in the market, that is pretty good. We now have 17 insurers and 240 plans for 2016. Consumers have more choices, the market is thriving. There are several things

that we wound up doing that I think made a big difference. The State of Washington expanded the Medicaid program, we have 530,000 people through Washington Apple Health.

And the other big decision action that I took was that when the President offered to say if you keep your canceled policies. I said, no, we need to keep the one pool so you didn't wind up with a good pool and a bad pool when it came to risk. And as a result of that, it helped to stabilize the market. So we don't have the problems with legacy plans, the grandfathered plans that many other States have.

Second was to create standards for narrow networks. We have standards in the State of Washington with network adequacy standards that we put into effect for 2015. In fact, we were the only State that wound up doing that. It is a level playing field. Insurers know what to expect. That is one reason why we are looking at a market where we have seen a significant increase in the number of insurers going from 11 insurers to now 17, that is a 50-percent increase in the number of insurers after the Affordable Care Act.

The increases are many some of the lowest in memory. Fifty percent or more of the insurers are in the market, and the insured run numbers in the State of Washington continue to plummet. The Affordable Care Act in Washington is working. I believe it is working for the country too. Thank you, Mr. Chairman.

[The prepared statement of Mr. Kreidler follows:]

**Testimony of Washington State Insurance Commissioner, Mike Kreidler**

**Before the House Ways and Means Committee  
Subcommittee on Oversight**

**June 24, 2015  
10:00 AM**

Good morning Chairman Roskam, Ranking Member Lewis, and members of the Subcommittee.

Thank you for the opportunity to testify today about the Affordable Care Act and its impact on health insurance premiums.

My name is Mike Kreidler, and I am the statewide-elected Insurance Commissioner for the state of Washington, the longest-serving insurance commissioner in the country, and a former member of Congress. I am testifying today on behalf of the people of Washington state.

I've spent most of my career in the health care field – either as a provider, elected policymaker or health administrator.

I have worked to reform our health care system for many years. Now, as insurance commissioner for the state of Washington, I am on the front lines.

**Washington state's health insurance market before the Affordable Care Act**

In my 14 years as insurance commissioner, I've heard hundreds of personal stories from consumers who struggled to either find or afford health insurance – too many to share with you today. But I'd like to tell you about one woman from Kent, Washington, who contacted my office just before the Affordable Care Act took effect.

She purchased an individual health plan before she got pregnant and knew the plan had a 9-month waiting period. She was set to deliver at the end of July, but had an emergency C-section early in the month. Her delivery was denied because her carrier considered it a pre-existing condition. We contacted the company and it agreed to cover some of the charges, but she was left with large medical bills, despite trying to do the right thing.

At the end of 2013, before the Affordable Care Act took effect, Washington state had almost a million uninsured people. That's 14 percent of our state's population.

We also had a pretty robust individual health insurance market with 11 carriers participating, but consumers wanted more choices.

We did a good job of reviewing rates and were deemed by the federal government to be an effective rate review state, but the individual market still experienced double-digit rate increases in the years leading up to the Affordable Care Act.

Most individual health plans in our state did not cover maternity or prescription drugs – two vital services for most families.

It was clear to me that without significant health reform, our current health care system was not sustainable. Medical costs would continue to rise and more people would become uninsured.

#### **The landscape after the Affordable Care Act**

Today, I'm happy to report that our state's uninsured rate is at 8.5 percent – representing a drop of almost 40 percent since the Affordable Care Act took effect and the lowest rate we've seen since at least 1987.

People have access to meaningful coverage that provides critical services when and if they need them.

We have not seen premiums soar. In fact, we're experiencing record low rate requests, and in most cases, approving even lower rates.

Many people are getting help with their health care costs. In fact, 78 percent of people enrolled in our Exchange receive a subsidy to help pay for their coverage. The average premium for a non-subsidized plan is \$384.19 and \$174.38 with a subsidy.

This year, insurers in the individual market have requested a record low average rate change of 5.4 percent. And 3 percent of this request is for an assessment to pay for our Health Benefit Exchange, which will likely be lower once our state Legislature approves our biennial budget.

Before health reform took effect we had 11 health insurers in our individual market. Today, 17 companies have filed more than 240 plans for sale starting Jan. 1, 2016. We are still reviewing these but it is clear that consumers will have additional choices.

**Thorough rate review and predictability are keys to our success**

Washington state made several early decisions that have helped our health insurance market thrive. Some of these were easier than others.

One easy decision was the expansion of Medicaid. Now, more than 530,000 adults have accessed coverage through our Washington Apple Health program.

This decision helped create a stable insurance market for our health insurers. So did two more controversial decisions I made as insurance commissioner.

One was deciding swiftly, despite what President Obama said, that canceled plans could not continue. To do so would have created two risk pools and seriously destabilized our health insurance market.

I also acted early to create standards for the narrow networks we were seeing from our insurers, especially in our Exchange market. We needed to do this to ensure that all of the insurers knew what was expected, that we had a level playing field, and most importantly, that consumers could access the services they had paid for.

I believe these decisions are among the reasons why our rates are lower than in recent memory, that the number of insurers in our individual market has jumped by more than 50 percent, and our uninsured rate continues to plummet.

The Affordable Care Act is working in Washington state, and I believe it's working for our country. Thank you.



Chairman ROSKAM. Thank you. Ms. McPeak.

**STATEMENT OF JULIE McPEAK, COMMISSIONER, TENNESSEE  
DEPARTMENT OF COMMERCE & INSURANCE**

Ms. MCPEAK. Thank you. Good morning Chairman Roskam, Ranking Member Lewis and Members of the Subcommittee. Thank you for inviting me to testify before the subcommittee on the impact that the Affordable Care Act has had on health insurance premiums. And thank you, particularly Congressman Black, for your kind introduction.

As mentioned, I am Julie McPeak, Commissioner of the Tennessee Department of Commerce & Insurance. I have spent most of my career in insurance regulation and I have a strong affinity for the country's State-based system of insurance oversight.

Tennessee has a Federally Facilitated Marketplace, FFM for brevity. The ACA legislation was intended to have significant impacts, and in that respect, it has definitely achieved its intent. The ACA introduced rating and underwriting requirements that fundamentally reshape how health insurance is priced, purchased, and administered. These new requirements make a comparison of pre ACA policies to ACA-compliant policies, a significant challenge. ACA requirements that are cost drivers in terms of premium prices are well documented, and include prohibitions on preexisting condition exclusions, guaranteed availability and issued requirements, and new essential health benefits benchmark plans that create a floor for ACA-compliant benefits.

The ACA significantly impacted an insurer's flexibility to design plans to meet consumer demands. In a post ACA world, plans across carriers are much more similar than they are different, and carriers compete primarily on name recognition, physician networks and premium price.

The impact of the ACA on Tennessee's consumers, its marketplace and rates, has created significant challenges and uncertainty across the State's insurance landscape. Tennessee has been fortunate enough to experience consistency among the carriers offering policies to our residents. In the first year of the FFM, 2014, Tennessee had four carriers total writing policies, but only one offering policies in all 95 counties. We have received filings for 2016 that show five carriers writing policies, but still only two carriers offering the policy statewide.

Outside the FFM, the ACA and its implementing regulations have had the effect of segmenting Tennessee's marketplace. So-called grandfather plans and grandmother plans, which were known as transitional plans, remain a large block of business across our State. This segmentation often creates confusion for consumers who know they have a policy with a certain insurer, but do not understand the block of business that includes their policy.

Tennessee had competitive marketplace before the ACA and that marketplace remains competitive today. Market competition, in part, gave Tennessee some of the lowest price FFM products in the country. In 2014 and 2015, Tennessee plans have ranked in the top five least expensive plans when ranked based on their premiums price of the second lowest cost silver plan on the FFM. Having a competitive market, however, does not isolate Tennesseans from

seeing significant rate increases. Tennessee insurance carriers offering plans on the FFM requested rate increases for plan year 2015 and 2016, from fourth-tenths of a percent to 36 percent, with the carriers comprising over 80 percent of the market, requesting increases of 32.6 percent and 36.3 percent respectively.

TDCI is reviewing the proposed 2016 rate increases, and according to Federal guidelines, will need to improve rates by the middle of August. These substantial rate increases can largely be attributed to medical trends and utilization. In fact, our largest FFM carrier reported for calendar year 2014, a medical loss ratio of well over 100 percent. To put that in perspective, for every \$1 in premium received, the company paid out over \$1 in claims, operating in a net loss, not including the administrative costs of the company. The ACA's strict underwriting and business requirements have left carriers with few options to maintain their reduce costs.

One option that Tennessee has experienced is use of limited provider networks. The ACA also established the consumer-operated and oriented plan, the co-op program to help create new market competition. Tennessee is one of 26 States to have an operating co-op, Community Health Alliance Mutual Insurance Company was awarded over \$73 million in low-interest loans to establish itself in Tennessee.

These first 2 years of operation have been challenging for CHA, as the company tried to assert itself in the marketplace while also maintaining financial capacity.

In 2014 CHA had rates that were on the high side of the market, and as a result, the company failed to achieve a significant amount of volume. CHA revised rates for 2015 and was very competitive with the market. In fact, CHA grew too big too quickly and approached the Department with a proposal to freeze enrollment under U.S. Department of Health and Human Services guidelines.

We agreed to the proposed freeze and worked with HHS to cease enrollment, thereby effectively taking CHA off the marketplace. The decision to freeze enrollment remains the right decision for the company, and most importantly, for Tennessee insurance consumers, but the process has not been as efficient as we had hoped.

For 2016, CHA has requested an average rate increase of over 32 percent. We continued to review the rate request as well as the company's frozen status for marketplace purposes. The ACA in its implementation by HHS has challenged State regulators and carriers by creating and continuing consistent uncertainty. Uncertainty in the business of risk can nearly always drive up cost or lessens competition. In the case of the ACA, I think it has done both.

In the early days of the ACA until exchanges were rolled out in 2014, Governors, insurance regulators, and carriers looked for guidance from the Federal Government on exchange structures and rules. Delayed or unclear guidance lead certain carriers to sit out of certain marketplaces in these first few years to better understand the new market.

I personally was told by two national carriers that this uncertainty contributed to their decision-making processes for the FFM and their decisions not to participate. My written testimony provides a more recent example of the HHS guidance, introducing un-

certainty to market, release after the carriers have submitted their rating proposal for 2016.

Implementation of the ACA has been a challenge. We continue to review policy forms and rates for next year, but anticipate that Tennessee consumers will again see increased insurance costs for 2016. Again, thank you for the opportunity to be here look forward to answering your questions.

[The prepared statement of Ms. McPeak follows:]

#### INTRODUCTION

Good morning Chairman Roskam, Ranking Member Lewis, and Members of the Subcommittee. Thank you for inviting me to testify before the Subcommittee on the impact that the Affordable Care Act (ACA) has had on health insurance premiums.

My name is Julie Mix McPeak, and I am Commissioner of the Tennessee Department of Commerce and Insurance (TDCI) and also serve as Tennessee's State Fire Marshal. TDCI oversees regulation of Tennessee's insurance industry, the state's fire codes and regulates several hundred thousand Tennesseans in their professions and businesses. I also serve in Committee leadership roles at the National Association of Insurance Commissioners (NAIC), as an Executive Committee Member of the International Association of Insurance Supervisors (IAIS), and as a Member of the Federal Advisory Committee on Insurance (FACI). I have spent most of my career in insurance regulation, having previously led Kentucky's insurance department, and I have a strong affinity for the country's state-based system of insurance oversight.

My testimony this morning will highlight the ACA's impact on the Tennessee insurance marketplace. Tennessee has a federally facilitated marketplace (FFM). My comments today will focus specifically on the ACA's impacts related to insurance premiums and health insurance marketplace participants, both on and off the FFM.

#### ACA IMPACT

The ACA legislation was intended to have significant impacts, and in that respect, it has achieved its intent. The ACA introduced rating and underwriting requirements that fundamentally reshaped how health insurance is priced, purchased, and administered. These new requirements make a comparison of pre-ACA policies to ACA-compliant policies a significant challenge. While it is easy to say that insurance premiums, in general, have increased, the insurance products themselves that are ACA-compliant are fundamentally different from the pre-ACA policies. Making a straight comparison of premiums throughout the ACA implementation timeline is not entirely appropriate.

ACA requirements that are cost-drivers in terms of premium prices are well documented and include:

- \*Prohibitions on pre-existing condition exclusions
- \*Guaranteed availability and issue requirements
- \*New essential health benefits (EHB) benchmark plans that create a floor for ACA-compliant plan benefits
- \*Three-to-one (3:1) rate bands based on age
- \*Prohibitions on annual and lifetime benefit limitations
- \*Increased overhead costs for insurance company administration.

By requiring all ACA-compliant plans to meet or exceed the new standard EHB benchmark and introducing new prohibitions, the ACA significantly impacted an insurer's flexibility to design plans to meet consumer demand. In a post-ACA world, plans across carriers are much more similar than they are different, and carriers compete primarily on name recognition, physician networks, and premium price.

The impact of the ACA on Tennessee's consumers, its marketplace and rates has created significant challenges and uncertainty across the state's insurance landscape.

#### ACA IMPACT ON TENNESSEE MARKETPLACE

Today, Tennessee has approximately 215,000 covered lives in ACA-compliant FFM plans, 65,000 covered lives under individual policies off the exchange, 63,000 covered lives under small group policies, and 312,000 covered lives in large fully insured plans.

Before the ACA was enacted, Tennessee had two carriers that made up more than 80 percent of its insurance marketplace. In 2014, when most ACA reforms went into effect, Tennessee continued to have two carriers make up more than 80 percent of its marketplace, although one of those carriers changed. Today, Tennessee continues to have two carriers making up more than 80 percent of its marketplace, and one of those carriers has changed since 2014.

Tennessee has been fortunate enough to experience consistency among the carriers offering policies to our residents. In the first year of the federally

facilitated marketplace (2014), Tennessee had four carriers total writing policies, but only one offering policies in all 95 counties. In 2015, we have five carriers writing policies with three of those carriers writing in all of our counties. We have received filings for 2016 that show five carriers writing policies, with two carriers offering policies statewide.

Outside of the FFM, the ACA and its implementing regulations have had the effect of segmenting Tennessee's marketplace. So-called grandfathered plans and grandmothered plans – also known as transitional plans – remain a large block of business across the state. This segmentation often creates confusion for consumers who know they have a policy with a certain insurer, but do not necessarily understand the block of business that includes their policy. When we help field their questions when they call our office, many times consumers do not realize the different benefit requirements applicable to such blocks of business.

Tennessee had approximately 131,000 covered lives under grandfathered policies in 2014. That number has decreased slightly to approximately 128,000 covered lives in 2015.

Tennessee had approximately 230,000 covered lives under grandmothered policies in 2014. That number has decreased significantly to approximately 170,000 covered lives in 2015 and will continue to drop further throughout the year as one large carrier has decided to terminate its grandmothered block of business.

#### ACA IMPACT ON TENNESSEE RATES

Tennessee had a competitive marketplace before the ACA and that marketplace remains competitive today. Market competition, in part, gave Tennessee some of the lowest priced FFM products in the country. In 2014 and 2015, Tennessee plans have ranked in the top five least expensive plans when ranked based on the premium price of the second lowest cost silver plan on the FFM.

Having a competitive market, however, does not isolate Tennesseans from seeing significant rate increases over the next few years. Tennessee insurance carriers offering plans on the FFM requested the following rate increases for plan years 2015 and 2016.

\*For Plan/Calendar Year 2015: Rates ranged from 7.5 percent to 19.1 percent.

\*For Plan/Calendar Year 2016: Proposed rates range from .4 percent to 36.3 percent.

TDCI is reviewing the proposed 2016 requested increases and per federal guidelines will need to approve rates by the middle of August.

These substantial rate increases can largely be attributed to medical trends and utilization. In fact, our largest FFM carrier reported for calendar year 2014 a medical-loss ratio of well over 100 percent. To put that in perspective, for every \$1 in premium received, the company paid out over \$1 in claims, operating at a net loss – not including administrative costs of the company.

Medical trends and utilization have also impacted Tennessee's grandfathered and grandmothered blocks of business. Grandfathered plan premiums have increased an average of 11 percent, 14 percent, 12 percent, and 10 percent for years 2012 through 2015, respectively. In addition, grandmothered blocks of business have seen increases of 15 percent in 2013 and 11 percent in 2014. These increases, particularly for grandfathered plans, have priced premiums at levels comparable to ACA-compliant plans in some cases.

The ACA's strict underwriting and business requirements have left carriers with few options to consider to maintain or reduce costs. One option that Tennessee has seen is the use of limited and/or exclusive provider networks. In most of our major metropolitan areas, Tennesseans have the option to select a plan with a tight network of provider options. We have urged consumers to comparison shop for their policies and to make sure they know what their plan covers, including provider options. We continue to receive complaints from consumers who signed up for the lowest cost plan in their area who later discovered they selected a limited network plan that does not include their family physicians.

**COMMUNITY HEALTH ALLIANCE: THE TENNESSEE CO-OP** The ACA also established the Consumer Operated and Oriented Plan (co-op) Program to help create new market competition. Tennessee is one of 26 States to have an operating co-op. Community Health Alliance Mutual Insurance Company (CHA) was awarded over \$73 million in low-interest loans to establish itself in Tennessee. These first two years of operation have been challenging for CHA, as they would be for nearly any

startup company, as the company has tried to assert itself in the marketplace while also maintaining financial capacity. In 2014, CHA had rates that were on the high side of the market. As a result, the company failed to achieve a significant amount of volume. CHA revised rates for 2015 and was very competitive with its market competition. In fact, CHA grew too big too quickly and approached the Department with a proposal to “freeze” enrollment under U.S. Department of Health and Human Services (HHS) guidance.

TDCI quickly agreed to the proposed freeze and worked with HHS to freeze enrollment thereby effectively taking CHA off the marketplace. The decision to freeze enrollment remains the right decision for the company and most importantly for Tennessee insurance consumers.

Since enacting the freeze, we have fielded numerous calls from CHA policyholders and have been in constant communications with HHS about the complaint process. The process has not been as efficient as we had hoped.

For 2016, CHA has requested an average rate increase of over 32 percent. The rate filing is currently under review, and our policy analysis team recently sent the company a list of questions to further investigate their rate request. We continue to review rate requests as well as the company’s frozen status for marketplace purposes.

#### KING V. BURWELL

The Supreme Court will soon issue a Decision in King v. Burwell that may have major implications for Tennesseans. That is probably a discussion for another day, so I will only provide the Subcommittee with these general numbers this morning:

\*Tennessee has approximately 215,000 covered lives in ACA-compliant FFM plans.

\*Approximately 80 percent of that population receives subsidies to help afford their premium payments.



\*The average monthly premium for FFM products in 2015 is \$321 and the average subsidy for Tennesseans is approximately \$211, leaving the consumer to pick up the net premium of \$110.

Tennessee does not anticipate making any decisions about how the State may respond to King v. Burwell until the decision is released to the public.

#### ACA'S CONSISTENT UNCERTAINTY

The ACA and its implementation by HHS has challenged state regulators and carriers by creating and continuing consistent uncertainty. Uncertainty in the business of risk nearly always drives up costs and/or lessens competition. In the case of the ACA, I think it has done both. From the early days of the ACA until exchanges were rolled out for 2014, governors, insurance regulators, and carriers looked for federal guidance on exchange structure (s) and rules. Delayed or unclear guidance led certain carriers to "sit out" of certain marketplaces in these first few years to better understand the new market. I personally was told by two national carriers that this uncertainty contributed to their decision-making processes for the FFM and their decisions not to participate in our exchange.

A most recent example of HHS guidance introducing uncertainty is market withdrawal guidance issued in the last two weeks. The guidance essentially states that if a company chooses to leave a certain service area (Tennessee has eight), or replace one product offering with another (for example, replacing a PPO with an exclusive provider network) that company is withdrawing from the market. In "regulator-speak", a market withdrawal prohibits a company from operating in that market for five years.

This recent HHS guidance came out after all plans and rates were filed for 2016 -- meaning it was too late, in most cases, for carriers to make any revisions in response to the guidance, and after several regulator calls with HHS representatives where states expressed strong concerns with the HHS approach. HHS decided that it would not enforce the guidance until the 2017 plan year.

Had HHS implemented this guidance for 2016, Tennessee would have lost two of five FFM carriers for five years, meaning consumers in certain rating areas would be left with far fewer options for coverage. This example is not atypical of the implementation effort, and the guidance places further challenges in the path of

states trying to enforce the federal law. The guidance also places significant limitations on business decisions of private insurance companies looking to compete most effectively in the marketplace.

#### CONCLUSION

The Tennessee Department of Commerce and Insurance is responsible for regulating the insurance marketplace in Tennessee, including compliance with the ACA.

Implementation of the ACA has been a challenge. The ACA required a minimum package of benefits that was greater than what some plans provided before the ACA was enacted. We continue to review policy forms and rates for next year but we anticipate that Tennessee consumers will see increased insurance costs in 2016.

Thank you for the opportunity to discuss the Tennessee ACA experience with this Subcommittee. I look forward to your questions.

Chairman ROSKAM. Thank you. Mr. Redmer.

**STATEMENT OF AL REDMER, JR., COMMISSIONER, MARYLAND  
INSURANCE ADMINISTRATION**

Mr. REDMER. Thank you, Mr. Chairman, Members of the Committee, I appreciate the opportunity to testify on proposed individual and small group rate increases in Maryland. And I especially appreciate being here on the day that you choose to give tribute to Congressman Lewis.

As some added perspective, I have been in the health insurance business my entire adult life, including time as a producer, time in the Maryland legislature, and time as a CEO of a regional health insurance carrier.

Maryland carriers were required to provide their proposed rate increases on May 1. We are currently going through our actuarial review of those proposed rate increases and will make a final determination by the end of July.

Maryland does have a State-based exchange. In the individual marketplace, we are seeing a low where we see a reduction of .3 percent by one carrier. We see an increase on the high side of a little over 30 percent by Care First, which is our Blue Cross/Blue Shield carrier, which lost a significant majority of the market share. It is, in part, because they lost significant money last year, in part, I believe due to the adverse selection of small employers disbanding their small group plans and those employees migrating into the individual marketplace.

As a reference point, Evergreen, which is our co-op, they are seeking a price increase of just under 10 percent. In the small group market, we see a low of, again, Care First our Blue's plan, asking for a reduction of a little over 16 percent. Evergreen, the co-op plan, is asking for an increase of almost 15 percent, which is on the high side in the small group marketplace.

For the proposed increases, what we are seeing as the cost drivers is an increase in the average morbidity as high as 15 percent; increased medical trend, we are seeing a low of 3.5, the highest point of projection is 7, with projected profit margins in the 1 to 2 percent space.

In 2016, we will see another year of uncertainty in the marketplace, one of the unforeseen factors we just don't know what the answer is, is the effect of the small group market from 50 to 100. As a matter of fact, Maryland increased the minimum allowable threshold for stop loss—minimum attachment point went from 10 to 22.5 in an effort to minimize adverse selection by going into self-funded plans.

In the individual market, the uncertainty in part is going to be the increase in the penalty, whether that is going to drive any of these younger folks into the insured marketplace, or if it is just going to be the folks who had been sick in the last year or two migrating to the guaranteed issue marketplace.

Also, I want to bring your attention to one of the unintended consequences of the Affordable Care Act. We have no regulatory control over it, but if you go back to January of 2014, we had thousands and thousands of small groups that wanted to delay the effects of the Affordable Care Act so they chose to early renew. In-

stead of renewing in January, February or March of 2014, they got in under the wire and they renewed in November or December of 2013. The effect of that, at least in Maryland, is we had a disproportionate amount of the marketplace, both small group plans and the individual marketplace renewing at the same time, and it is an operational nightmare for both the carriers and the producers to handle that amount of work at the same time.

Also, finally, Maryland is a little unique; there hasn't been an access issue in over 20 years. Everybody in Maryland before the Affordable Care Act had access, whether it was Medicaid for the poor or Medicare for the seniors. We had underwritten individual plans, we had guaranteed issue, guaranteed renewability with no pre X in the small group market for those who couldn't get an individual underwritten plan, we had to State subsidize the individual high risk pool. So access was not an issue before the ACA.

With that, I will be happy to answer any questions.

[The prepared statement of Mr. Redmer follows:]

Ways & Means Oversight Subcommittee Congressional Hearing  
 Testimony By: Al Redmer, Jr., Commissioner, Maryland Insurance Administration  
 Wednesday, June 24, 2015 at 10:00 a.m.  
 1100 Longworth House Office Building, Washington, DC

Thank you for the opportunity to testify on the proposed individual and small group rate increases in Maryland.

Maryland carriers were required to submit proposed rates for 2016 on May 1, 2015. We are currently going through our actuarial review and expect to make our final determination by August 1, 2015.

The requested rate changes for 2016 in the individual market are:

All Savers (United Healthcare)	-3.2%
Carefirst (CFMI)	26.7%
Carefirst (Bluechoice)	30.4%
Carefirst (GHMSI)	30.4%
CIGNA	-2.9%
Evergreen (CO-OP)	9.7%
Kaiser	4.8%
UnitedHealthCare of the Mid-Atlantic Inc.	-0.5%

The requested rate changes for 2016 in the small group market are:

Aetna (HMO)	6.4%
Aetna Life	8.5%
Carefirst (CFMI)	-3.1%
Carefirst (Bluechoice)	-16.6%
Carefirst (GHMSI)	-16.6%
Evergreen (CO-OP)	14.8%
Kaiser	5.5%
MAMSI (UnitedHealthCare)	4.3%
United Healthcare	4.3%
UnitedHealthcare of the Mid-Atlantic	4.3%
Optimum Choice (UnitedHealthCare)	-0.4%

In part, based on the direction from Governor Hogan to conduct ourselves in an open, transparent way, the Maryland Insurance Administration is engaged in a number of activities to solicit feedback. Last Wednesday, June 17, 2015, we held a public hearing on individual and small group rates where we invited testimony from interested parties. On Monday, June 22<sup>nd</sup>, we held our first two of eight "Town Hall" meetings around the state. We have invited consumers, producers, businesses and any interested parties to provide comment on all aspects of the Affordable Care Act including, premiums, coverage, the Maryland Health Benefit Exchange and any operational issues. We have also scheduled a similar meeting where we are hosting our carriers for comment. We are hopeful that we will get useful information that will allow us to improve the marketplace in Maryland.

For the proposed increases we are seeing projections of the following cost drivers:

Increase in average morbidity as high as	15%
Increased medical trend of	3.5 – 7.0%
Projected profit margins	1.0 -2.0%

In 2016, we will mark another year of uncertainty in the marketplace. One of the unknown factors that will affect the market is the expansion of the small group market to businesses with as many as 100 employees. The Maryland legislature increased the minimum stop loss attachment point to \$22,500 in an effort to reduce cherry-picking and adverse selection.

In the individual market there is uncertainty regarding the effects of increasing the penalty for those who choose to remain uninsured, and if it will drive younger enrollees into participation. One of our carriers is actually projecting a slight increase in the average age of their pool.

One of the unintended consequences of the Affordable Care Act that concerns me is the operational inefficiency that has resulted from its implementation. As a result of the small group market being effective January 1, 2014, many small groups in Maryland renewed their plans early (in November and December of 2013) to avoid the ACA regulations. As a result, we have a significant percentage of the small group market and the individual market renewing at the same time. This has created operational issues for both carriers and producers, which has resulted in increased administrative costs.

Once again, I appreciate the opportunity to participate in the discussion and will look forward to your questions.

Chairman ROSKAM. Thank you all. We will start our inquiry. Mr. Kelly of Pennsylvania.

Mr. KELLY. I thank the chairman. I think all of you were here today I really appreciate you being here and I want to make sure we get off on the right foot. This has nothing to do with us not having a heart and not wanting to help people who need health insurance. So I want to make sure we understand that.

One of the things that I think that is really critical and Professor, I really appreciate your input, Mr. Redmer, thank you for what you are talking about. I am an automobile dealer. We just went through the new package for our people, it is up over 30 percent. The way we really keep it at little over 30 percent is by working with the deductible a little bit. I have got to tell you, back home where I am from, sustainable means capable of being sustained. I looked it up, because I wanted to make sure we understand. Sustainable is a method of harvesting or using a resource so that resource is not depleted or permanently damaged.

So when we talk about these programs, as a private business person your model has to be sustainable or you are on a fool's errand, you won't be able to stay in business. So as I listen to your testimony, I am really interested.

I have to tell you a little bit of what happened to me back home. I go to this little restaurant Natili's in Butler, been there a long time. Cindy is the girl who always waits on me. A year ago, she says is there something you can do about health insurance. I said, well, what is the problem? She goes well, my husband's firm used to include me, now they are not. I am shopping right now. My monthly cost is going to be \$700 to \$800, and my deductible is \$10,000 so I can get insurance, but for all intents and purposes I am not insured. So having an insurance policy and actually being insured against out-of-pocket, or what it is actually going to defray for you—there is two different worlds out there. And that is why I appreciate you all being here, because I hear that in some cases it is down; in Pennsylvania it is not down, it is going up.

But rather than talk in government terms that are too lofty and often leave people confused and scratching their head and say, you know what? I don't get it and I will just walk away, because I know the government will at some point take care of it all.

Mr. Chandler, that model that we are on right now is not sustainable, is it? From a business standpoint, the model that we on right now in the Affordable Care Act—first of all, it is not affordable, in a lot of ways, I am talking about people who actually have to buy it and pay for it. And then others that have to help invest in subsidies in order to make it more affordable for other people. So somebody has an out-of-pocket cost, nothing is for nothing.

Your testimony, I thought it was fascinating, because I think you talked in real-world terms about what this means to people. Ms. McPeak, you are the same way, Mr. Redmer the same way. We are talking about everyday guys and gals who get up in the morning, throw their feet out over the bed, go to work, put a roof over the head of their kids, put food on the table, clothes on their back, prepare for the future and try to make sure that they are healthy. Every one of you talked in your testimony about a trajectory that is unsustainable. Am I missing something there or not?

Mr. CHANDLER. In my opinion, Representative, it is very unrealistic to think that this country can afford a situation in which 17 percent of our GDP goes to health care, and that that starts to keep going up and keep going up, it is estimated to go to 23 percent, okay? Think about, yes, health care is important, but we can't run businesses, we can't run a society well in which that large a proportion of our GDP is being diverted into health care.

Mr. KELLY. See, our State is getting killed with this. Ms. McPeak and Mr. Redmer, if you could.

Ms. MCPEAK. Thank you for your question. It is an interesting concept of sustainability. Certainly what concerns me are the large cost increases for premiums that have been requested in Tennessee. I will tell you, we as regulators test every one of the assumptions that is included in that rate request. In fact, the loss experience is there. So when you are considering a rate increase in the 30 percent range, and you know that that is going to affect people in your State, you really want to see if there is any margin to assess whether or not there is anything you can do make that less uncomfortable for the residents of our State. The problem is under our State's authority we have to look the rates and whether they are unfair discriminatory or actually insufficient.

In some instances, with the experience that we have seen and have been filed in with the rate requests, even the 30 percent increases may still be deemed insufficient and we made need to order increases above those rates in order to protect the financial stability of the company. In that regard, I don't think those rate increases are sustainable, because those insurers need to stay in business to make good on their promises that they have sold to every resident of our State.

Mr. KELLY. Well, I think you are all here for the same reason. I think we have the same purpose. The worst thing in your life is to make a promise that you can't keep. I think that somehow we went so far down the road on this being affordable and accessible that we really missed the part about it being accessible and truly being affordable. And my worry is the sustainability of the model that we have out there right now, it just doesn't work; the President is right, do the arithmetic and you are going to find out it doesn't bode well in the future.

Thank you for being here, appreciate your testimony.

Chairman ROSKAM. Mr. Lewis.

Mr. LEWIS. Thank you very much, Mr. Chairman. Again, let me thank each of the witnesses for being here today. A good-looking group, beautiful, handsome.

Commissioner Kreidler, welcome back my dear friend and colleague. Again, thank you for being here. I want to learn more about how people gaining Medicaid coverage help State insurance markets?

Ms. KREIDLER. Say that again.

Mr. LEWIS. I want to learn more about how people gaining Medicaid coverage help State insurance markets.

Ms. KREIDLER. Thank you, Mr. Lewis. And the complimentary words that were directed to you were totally insufficient to recognize your broad achievement. So it is a pleasure to be here to have an opportunity to take this question.



Its failure to expand the Medicaid program, in my opinion, has had very negative impacts on most States, it did not from the standpoint of their exchange market, whether it is—most of those will be going to be Federally-facilitated exchanges. By virtue of not expanding, you wound up with people who would have been eligible for Medicaid, either because of family members or others who get them into the insured market, into the exchange, and as a result, you see much higher claims experience, morbidity numbers from the standpoint of the exchange. It is very positive to have done a Medicaid expansion from the standpoint of helping to hold down the rate increases, you artificially push up the rates inside the exchange by virtue of not also moving to the Medicaid expansion simultaneously.

Mr. LEWIS. Do you think this process that helps States that have not expanded Medicaid, like my home State of Georgia?

Ms. KREIDLER. Mr. Lewis, I would say that one of the things that I have seen as a very positive indication is that we see a number of States now moving to—Governors moving to try to address the issue of Medicaid expansion. I think it is going to be growing recognition. When Medicaid was first adopted back in 1965, we wound up with at least one State, Arizona, as I recall, held out for a number of years, but finally wound up joining. We have many more States who have not made the Medicaid expansion here now. But I think as they look at it and start to see the effects, one on that the rates inside the exchange, but also the effects on their citizens who would be eligible for Medicaid who are effectively locked out right now. We need to do something about it.

Mr. LEWIS. I know that Washington has a State exchange. If the Supreme Court were to decide against the government, will you please describe the possible impact on those people living in States with a Federal exchange?

Ms. KREIDLER. We actually had some experience with that. Mr. McDermott will remember this, he was in Congress then, so he was away from it, but in the late 1990s, we actually had healthcare reform that had passed in 1993. It was repealed in 1995, but it left in place that you could get health insurance after a 3-month pre-existing waiting period. What the net result was, we effectively had what would be left with the Affordable Care Act is you have a guaranteed issue, and you would wind up with the healthy people dropping out as rates started to rise, the sick people staying, and you couldn't stick with it.

In the State of Washington where we had a comparable situation in the 1990s, the market actually collapsed. We lost our individual market. It took legislative action to see it restored just as I came into office in 2001. We would see, in those 34 States that are in a position right now to have Federally facilitated today, in fact, could be in a position to see exactly what happened in the State of Washington, which is a collapse. This is based, of course, on the failure of Congress to come together with a satisfactory resolution, and I trust that would be the case.

Mr. LEWIS. Again, Mr. Commissioner, thank you for being here. Good to see you, thank you for your leadership.

Mr. CHANDLER. My pleasure.

Chairman ROSKAM. Mr. Meehan of Pennsylvania.

Mr. MEEHAN. Mr. Chairman, thank you. I thank the panelists for being here. Mr. Redmer, your testimony, you made a statement that you have seen costs generated because there has been a 15 percent increase in morbidity. What is that?

Mr. REDMER. That is basically—I will describe it as the health status of the pool is getting sicker. So they are going to be utilizing more services.

Mr. MEEHAN. Okay, all right, I understand, and that is one of the cost drivers.

Mr. Kreidler, we are sitting here, hearing testimony from two different places. We have got 30 percent increases on average in Tennessee. Mr. Chandler has talked about extensive increases in Texas. I am seeing them in Pennsylvania, and yet you are saying that you have half a percent increase. What is going on?

Mr. KREIDLER. Thank you for the question. Clearly there are some stark differences among the States. I think part of what I tried to point out was that I think we were one, fortunate that we had a very competitive market in the State of Washington before the ACA came in. It has become significantly more competitive, 50 percent more carriers in the market. Not all States have had the benefit of that.

The second is—

Mr. MEEHAN. Your starting point, the beginning line is at a different place than other States.

Mr. KREIDLER. Exactly, and it has had an impact in as we went through the process of implementing the Affordable Care Act; where you started made a difference. We also had a strong history of doing rate review, and by virtue of having a competitive market, we saw better rates in the State of Washington than you saw in any other because of a competitive market.

Mr. MEEHAN. Well, so that is a point though, and that is, I think, what is lost because we don't talk about it, it was never sold. If you are in this State, it is a generalization that all Americans will either benefit, or the costs will go down and that doesn't seem to be occurring. What is the experience you are having with your copays and your deductibles?

Mr. KREIDLER. Copays and deductibles, I will be frank with you are a bit of a challenge.

Mr. MEEHAN. They are going up?

Mr. KREIDLER. While you have been successful in limiting the total out-of-pocket expense for individuals, copays and deductibles have gone up.

Mr. MEEHAN. That is capturing them on the other end.

Ms. KREIDLER. It winds up having net effect for individuals. But if they get really sick, they really benefit, and it puts a limit on their total out-of-pocket. You want the insurance, if you really, really absolutely need it or you are willing to pay for some of the copays and deductibles before you reach the point where you achieve that out-of-pocket expense limit.

Mr. MEEHAN. Let me close with Mr. Chandler and Ms. McPeak and Mr. Redmer if you have insights on these too. I made this point: generalizations that were made that the average American is going to save \$2,500 under the plan, if you like your doctor, you are going to keep your doctor. Now we are seeing in Pennsylvania

as an example, the rate increases in western Pennsylvania where my colleague Mr. Kelly is from, 30, as high as 40 percent on average. And networks are narrowing, not expanding. So can you explain to me what is happening in the marketplace in the aftermath of those promises, are we seeing the \$2,500 savings or are people keeping their doctors or are networks getting narrower, or are narrower networks a good thing. Mr. Chandler?

Mr. CHANDLER. I think that assertion deserved every Pinocchio that it received. What you are seeing is an entirely predictable result. Community-rated plans in most jurisdictions have been subject to severe adverse selection problems. And I believe we are beginning to see precisely that with the rate increases we are seeing here.

Mr. MEEHAN. Ms. McPeak.

Ms. MCPEAK. Well, I certainly don't hear from consumers who are saving any money on insurance premiums. I hear quite the opposite from consumers who are calling my office.

What I would suggest about the transitional plans, if you can keep your policy—if you like your policy you can keep it. In Tennessee we allowed those transitional policies to continue knowing that that was going to further segment the market because we wanted to have those choices available to our Tennessee consumers.

The problem was that position was decided by President Obama 45 days before the plan year started, so the rates were already filed and approved in our office. The plans were already on the Federally facilitated exchange rates to be purchased. So allowing those transitional plans to continue didn't have nearly the significant effect, and the insurers were already locked into rates that they had already seen.

I think what you are seeing in the marketplace, with the increased deductible, copays and limited networks are insurers and consumers trying to moderate some of those claims-based rate increases that are justified in trying to moderate those 30 percent into lower amounts. So they are choosing policies that, again, have payment on the back end as you described, or have such limited network that they don't have the provider choice as before the ACA.

Mr. MEEHAN. Mr. Redmer.

Mr. REDMER. Yes, two things, number one, the narrow provider markets, this gives the carrier the ability to demand and extract greater concessions from those providers that are left in that narrow market. And I would speculate that if the markets are made broader, and they have more providers, that is going to result in even higher price increases than we are seeing now. And when you talk about the effects on the consumer, and I just want to throw this on your radar screen, because I think it is a national issue, and that is the significant, unbridled cost of air transportation, primarily helicopters, that is resulting in balance billing for the consumers, thousands and thousands and thousands of dollars. And these are folks who are not in networks; it is a significant national issue.

Mr. MEEHAN. What choice do you have if you are lying on a turnpike after an accident and they call—

Mr. REDMER. You don't, that is the problem. You don't. And oftentimes the patient, who has no choice, has no clue that they are going to get a \$25,000 to \$40,000 bill, there is going to be a balance bill from a helicopter service.

Chairman ROSKAM. The time has expired. Mr. Doggett.

Mr. DOGGETT. Thank you, Mr. Chairman. Thanks to all of our witnesses. Mr. Chandler, I was pleased that you drew attention to the fact that 17 percent of our gross domestic product is focused on health care and it could rise to almost a fourth of our total national economic output. That was certainly a consideration of our writing the Affordable Care Act, in noting that despite the fact that we devote some resources to health care that we don't get the best outcomes verses some of the countries that are devoting significantly less. Of course, one of the objectives, and there were modest improvements in the Affordable Care Act, was to address the problem of soaring costs.

One of the major omissions of the Affordable Care Act has been the failure to address soaring pharmaceutical costs. Indeed, particularly in the last year, the cost of the—soaring costs of cancer drugs has been almost inconceivable to see those who are facing a diagnosis of death, facing not only that, but a diagnosis of personal bankruptcy on their copays for drugs that are costing tens of thousands of dollars, over \$100,000 for some. Not only having the impact of personal bankruptcies, but threatening insurers and Medicare, given our inability to negotiate for Medicare on drug prices.

One of the very modest steps taken in the Affordable Care Act was to set up an independent panel given the inability of Congress to address soaring health care costs. And so the action that was taken is that yesterday, we repealed that modest cost containment provision, that won't take effect for another 9 years, and pay for the repeal by limiting the prevention fund, taking money that was designed to encourage preventative steps such as treating diabetes and preventing diabetes instead of paying for amputations. All of this done without any alternatives being offered, as to how rising healthcare costs would be addressed.

Today, we are speculating on an incomplete of proposed premium increases that will not be finalized for months, that some States have the ability to deny or limit in the rate review process, and many States do not. Against that speculation, we have a certainty and that is that if tomorrow at 10 o'clock or one of the next few days, the United States Supreme Court provides an adverse decision in King against Burwell, provides the result that Chairman Roskam, Chairman Ryan, my two Texas Senators have sought that would deny tax credits for families who live in our States, that those folks will see an extraordinary increase in their out-of-pocket cost.

About 6.4 million people living in States that have refused to set up private insurance marketplaces at the State level will lose their tax credits, that is a cumulative loss of about \$1.7 billion every month. In Texas, that would mean an average 305 percent premium increase for 800,000 Texans, at least in terms of what their out-of-pocket premium costs are.

Mr. DOGGETT. I am concerned about what is happening with rising premiums. Commissioner Kreidler, is the increase in health

insurance premiums, did that start with the passage of the Affordable Care Act, or did we have some issues concerning rising healthcare premiums before that Act ever came law?

Mr. KREIDLER. Thank you, Mr. Doggett.

The issue of rising premiums has been with us for a long time. And since I have been serving as insurance commissioner 14-plus years now, I can tell you it has been a real problem that is actually looking better right now with the Affordable Care Act than what we saw before, the routine nature. We were seeing people who were sicker, buying health insurance. If you were healthier, you didn't buy it. You opt in. If you try to buy it when you are sick, that has a very negative impact on the market. Now with a mandate to have it, it has had the effect of helping to hold down the rate increases. But we need to do more than that. And one of the issues that you mentioned, Mr. Doggett, was the issue of pharmaceuticals. We need, and we are seeing a major transition to generics. And I am very supportive of the health insurers who want to make sure they go to generics first, but they need to be able to go to brand name at the appropriate time. They can't discriminate unfairly against consumers who have bought health insurance.

And when it comes to the issue of narrow networks, that is not new. That was there before healthcare reform went into effect. It was something that large employers were instituting, had instituted in the past. The self-insurance plans, which we as regulators don't regulate, it came into the regulated market, particularly inside the exchange starting in 2014. But if it is done right, and that is why I adopted rules on network adequacy, if it is done right, it can improve quality and outcome and lower the cost, but you need to make sure you are holding carriers accountable, don't let them determine the rules for themselves.

Mr. DOGETT. Thank you very much.

Chairman ROSKAM. Mr. Renacci.

Mr. RENACCI. Thank you, Mr. Chairman. I want to thank you for the book.

Mr. Lewis, it is an honor to serve with you. I look forward to reading that book.

And, the witnesses, I appreciate you all being here. It is interesting, I was in business for 28 years before I came here. I was in the health care business. And yes, premiums did go up, but if I ever saw a premium go up more than 8 or 9 percent, it was a shock. Today, when I go through my district and I hear 62 percent increase, 48 percent increase, 39 percent increase, it shocks me when I hear premiums costs are coming down, or we hear new statistics that say they are coming down, because that is not what the real world is telling me when I go back to my district and I go to these employers.

And one thing when I do go to the employers, I ask them if I can talk to the employees. And it is interesting, because it is a requirement. I want to talk to your employees. I ask every one of them that are buying their own insurance, tell me if your healthcare costs are coming down. Put your hand up. Now, I realize people are always afraid of putting their hand up, but I have had only one person tell me that the Affordable Care Act is helping them. Now, maybe I am going to the wrong businesses, I don't know. But I

seem to be going to business after business and talking to employees.

And I also had a similar situation Mr. Kelly had. I had an individual at a local restaurant, Wadsworth, Ohio, say to me, Congressman, I now am part of the Affordable Care Act, but can you help me, because my husband and I work 40 hours a week, and we can't afford this deductible. So we really don't have insurance. And it is shocking when you hear some of those stories as well.

I do go around to the hospitals. Again, being in health care, I am always trying to find out what the Affordable Care Act has done. And I ask the question, have the emergency room visits increased? At the same time, you know, we are learning about these insurance premium increases. We have been hearing and I have been hearing emergency room visits are increasing.

Without objection, I would like to enter this May 5, 2015, Wall Street Journal article entitled U.S. Emergency Room Visits Keep Climbing into the record.

Chairman ROSKAM. So ordered.

[The information follows:]

## U.S. Emergency-Room Visits Keep Climbing

People on Medicaid turn to hospital care when doctor access is limited, new survey suggests



Dr. Leon Yeh speaks to an emergency-room patient at OSF Saint Francis Medical Center in Peoria, Ill. Doctors say they are seeing more ER visits. *PHOTO: JIM YOUNG/REUTERS*

By STEPHANIE ARMOUR  
Wall Street Journal

Updated May 4, 2015 5:34 p.m. ET

Emergency-room visits continued to climb in the second year of the Affordable Care Act, contradicting the law's supporters who had predicted a decline in traffic as more people gained access to doctors and other health-care providers.

A survey of 2,098 emergency-room doctors conducted in March showed about three-quarters said visits had risen since January 2014. That was a significant uptick from a year earlier, when less than half of doctors surveyed reported an increase. The survey by the American College of Emergency Physicians is scheduled to be published Monday. Medicaid recipients newly insured under the health law are struggling to get appointments or find doctors who will accept their coverage, and consequently wind up in the ER, ACEP said. Volume might also be increasing due to hospital and emergency-department closures—a long-standing trend.

Emergency-room visits are climbing, despite predictions that the Affordable Care Act would lead to less traffic. WSJ's Stephanie Armour joins the News Hub. Photo: Getty

"There was a grand theory the law would reduce ER visits," said Dr. Howard Mell, a spokesman for ACEP. "Well, guess what, it hasn't happened. Visits are going up despite the ACA, and in a lot of cases because of it."

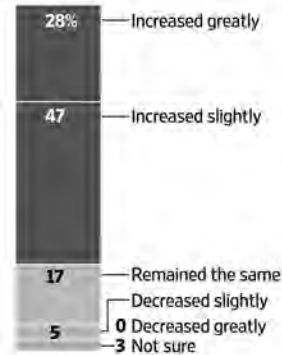
The health law's impact on emergency departments has been closely watched because it has significant implications for the public. ER crowding has been linked to longer wait times and higher mortality rates.

"As people gain access to affordable, high-quality coverage, they are more likely to get the right care when they need it," said Aaron Albright, a spokesman for the Centers for Medicare and Medicaid Services. "For people who have utilized emergency rooms for nonemergency care in the past, we are continuing to work to reach out and provide information on how to best use their new coverage."

The Affordable Care Act is also making critical investments to train more doctors and nurses, especially in communities that have lacked access to quality, affordable care in the past, he said.

### Seeking Care

Three-quarters of 2,098 doctors surveyed in March have noticed an increase in patients in the emergency room since January 2014.



Source: American College of Emergency Physicians  
THE WALL STREET JOURNAL.

More than half of providers listed in Medicaid managed-care plans couldn't schedule appointments for enrollees, according to a December report by the Health and Human Services Office of the Inspector General. Among providers who could offer appointments, the median wait time was two weeks, but more than a quarter of doctors had wait times of more than a month for an appointment.



Many doctors don't accept Medicaid patients because the state-federal coverage provides lower reimbursement rates than many private health-insurance plans. The waits for primary and specialty care by participating doctors appear to be leaving some Medicaid patients with the ER as the only option, according to ACEP.

"We're seeing a huge backlog in the ER because the volume has increased," said Ryan Stanton, an emergency-room doctor at Baptist Health Lexington in Kentucky. "This year we already have had to board people in the ER because of the sheer volumes," he said, referring to a practice of keeping patients in the ER until a hospital room becomes available.

Dr. Stanton said ER volume rose about 10% in 2014 from 2013, and was up almost 20% in the first few months of this year.

The ACEP survey also found that ERs are seeing sicker patients: About 90% of the doctors polled said the severity of illness has stayed the same or gotten worse. That might be explained in part by an aging population, newly insured people with multiple maladies, and people delaying care because they have high-deductible insurance plans. Nicholas Vasquez, a medical director for an emergency department in Mesa, Ariz., said volume rose 5% in a year, representing about 10 more patients a day. The stress from bigger caseloads prompted some nurses to resign, he said. "Physicians are working more shifts—that pushes them a lot," Dr. Vasquez said. "If they work too much, they get burnt out. For patients, it means longer waits."

Some states have been trying to curb ER use by Medicaid recipients by requiring higher copayments for visits deemed nonurgent. Critics have denounced that practice as punitive, and warn that it will dissuade low-income patients from seeking care that may be necessary.

A 2013 study by Truven Health Analytics that examined insurance claims for more than 6.5 million ER visits by commercially insured people under age 65 found just 29% of patients required immediate attention. Twenty-four percent didn't require immediate attention, 41% received care that could have been provided in a primary-care setting, and 6% got care that would have been preventable or avoidable with proper primary care.

More than 40% of emergency physicians said they expect emergency-room visits to increase if the Supreme Court rules that subsidies provided to people who obtain insurance on the federal exchange are invalid. The court is expected to rule by late June.



Mr. RENACCI. The article explains that even though people have insurance, they can't find providers or get appointments with providers they can find, so they are still going to the emergency room.

Now, for the panel, I think you would all agree with this, but doesn't greater emergency room use lead—does it lead to higher costs or lower costs? Each one of the panel members, higher costs or lower costs if we are going to the emergency room?

Mr. REDMER. Certainly, I think higher.

Mr. RENACCI. Mr. Kreidler.

Mr. KREIDLER. I would also say definitely higher. But in the State of Washington, we have actually seen about a 10 percent reduction in emergency room visits. Frequently—

Mr. RENACCI. Washington must be the only State. Ohio is not doing that. But I appreciate—

Mr. KREIDLER. If you go into an emergency room, what they wind up telling you is, if it is not an emergency situation, go down to urgent care down the street. It is going to cost you a lot less. And that has had a dramatic impact.

Mr. RENACCI. Ms. McPeak.

Ms. MCPEAK. I cannot dispute. I would say higher.

Mr. RENACCI. Mr. Chandler.

Mr. CHANDLER. The issue is that once you are in the emergency room, there are a wild number of tests that will be performed. Insurers are not capable of exercising sensible utilization review, and as a result, the costs can often be higher.

Mr. RENACCI. It is amazing, because I always thought the purpose of ACA was really, especially with subsidized insurance, to reduce emergency room visits. And, again, that is not what I am seeing in Ohio.

Ms. McPeak, you mentioned that many insurers have made changes to their networks to limit the providers people can see. What has your State experience been?

Ms. MCPEAK. We are just now beginning to see very limited networks attached to rates implants for the 2016 plan year. As I mentioned before, I do think that is an attempt by the insurers to moderate the rate increases that has been requested and provide choice to consumers so that you can have a skinnier network, and potentially reduce your own costs if you are willing to take the risk that you may not have full access to the wide provider network to which you are accustomed.

Mr. RENACCI. How has the President's promise that you can keep your doctor if you like your doctor worked out in Tennessee?

Ms. MCPEAK. Well, that is about the same as the promise that you can keep your policy if you like it, in my opinion. That is not working out very well. And we are hearing from consumers who are having difficulty navigating the federally-facilitated marketplace to see where the provider lists are maintained and whether their providers are included, and they might get into a product that, in fact, does not have the doctor which they like.

Mr. RENACCI. It is the same thing I am seeing in Ohio. I think this is an important point, just having an insurance card doesn't really mean you have access to care. I think you all agree?

Ms. MCPEAK. I would agree. For, you know, economic reasons, access reasons, and utilization, certainly.

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

Chairman ROSKAM. Mr. Crowley of New York.

Mr. CROWLEY. Thank you, Mr. Chairman. Thank you, as well, for the book. I appreciate your kindness in giving it to all of us. And we can never say enough about the honor it is to serve with Mr. John Lewis here in the House of Representatives, particularly in light of what took place last week in the south and all that he has lived for, has put his life on the line for. The ripping events of last week has left a scar upon our Nation, and no one knows it more than John Lewis. Thank you, John. I love you. You are a great man.

Mr. LEWIS. Thank you.

Mr. CROWLEY. I am a little bit baffled, though, by what my colleagues think they are going to accomplish today by holding this hearing. Yes, opponents to the Affordable Care Act have tried numerous tactics to scare people away from the law. That is nothing new. They seem to think if they keep on shouting premium increases, ObamaCare, death panels, then people will avoid getting insurance through the law, which is somehow a victory for them. But that is no victory for anyone.

Commissioner Kreidler, you have mentioned that enrollment plays a big part in keeping premiums stable. That is part of the very concept of insurance, isn't it? Bigger—let me just finish. Bigger, healthier pool of enrollees spreads out costs so premiums can stay steady; is that not the case?

Mr. KREIDLER. Very definitely. It is the law of large numbers. If you don't get good risk and bad risk and have large numbers, a large pool, it is very hard to control rates.

Mr. CROWLEY. So all of a sudden, this sudden outrage over premium increases is going to have the effect of scaring people away from the ACA's insurance markets, making it harder to prevent those very premium increases. But aside from that, I don't understand this nostalgia for the way things used to be before the Affordable Care Act was in place, when insurance companies could do whatever they wanted for however much they wanted to charge. It is as if there were never premium increases, never problems with health care in the past. But that is not what my constituents experience back in New York. My constituents in Queens and the Bronx are small business owners who saw their insurance bills go up every year with no explanation.

They were families buying insurance on the individual market, or maybe couldn't shop around after getting hit with a double-digit increase because they had an old injury that would get called a pre-existing condition, and they would be denied new coverage. I am proud that those days are days of the past.

Commissioner Kreidler, today if an insurance company just feels like raising rates to pad their profits without spending more on patient care, can they do that?

Mr. KREIDLER. Mr. Crowley, what we see now is the insurance companies have to play by a standard set of rules. So they can't game the system. The game before was try to avoid sick people, only insure healthy people. And if you were one of the sick people,

you were obviously kind of left out. Now with standard rules, we are actually introducing real competition between insurance companies. And that is one reason I am so proud that in the State of Washington, we have had a 50 percent increase in the number of insurers. So they are competing with a standard set of rules. It isn't the gaming that was employed in the past.

Mr. CROWLEY. Well, it is also because the Affordable Care Act requires that 80 percent of the premiums go directly to better care. If consumers do get a rate increase notice, they are left to just—they would love to just shrug their shoulders. That is just the way it is. That is not the case anymore, is it?

Mr. KREIDLER. That is correct. You know, in the State of Washington, we were fortunate because we had a very competitive market, we had none that had problems meeting the 80 percent rule. That wasn't true for many other States. And it is now because of the Federal law that they have to meet as the standard.

Mr. CROWLEY. What can regulators in States like my home State of New York or Washington do when they see exorbitantly high rates going into—or the request for that? What can they do now?

Mr. KREIDLER. One is they have an opportunity to shop. They can go—if they had a carrier before, if you had a preexisting condition, you couldn't move to another insurer, because they wouldn't want to insure you because of your preexisting medical condition. Now you have guaranteed issue. You can make choices. You can make decisions as to which plan, how much out-of-pocket expense do you want to have, what kind of coverage do you want? And you also want to make sure that your doctor is in a hospital. I will agree this has been one of the challenges that we have had is making it a lot more transparent so it is easier to identify the hospitals and doctors that are in a particular carrier's network when you make the decision, but you have those kind of choices and didn't before.

Mr. CROWLEY. What I can tell you is that in New York State, we have consistently used the authority to encourage—that was authorized by the ACA to fight premium increases. The State has come to the rescue and to stop that.

So, Mr. Chairman, I just want to say, I would suggest that three out of the four panelists would be opposed to the ACA, I am just taking a guess, and one would be in favor of it. With that, I yield back the balance of my time.

Chairman ROSKAM. It was a rhetorical question, but I will answer it. What are we trying to accomplish? What we are trying to accomplish is the work of the subcommittee under the House rules, which is to evaluate Federal programs. We haven't had a bigger Federal program since the passage of the Affordable Care Act. There is nobody that is nostalgic about the past. The irony is, when President Obama won his election, overwhelming majority of Americans agreed on two things: They agreed that healthcare costs were going up at a rate which was basically unsustainable, and they were basically scandalized by the idea of not being able to get access to an insurance pool based on a preexisting condition. The loss and the regret is—that we are focusing in today is to say, we should have focused in on those things, concentrate it there, but in-

stead the administration, and it was their prerogative, went in a different direction. The false claim and false narrative was it is all going to be great. You get to keep your doctor. Premiums are going down.

So it is not as if we are scaring people away from the Affordable Care Act. The Affordable Care Act is scaring people away from the Affordable Care Act.

And with that, I recognize the gentleman from North Carolina, Mr. Holding.

Mr. HOLDING. Thank you, Mr. Chairman.

It is somewhat striking to me that there are many insurers out there that appear to have paid out more in claims than they are collecting in premiums. For example, Blue Cross/Blue Shield of Texas has reported that it collected \$2.1 billion in 2014, but paid out \$2.5 billion in claims. So does anyone on the panel think that it is sustainable for an insurer to pay out more in claims than it collects in premiums?

Ms. MCPEAK. No.

Mr. REDMER. No, it is not sustainable, and of—an observation is, our Blue Cross plan has lost money in the last couple of years, and we have seen a reduction in their reserves.

One of the reasons that they are coming back with the large rate increase, obviously, is because they have lost money. The gentleman from New York mentioned that if carriers don't hit a certain loss ratio, they pay rebates back to the consumer. So we have got a phenomenon where if you lose money, it stays lost, but you can only make it up incrementally, because if you make too much, it goes back to the consumer.

Mr. HOLDING. Right.

Mr. REDMER. So we can debate whether that is good or bad, but you can only incrementally make any losses back. You can't make it up in 1 or 2 years.

Mr. HOLDING. So if you are an insurer losing money under this scenario, and your options are you can either raise your rates, raise your premiums, you can just pack up and leave and stop insuring people in this segment, you know, leave the State. Now, this year, obviously, we have a very complete set of numbers, because we have already had a year of the program being in place, as insurers have a good idea of what they are dealing with. So what impact is the data review for the upcoming year having on the rates?

Mr. Redmer, you want to talk about that a little bit?

Mr. REDMER. Well, certainly, you can see on my testimony, we have had one carrier that actually came in and was asking for a small reduction in the individual rates. And CareFirst, our Blues plan, is asking for a 30 percent rate increase, and it is anywhere in between. So that is a result of increased costs. It is also a result, though, of having a lot of uncertainty in the marketplace.

You know, with the open enrollment last year, you didn't know who you were going to get, and what that experience was going to be. If you go back to my testimony, I speculated that Blue Cross and Blue Shield, our large carrier, they saw a phenomenon that because of the disparity between the individual market crisis and the small group crisis, there were a lot of small employers, thousands of them in Maryland, that just threw up their hands. They can-

celed their plans. They disbanded them, and those folks moved and migrated to the individual marketplace.

I believe that—and this is my speculation—that a lot of those folks, that if they were already sicker and utilizing care, and they were with CareFirst, they migrated to CareFirst with the lower individual premiums; and those that were young and healthy, they were buying based on price, and they went to some of the other carriers. So I think they were victims of adverse selection when thousands of these small employers just disbanded their plans.

Mr. HOLDING. Right.

Mr. CHANDLER. Representative Holding, could I—

Mr. HOLDING. She was raising her hand.

Ms. MCPEAK. Thank you. I appreciate the opportunity to respond. The year of data has been extremely helpful from the 2014 calendar year. But as I mentioned, our loss ratios were extremely high for that year. One of the functional challenges, though, is that because of the time schedule arranged by HHS, we were requiring insurers to file the 2016 rates before they had a very clear picture of their enrollees for 2015.

Because of the expanded open enrollment period and the 90-day grace period to pay premiums, insurers were filing rate for 2016 without even knowing who they had for 2015. Now, we are an effective rate review State. We take our rate review responsibility very seriously, so we are asking for supplemental information on a month-by-month basis as real data comes in for 2015. But it is still very, very new, and we haven't actually seen a large uptick and a positive trend on loss ratio yet.

Mr. HOLDING. Thank you. Mr. Chairman, does Mr. Chandler have 30 seconds just to respond to that?

Chairman ROSKAM. He does.

Mr. HOLDING. He is anxious. Thank you.

Mr. CHANDLER. Thank you. I would just say the following, don't trust my numbers. Trust the Obama administration's numbers, at least on this. Their calculator shows a 14 percent increase in claims experience projected for 2016. Yes, of course, insurance commissioners can review rates. And if insurers are being greedy, they can strike that down. But if they strike down rates that are, in fact, reasonable due to claims increases, I expect to see exit from the market. It is not sustainable for an insurer to keep losing money.

Mr. HOLDING. Thank you.

Mr. Chairman, thanks.

Chairman ROSKAM. Mr. Smith of Missouri.

Mr. SMITH of Missouri. Thank you, Mr. Chairman.

I want to thank the witnesses for being here.

The President campaigned aggressively on the promise to lower out-of-pocket expenses for families by roughly \$2,500 a year. However, insurers that cover my constituents, just in the last 2 years, we have seen an increase by one insurance provider of 22.9 percent in 2014. This year they have requested an additional 22.7 percent increase because of the one-size-fits-all approach under ObamaCare of all the different burdensome regulations, rules, everything that is coming into place. But in my opinion, this administration cannot continue to believe that ObamaCare would reduce costs for families

and individuals throughout my district. That is not what I am hearing back home, and that is what I don't believe is a reality.

But the families in my district need a healthcare system with more choice, more access, and that is more affordable. But what I seem to be reading on a daily basis is that instead of more choices, we are getting fewer. The burden on insurers is so high that they are consolidating. Providers are also consolidating for the same reason, the extra costs and bureaucracy costs of the healthcare system that this administration has created.

Now the Supreme Court decision may expose another broken promise by the President and the congressional Democrats to my constituents who may be required to get health care, but may lose their subsidies.

My question, Mr. Chandler, why do you think these premiums are increasing across the country and in my district?

Mr. CHANDLER. I think the reason, first of all, is the continued escalation of healthcare costs, of underlying healthcare costs. And the Affordable Care Act did very little. Yes, it did a few things, but it did very little to address that. And in some sense, by providing insurance without effective utilization review to a larger number of people, it put yet more strain on the system.

The second reason is the adverse selection story, which is perfectly foreseeable where you have inadequate controls built into the law. The people who are going to purchase insurance are, as has been experienced, disproportionately ill. And that is one of the reasons that you see premium increases going up.

The phase-out of subsidies is a factor, but it is not the primary factor in my opinion.

Mr. SMITH of Missouri. So do you think that with, say, the increase in all premiums, I gave the example of 22.9 percent last year in my district and then an additional 22.7 requested, do you see that my constituent is getting the increase in benefits, or is it the same care or less care?

Mr. CHANDLER. I am not aware that insurers are providing additional benefits pursuant to these policies.

Mr. SMITH of Missouri. Okay. So they are just getting the same kind of care for more expenses, probably.

Mr. Kreidler, my concern is, you made a statement earlier that you felt like things were looking a little bit better when it comes to premiums and that case. How do you feel like it is looking at individuals that are 27 years old?

Mr. KREIDLER. Thank you for the question. I think from the standpoint of somebody who is younger, they are not immortal. They run the risks. And by virtue of having insurance, it is a lot better for them. If they are under age 26, frequently, they can stay on their parents' policy.

At the same time, you know, it is—what we are—if you looked at the healthcare spending and thought you were going to actually reduce it in this country, I think that would be unrealistic, both because of an aging population, but also because of the changes in healthcare delivery. Those costs are going to go up. What we have to do is bend that cost curve down so it doesn't go up as rapidly as it has been.

Mr. SMITH of Missouri. And that is my concern, is the cost curve. And I am second youngest Republican member of Congress. So when I look at a 27-year-old, who according to the Manhattan Institute have had their premiums increase since ObamaCare has come into effect by 97 percent, that is not managing the cost curve for the younger Americans. That, to me, says that they are definitely not going to purchase insurance if there are going to be a 97 percent increase prior to the ACA.

What are your thoughts on that? It doesn't look like it is looking better to me as a young American.

Mr. KREIDLER. I am not familiar with any numbers like that from the standpoint—

Mr. SMITH of Missouri. What numbers are you familiar with?

Mr. KREIDLER [continuing]. From the numbers I am reviewing that you are describing. I am not saying it is not true. I am not familiar, my actuaries are not familiar with seeing those kind of numbers in my office.

Mr. SMITH of Missouri. Do you have any numbers on individuals in their late 20s experiencing premium increases?

Mr. KREIDLER. Yes, we would and do.

Mr. SMITH of Missouri. Do you know them offhand?

Mr. KREIDLER. No, I don't know.

Mr. SMITH of Missouri. Okay. I would be interested to see what your numbers are.

Mr. KREIDLER. Sure. It is. This is clear that I think the real challenge is what we face right now is bending that cost curve down as a Nation, and we have to do it fairly and equitably. But leaving 27-year-olds without health insurance is obviously going to be a problem. The test is going to be making sure we are bending that cost curve down so they are getting adequate insurance so that they don't cost impact the rest of us when bad things happen.

Mr. SMITH of Missouri. I would totally agree. I think the cost curve causes us to lose more people that would have health insurance.

Mr. Chairman, thank you for your time.

Chairman ROSKAM. Dr. McDermott.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I appreciate you letting me be an adjunct member of the committee.

There is a recent article in The Wall Street Journal talking about the conglomeration or the merging of healthcare providers, insurance companies. And they are talking about what is happening in a variety of markets around the United States, and I—and talking about antitrust questions. And the whole question, our fraud laws are really based, up to this point, on a fee-for-service system, meaning the Stark Law and other aspects of it, are really designed to deal with a fee-for-service system. Now, we have got managed care and we have got all these things going on.

I would like to hear you talk about where you think health care is going in terms of the mergers in these States where you are going to have—if the re-enterprise system is based on competition, it means you have got to have more than one or maybe more than two to have anything that could be called real competition. And if it is just 2 gorillas dividing up the pie in the State of whatever, it becomes not very competitive. And so I am interested in hearing



your anticipation of where you think this scheme of Affordable Care Act is going to go in the future. So anybody can pile in on it. You want to start?

Mr. REDMER. I think your instincts are correct. I think mergers and a reduction of the number of carriers, in and of itself, is bad for the consumer and is probably bad for providers as well as the larger entities can extract greater concessions from the providers.

Another observation, though, in addition to that, is there are a number of provisions of the Affordable Care Act that are encouraging and resulting in these hospital-owned provider organizations where physicians are becoming employed by hospitals. And I don't know about your States, but I can tell you in Maryland, that market has come and gone a couple of times in the last 30 years. And at least in Maryland, these hospitals really haven't shown a lot of talent in running efficiently and cost effectively physician practices.

So I am concerned that that is going to lead to greater inefficiency and greater costs in the long term.

Mr. MCDERMOTT. Can I just clarify on that? One of the things that happens, of course, is if you buy a doctor's practice, and you are used to seeing patients in your practice and now you are seeing them in the hospital, the hospital charges a facility fee of some sort, which jacks up the price on—and people are very surprised that I got over here for \$30 and now I am getting it for \$75 having it done, the same thing—

Mr. REDMER. Well, there is some of that, but, you know, we are also seeing hospital-owned physician practices that are outside of the hospital setting. You know, sometimes you just see the changing of the sign, and they are—they are community-based and outside the hospital, but they are not necessarily more efficient nor cost effective than an individual practice.

Ms. MCPEAK. Thank you. I would agree that your instincts are correct, and that we are going to see continued consolidation on behalf of health insurers and providers. In a certain sense, while we all need to be concerned from antitrust issues, it makes a bit of sense from the insurers' standpoint because they are looking to consolidate and gain efficiency in administration and gain provider networks. Now, on the consumer side, when the ACA limits the amount of areas upon which an insurer can compete because all insurers have to offer products on the essential health benefits platform, has to offer products from the metallic tiers of certain actuarial value percentages and amounts, you know, the consumers appreciate that because it is transparency and it is easy to compare policies. But insurers don't have much to compete on at that point except for provider networks, administrative efficiencies, and anything else that they can distinguish themselves, that they can no longer designate products and compete on that basis. So the ACA in itself limits those areas of competition that I think are leading to consolidations that we are witnessing.

Mr. KREIDLER. Mr. McDermott, I don't know that we can really attribute the consolidation that we are seeing right now in the health care environment, whether it is the insurers or providers, to the Affordable Care Act. I think particularly in the case of providers, that trend was well underway before the Affordable Care Act. My concern is that we are now starting to see it with the in-

surers, which may be more of a reaction to providers doing it. Hospitals who are buying outpatient clinics and, as you point out, they can charge higher rates. It means physicians. When I took office in the year 2001, most of them were not employees. Now you see a very large percentage of physicians who are employees because their clinics—they have either sold their clinics to the hospital, or they were acquired by the hospital and are now salaried. I worry about that. I also worry about what happens with the consolidation among insurers, and I think that is something that, as regulators, we will have a mutual concern about to make sure we maintain the viability of the health insurance market, whether it is the providers or the insurers themselves.

Chairman ROSKAM. Mrs. Noem.

Mrs. NOEM. Thank you, Mr. Chairman. And, Mr. Chairman, I want to thank you for mentioning my home State in your opening comments, because we do face some unique challenges in South Dakota with one of our largest insurance companies recently announcing some of the increases to premiums up to 51 percent with an average of about 42 percent. So that is a lot for anyone to try to deal with in one calendar year, much less try to continue to insure their family and make sure they are making the best decision. What my question wanted to cover specifically was if the Affordable Care Act is requiring individuals and families to purchase coverage that they don't need, and this is one of the challenges that we have seen and possibly has driven up costs in line with that as well.

So, Dr. Chandler, I know that you before, in this hearing, described why premiums are increasing. Could you just restate for me if you believe that ObamaCare was meant to address healthcare costs and what it was, especially considering some of the testimony of Mr. Kreidler earlier, I want to have it clarified what ObamaCare was meant to do to healthcare costs. What was the intention of the Act, and how was it to impact healthcare costs for Americans?

Mr. CHANDLER. Well, I would say the problem is that ObamaCare, or the Affordable Care Act, conceptualized wrongly the problem as one within the insurance industry rather than a problem primarily located within health care itself as fed back to by insurance. And so while it attempted to deal with insurance, I believe unsuccessfully by and large, it really failed, with one exception I can talk about, to address the major problem, which is cost increases for medicine, more procedures, more costly procedures. As one of the gentlemen mentioned, higher pharmaceutical drug prices. And so the one exception I would say is the creation of accountable care organizations, which may or may not reduce costs.

Mrs. NOEM. But by and large the Act has gradually increased the burden on Americans, do you believe, since it has been enacted?

Mr. CHANDLER. I do.

Mrs. NOEM. Ms. McPeak, in your testimony you say ObamaCare significantly changes requirements for health care plans. Can you briefly describe some of those changes?

Ms. MCPEAK. Yes. I alluded to those a moment ago. The essential health benefit platform, I think, does require citizens to pur-

chase coverages that they might not necessarily need and wouldn't choose to purchase on their own. What we hear frequently in Tennessee is, I am a 27-year-old male; I don't want maternity coverage, and I have to have a plan that includes something like that. So I do think that the inability to tailor products to the needs of your individual consumers has been affected by the Affordable Care Act, and the insurers can no longer tailor those plans to the distinct segment of the populations they are trying to serve.

Mrs. NOEM. So can I buy a policy with fewer benefits that could cost me less?

Ms. MCPEAK. Not unless it was compliant with the essential health benefits. I mean, you can certainly modify your cost sharing and your deductible amounts. You can limit the providers that you would agree to see under the plan, but the basic benefits have to be standardized under the essential health benefits platform.

Mrs. NOEM. So the Federal Government is requiring my constituents to buy benefits that they may or may not want at a higher cost to them?

Ms. MCPEAK. We do hear that from our own citizens in Tennessee, yes.

Mrs. NOEM. I just wanted to close with this- we have talked to many individuals and families across my State and across the country. I would be remiss if I didn't mention the rate hikes for small businesses as well. And I am talking about the small group market. The law completely upsets the traditional small group market, lumping mid-sized businesses with small businesses. And this definition change would have a huge impact. In fact, studies from Oliver Wyman and the agency for health care research and quality estimates that 22,000 South Dakota employees and their dependents will receive cancellation notices, and most will see an average premium increase of 18 percent.

So for Obama administration bureaucrats here in Washington, these 22,000 South Dakotans are not just points on a graph. They are people that would be impacted. It is their real lives. And with that, Mr. Chairman, I wanted to draw light to that. And I thank you for holding this hearing. I yield back.

Chairman ROSKAM. Mrs. Black of Tennessee.

Mrs. BLACK. Thank you, again, Mr. Chairman, for allowing me to be here as a guest and have an opportunity to be able to ask questions. I thank you for bringing this very critical topic before the public so that those that are listening to this know that we do care about either the lack of care or the costs for them to get care.

And I also want to say, Mr. Lewis, you are absolutely a giant in the civil rights movement, and it is such an honor to serve with you and get to know you personally. And I will get you my book so you can sign it for me as well.

Mr. LEWIS. Thank you.

Mrs. BLACK. Ms. McPeak, I want to thank you, again, for being here. And you have in your testimony that there is a consistent uncertainty on the part of the Obama administration in the ACA's implementation. I can say that we have seen so many changes that the Congressional Budget Office, the CBO, has now said they are no longer even to score the changes that have taken place. But most recently, there was a change that was released in the guid-

ance of the market withdrawal. And according to the guidance, if an insurance company chooses to leave a service area, or if they change the type of product that they are offering from, for instance, a PPO to an EPO, then the company is excluded from operating in that market for 5 years. The guidance was apparently issued after all the plans had filed their rates with the Department of Insurance, and meaning that it was too late for any of these carriers to revise any of those filings in response to what this guidance was.

Can you elaborate why this guidance would potentially disrupt the market in Tennessee?

Ms. MCPEAK. Certainly. And I do have a very specific information about that particular guidance in my written testimony as well, because it was a distinct challenge for us in Tennessee. As you mentioned, the carriers had already filed their service areas and their rates for 2016 when the guidance was issued. And we have eight different service areas in Tennessee, and the guidance suggested that leaving one service area was going to be considered a market withdrawal, and the carrier would be prohibited for 5 years from selling insurance in the State of Tennessee. Also a change in the plan. So moving from a PPO to an EPO plan was considered a market withdrawal.

So insurers who filed the rates didn't have any idea that this interpretation was outstanding, and then we received a guidance from HHS in this regard. And for Tennessee, that means that we would have lost five of our carriers for 2016 because of this guidance. And we were very, very concerned. We had a lot of conversations with HHS. And finally, HHS agreed that they would only implement this guidance for plan years 2017 and beyond. So it is still going to be an issue going forward.

Mr. CHANDLER. Could I further respond to that?

Mrs. BLACK. Yes.

Mr. CHANDLER. It is a very important development that you have highlighted, Representative Black. And I would urge the Congress to take a look at two things. First, is that guidance actually within the scope of the Affordable Care Act? This is traditionally an area of State regulation, and I really wonder what provision in the ACA authorizes it.

The second thing I would look at is whether the McCarran-Ferguson Act actually prohibits this sort of Federal interference in an area of traditional State regulation. So even putting the wisdom of the provision aside, I actually think there is a serious question that ought to be looked into, and for which for once there will be standing about the legality of this guidance.

Mrs. BLACK. I have a very brief period of time.

Mr. Redmer, did you want to reply to this as well?

Mr. REDMER. I have nothing to add.

Mrs. BLACK. Mr. Kreidler.

Mr. KREIDLER. I actually agree. I think, as regulators, we found it a very difficult action on the part of the HHS and how they applied it. It was problematic. I think the real question is, is this one where HHS sees the problem? And the problem would be if you come in with a new plan, you can totally avoid showing your rates as going up precipitously. I think all Members of Congress, certainly the public, wants to know that information. They can't

use it as a way of obfuscating significant rate increases, make sure it is transparent. And if the only tool that is available to HHS is this Draconian steps that they have taken, it is obviously one where maybe this is where you could get unanimity to amend the Affordable Care Act in Congress so that they have a tool that is much more sensitive rather than saying you are out of business for 5 years, which is the only option, I believe, that they have. It was inappropriate to try to do it the way they were doing it, though.

Mrs. BLACK. Thank you. Mr. Chairman, I yield back.

Chairman ROSKAM. Mr. Smith of Nebraska.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman. Thank you for allowing me to join the committee today. I appreciate our panel today. I wish we had more time, because I think we are covering some very important topics. And I am concerned about the consumer operated and oriented plans. It may be no surprise to you from Tennessee, being from Nebraska, we have had some issues. To date, HHS has awarded a reported \$2 billion in Federal loans to establish these plans. I have asked HHS some questions, and I await the answers even still.

Co-Opportunity in Nebraska and Iowa served over 100,000 individuals. And it was seized by the State of Iowa after only 1 year and has since been liquidated, as you know. And people who were on these plans have been left confused, understandably, and frustrated as well. And, once again, being forced to look for other insurance. And some even lost their plans that they were told they can keep, so that is why they went to Co-Opportunity, and yet, lost that as well.

Tennessee Community Health Alliance, obviously, serves some folks there. Now, it is my understanding that there have been some troubling signs, and actual enrollment was suspended, is that accurate?

Ms. MCPEAK. That is correct.

Mr. SMITH of Nebraska. That was suspended when?

Ms. MCPEAK. This was suspended in the middle of January of this year.

Mr. SMITH of Nebraska. Okay. Certainly, I appreciate your work on the issue. I know that these are difficult things to manage and to deal with. Now, my understanding was that the State of Iowa wanted to suspend enrollment but were told they cannot suspend and were forced to still offer a so-called qualified health plan. And can you walk me through the process that Tennessee engaged in to be able to suspend the enrollment?

Ms. MCPEAK. Well, certainly. Thank you for the question. It was a very difficult time for us, because we were first approached by Community Health Alliance that had been witnessing their enrollment increase substantially during the open enrollment period. And of course, middle of January was still during the open enrollment period. We did a quick examination. We shared their concern. We considered the co-op to be at financial capacity.

A few triggers in our State statute for hazard plans of condition had been met. And we notified HHS. And I will tell you, our interaction was not as efficient as we had hoped at that point with HHS. They certainly had a differing opinion about the financial stability of the company. I took a very conservative approach, I

think, because as Iowa and Nebraska experience had something occurred with the co-op, it would be my responsibility to take receivership action or liquidation or seizure of the company. And so we were not comfortable with the level of enrollment. There was a tremendous amount of back and forth. Eventually, it did take about a week's time for HHS to agree to suspend the enrollment. But even that small victory, which, again, as I mention in my comments, we think was the right decision for Tennessee, has been problematic for our Tennessee residents. Because our residents that had a plan with Community Health Alliance had extreme difficulty when HHS froze the enrollment and suspended them from the exchange. There was no ability to add a child that was born or adopted or any other qualifying event, because in the mind of the federally-facilitated marketplace, the plan ceased to exist. So all of those changes had to be performed manually, and it has not gone smoothly.

Mr. SMITH of Nebraska. Very interesting. I am curious, were you aware of Iowa's request to suspend enrollment?

Ms. MCPEAK. I was not aware of the request to suspend before the seizure occurred. I knew that it was possible to stop enrollment and to essentially turn off the exchange enrollees, but in my opinion, in Iowa and Nebraska, only after the seizure was ordered.

Mr. SMITH of Nebraska. Okay. Do you have a pretty good feeling about where the Community Health Alliance stands today?

Ms. MCPEAK. At our request, at Community Health Alliance has drawn down the full amount of startup loans from the Federal Government. We have a financial exam underway so that we know exactly where they stand. We have provided some helpful—we thought helpful—information about administrative expenses to the company. And the rate request for 2016 that they have filed is over 32 percent increase. I don't know that that is going to be sufficient to make the company sustainable and to remove the freeze for the upcoming year.

Mr. SMITH of Nebraska. Okay. And to the best of your knowledge, is it true that only one of the 22 plans nationwide did not have an operating loss for 2014?

Ms. MCPEAK. I did see a report that was consistent with that figure, yes, sir.

Mr. SMITH of Nebraska. And would that maybe lead you to some concerns that maybe calling them loans wouldn't be the most accurate description?

Ms. MCPEAK. I would agree, yes.

Mr. SMITH of Nebraska. Okay. Thank you. I yield back.

Chairman ROSKAM. Thank you.

I have got just a question for each of you. And, Mr. Redmer, I will start with you, because I know you have got a hard stop at 12 noon. So go ahead, you have got our permission to head out when you need to head out.

Mr. REDMER. Thank you.

Chairman ROSKAM. But in your written testimony, one of the things that you said was that, in insuring your State, their predictions are that the pool is going to be actually older next year.

Mr. REDMER. Correct.

Chairman ROSKAM. Could you speak to that? That seems, it is not a term of art, but that is a trend that is toxic, isn't it? I mean, what is the ramification of that?

Mr. REDMER. That is true. That will, obviously, continue to drive up costs. So it is something that we are concerned about. Again, there is still a lot of uncertainty as to what the effect of the increased penalty would be and whether that is going to drive any younger folks into the marketplace. Or the flip side is the young folks will sit tight and remain uninsured, pay the penalty and only those folks that migrate into the pool will be those that were uninsured and now are sick, which obviously, will probably mean even—even a higher average age and increased morbidity.

Chairman ROSKAM. So it is a ramification of adverse selection?

Mr. REDMER. Correct. Potentially.

Chairman ROSKAM. Okay. Ms. McPeak, could you give us an insight in terms of long-term trends that you are seeing in Tennessee as it relates to others things, Cadillac tax and so forth. How is this playing out for you?

Ms. MCPEAK. In Tennessee right now, we are hearing a tremendous amount of feedback from our large employers that are concerned about being assessed what has been described as the Cadillac tax by having a high value health insurance plan available to their employees and executives. Of particular concern, and I share this concern when I hear it from the employers, I know Representative Black has probably heard the very same thing, the cost of on-site clinics for employers is being included in the value, in the costs of that—that health plan, that high value health plan, for purposes of calculating the Cadillac tax. And employers rather than—and that is a decision or a guidance that is underway through the Internal Revenue Service. Employers instead of paying that Cadillac tax, or instead choosing to close those onsite clinics, and it is very troubling, because reducing healthcare costs and certainly convenience to the employees and potentially a lack or a reduced amount of the co-pay or cost sharing for attending, seeking service at an onsite clinic, certainly seems to benefit all of us in reducing costs and providing care. And so including the costs of that clinic as a part of the high value health plan for purposes of Cadillac tax is certainly problematic, and we are hearing a great deal about that in Tennessee right now.

Chairman ROSKAM. Mr. Kreidler, I realize that I have got the benefit of having John Lewis's book many copies around me. And you don't. But on page 178 of that book, Mr. Lewis points out that one of his phrases is, put all your cards on the table and put them face up. When I read that, I thought, wow, I have heard him say that. I was at a meeting in the back in that library behind us, and we had the Commissioner of the IRS at the time, we have had several, but one of the Commissioners of the IRS at the time, and Mr. Lewis, then chairman of this oversight subcommittee, said put all your cards on the table and put them face up. Just saying it would have been better if they had done that. They didn't.

But my cards faced up are this: I participated in the White House health care summit. This was one of the Affordable Care Act was being debated. It was an event at the Blair House. You may recall it. It was an all-day long sort of thing. The President was

there, and Members of Congress and so forth. One of the points that I made to the President is contrary to one of the arguments that you are making. And I want to get just a little bit of a better sense from you about why you are making the argument. And it has to do with Medicaid expansion. One of the things, and I don't recall sort of chapter and verse about this interaction, but one of the points that I made at this summit was, look, isn't Medicaid expansion simply an expansion of welfare, and isn't Medicaid a terribly broken system? And if you have a terribly broken system, why would you make that a foundation upon which you build a whole health care reform movement?

So a couple of minutes ago you said, look, one of the reasons that it is working in Washington State is because of Medicaid expansion. That, I think that is a problem. I think it is a problem long term. So I am from Illinois, our Medicaid system is really a mess. You have got huge access issues on the one point, and Medicaid is basically cost shifted in a lot of ways. I know it is split, but it is cost shifted under the Federal taxpayer. So isn't there a little bit of a cautionary tale in just Medicaid expansion as being part of this remedy? And isn't that almost a structural weakness to the Affordable Care Act?

Mr. KREIDLER. Mr. Chairman, one of the things that I found somewhat unique, that we are witnessing because we have expanded the Medicaid program is that you are actually starting to drive the Medicaid program closer to looking like what we see in the commercial market. That means both on the issues related to the networks that they have, which tended to be much—very different than what we saw in the commercial market. And certainly, as we have all heard if you're in an elected position in particular, you look at the kind of rates that Medicaid offers to providers being considerably lower than what it is in the commercial market.

We are starting to see that driven together. I think it inevitably has to. You cannot have the Medicaid market significantly underpricing what it offers to providers, and not see that, in effect, almost being one where the commercial market is having to subsidize the Medicaid market. Public programs and the commercial market have to operate on a level playing field. And we are seeing—starting to see that driven together in ways that we hadn't before.

But I believe that the real driver here is expansion of the Medicaid program that has done it. Before this time, we had very little limited interaction with the Medicaid program operated by the State. Now we have routine meetings talking about networks, talking about rates, and issues like that.

So I think it is having a beneficial effect that kind of goes outside of just what expansion itself would have been maybe the focus of discussion. It is actually, I think, helping medicinally to make sure that more people are insured, and you don't have this huge problem of uncompensated care happening, which obviously gets shifted then to other payers.

Chairman ROSKAM. You know, any insight that you have on your experience, if you or your staff would be willing to share that with us, I think it would be helpful. So thank you.

Mr. KREIDLER. Thank you, sir.



Chairman ROSKAM. Mr. Chandler, let's close out with you. I thought your insight as it relates to—the way I put it down in my notes when you were talking was the Affordable Care Act deals with—with a symptom, but not the cause. Systematically, health insurance rates are spiraling, but it doesn't deal with healthcare costs.

What insight do you have moving forward, if you could hit a reset button, how would you focus in? And you heard my rhetorical answer to Representative Crowley when he was saying, what are we doing? And are we nostalgic about the past? No. There is nobody that is defending the past. There is nobody that is celebrating about various structural weaknesses and so forth. But if you had an opportunity to hit a reset button and focus in and say how do we actually do this, where would you direct the Congress as it relates to dealing with healthcare costs, which, as a foundational point, if you have got that under control, you are well on your way to an actual remedy?

Mr. CHANDLER. Let me talk about two points, one big, one small. The big point is there may be some temptation on the part of Congress to regulate more, push it down, push it down. That is unlikely to be effective. That is, adding additional complexity to the system which we are already seeing, is going to drive costs up. It is going to lead to more gaming behavior and more diversion of resources into how to beat the Federal Government.

What we have in health care is a unique situation in which the consumer is basically taken out of the equation, and instead, health care is mediated by insurers who may or may not have the best interest of the patient at heart, and who may not have an interest in trying to figure out creative ways using technology and other means to drive down healthcare costs.

And so one of the things I would urge you to look at, and I know this is abhorrent to some Members, but I really believe you ought to look at consumer-driven health care so that we get probably the most powerful force that you have, which is individual greed, and individual desire to take care of one's self and one's family driving down healthcare costs.

Let me give you my second little point. You may have an opportunity, for better or worse, to renegotiate the Affordable Care Act in the coming weeks. I would urge both sides of the aisle to take a serious look at that employer mandate. What it is doing is it is keeping people out of the individual exchanges, keeping healthy people out of the individual exchanges. If you want to stabilize them, if you believe—if you happen to believe in the principles of the Affordable Care Act, those are the very people that you want in those individual exchanges so that we do not see an adverse selection death spiral.

If you also believe in free market principles, you ought to think why is it that we should be forcing employers to divert resources into the provision of health care rather, in some instances, into the provision of things that employees may value more, like a higher paycheck with which to pay rent and buy fresh food, and go to parks and engage in other activities that may be more likely to improve their health.

And so it strikes me that there is an opportunity—and I grant you, this is not the biggest issue on earth—but there is an opportunity to do some good here in an area which if people really rethought it and took the blinders and ideology off, there is some room for gain.

Chairman ROSKAM. Mr. Chandler, Mr. Kreidler, Ms. McPeak, and Mr. Redmer, we are deeply grateful for your time and your attention today. I know I speak for every member here, we value your insight and your willingness to share it with us. And lo and behold, let the record reflect that the United States Congress had a hearing on the Affordable Care Act, also known as ObamaCare, that actually happened to shed more light than heat, thanks be to God. So with that, the meeting is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

[Submission for the record follows:]



## **FOR THE RECORD**

**Statement  
on  
Health Insurance Premiums Under the Affordable Care Act**

**America's Health Insurance Plans  
601 Pennsylvania Avenue, NW  
South Building, Suite 500  
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**Submitted to the  
House Ways and Means Committee  
Subcommittee on Oversight**

**June 24, 2015**

## I. Introduction

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

We appreciate the subcommittee's interest in the cost of health coverage for consumers in the individual insurance market. Affordability of coverage is a top priority for AHIP and our member plans. Health plans are actively competing in the new marketplaces and are doing everything possible to offer competitive and affordable coverage options that provide value to consumers.

As Congress seeks to understand the impact of the Affordable Care Act (ACA) on health insurance premiums, we urge you to consider three major points:

- Premiums are based on a complex set of factors that reflect the cost of providing coverage to individuals in each state's marketplace. A number of factors are placing upward pressure on premiums and we need to address these cost drivers – including soaring prescription drug prices and rising provider costs driven by hospital consolidation.
- There is wide variation in proposed premium rates that will affect consumers in different ways, depending on where they live, their current coverage, their age, their income and eligibility for subsidies, and other factors.
- Consumers benefit from competition and choice, and health plans provide a wide range of coverage options, including choice of provider network, cost-sharing, and monthly premium costs. In the new marketplace, individuals are making their own decisions about the coverage that is right for them and their family. Affordability of premiums is a key part of the decision-making process and plans are working hard to keep premiums as affordable as possible in these new competitive markets.

With these points in mind, our statement focuses on: (1) specific factors that will affect premiums in the 2016 benefit year; and (2) a new Avalere analysis that examined proposed 2016 premiums for individual Exchange plans in seven states and the District of Columbia.

## **II. Specific Factors That Will Affect Premiums in the 2016 Benefit Year**

To better understand the issues that impact health insurance premiums, it is important for policymakers to focus on the following factors: (1) underlying health care costs; (2) provider consolidation; (3) the covered population; (4) taxes and fees; (5) benefit mandates; (6) the ACA's premium stabilization programs; and (7) premium subsidies and related factors.

### **Underlying Health Care Costs**

Health insurance premiums track directly with the underlying cost of medical care. Rising prices for care, particularly for prescription drugs and medical treatments, continue to make coverage more expensive for consumers.

A recent analysis of Census Bureau data by the Kaiser Family Foundation<sup>1</sup> found that health care costs increased by 7.3 percent in the first quarter of 2015 (compared to the first quarter of 2014), with hospital spending increasing by 9.2 percent.

Additionally, an October 2014 study<sup>2</sup> by the Health Care Cost Institute found that rising prices “were the primary drivers of spending growth for all medical service categories and brand prescriptions” in 2013. This study found that the average price paid per service increased by 6.7 percent for inpatient services, 5.8 percent for outpatient services, 2.5 percent for professional procedures, and 21.2 percent for brand name prescription drugs.

Prescription drug prices, particularly for high-priced specialty medications, continue to soar and are one of the leading drivers of health care cost increases. In 2014, national spending on prescription drugs increased 13 percent – representing the largest annual increase since 2001 – and specialty drug spending increased 26.5 percent.<sup>3</sup>

<sup>1</sup> *Wall Street Journal*, “New Evidence Health Spending Is Growing Faster Again,” Drew Altman, President and CEO of the Kaiser Family Foundation, June 11, 2015.

<sup>2</sup> Health Care Cost Institute, *2013 Health Care Cost and Utilization Report*, October 2014.

<sup>3</sup> IMS Institute for Healthcare Informatics, *IMS Health Study: 2014 a Record-Setting Year for U.S. Medicines*, April 14, 2015.

### **Provider Consolidation**

A new AHIP data brief<sup>4</sup> highlights research showing a statistically significant positive correlation between increases in health insurance premiums and the degree of hospital consolidation in Exchange markets in three states. The findings of this research, based on an analysis of monthly premium data from October 2014, demonstrate that:

- In Georgia, insurance premiums were 35 percent to 52 percent higher in highly consolidated markets compared to premiums for plans offered to residents in markets having less provider consolidation.
- In Missouri, people living in highly consolidated markets paid 31 percent to 46 percent more than those living in areas of the state with greater levels of hospital competition.
- In Ohio, premiums were 9 percent to 13 percent higher in the least competitive hospital marketplaces compared to premiums in more competitive markets.

Our data brief also highlights research from other studies showing, for example, that: (1) physician prices increased, on average, by 14 percent for medical groups acquired by hospital systems; (2) hospital mergers in already concentrated markets could result in price increases of as much as 20 percent, without any corresponding improvement in the quality of care; and (3) local hospital ownership and multi-hospital health system ownership of provider groups resulted in per patient expenditures that were 10 percent to 20 percent higher than for patients seen at independently owned groups.

### **Covered Population**

The mix of enrollees participating in the new marketplaces – particularly with respect to age and health status – has a significant impact on the cost of providing coverage. Across many states, costs are higher because Exchange enrollees tend to be relatively older and have chronic conditions.

Under the Administration's transitional policy for pre-ACA plans, a number of states have allowed consumers to renew policies that pre-date the law's coverage requirements. The marketplaces in these states may not have the broad participation that is needed among the young

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<sup>4</sup> AHIP Data Brief, *Impact of Hospital Consolidation on Health Insurance Premiums*, June 2015

and the healthy to offset some of the cost increases associated with the ACA's requirements. According to the American Academy of Actuaries<sup>5</sup>, "if lower cost individuals retain their prior coverage and higher cost people move to new coverage, the medical spending for those purchasing new coverage could be higher than expected." This expectation is reinforced by an analysis by the National Institute for Healthcare Management Foundation<sup>6</sup>, which projected that states that adopted the transitional policy will experience premium increases that are 10 percent larger, on average, than in other states.

The continued adverse selection created by the extension of the transitional policy can be expected to place upward pressure on premiums in some states. Conversely, as the transitional policy begins to phase out and as more individuals enter the ACA-compliant risk pool, this could have a stabilizing effect on premiums in future years.

#### **Taxes and Fees**

The ACA imposes an assortment of taxes and fees at the federal level – most notably the health insurance tax. Additionally, some states have imposed taxes and fees, including those intended to help finance the operations of the new marketplaces.

The ACA health insurance tax is set at \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017, and \$14.3 billion in 2018. In subsequent years, the tax will increase annually based on premium growth. The most recent estimate from the Congressional Budget Office indicates that this tax will cost \$142 billion over ten years.

We are deeply concerned that implementation of the new health insurance tax is undermining efforts to control costs and provide affordable coverage options. An Oliver Wyman study<sup>7</sup>, commissioned by AHIP, has concluded that the health insurance tax alone will increase the cost of family coverage in the individual market by an average of \$5,080 over the ten-year period of 2014-2023. This study also estimated that the health insurance tax will increase the cost of family coverage in the small group market by an average of \$6,830 over the same ten-year period. Additionally, a state-by-state analysis<sup>8</sup> by Oliver Wyman has provided per-person and cumulative estimates of the impact this tax will have on individual market consumers,

<sup>5</sup> American Academy of Actuaries, *Proposals to Address Insurance Cancellations Could Threaten Viability of New ACA Insurance Markets*, press release, November 14, 2013

<sup>6</sup> National Institute for Healthcare Management Foundation, *What to Expect for 2015 ACA Premiums: An Actuary Opens the Black Box*, May 2014

<sup>7</sup> Oliver Wyman, *Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans*, October 2011

<sup>8</sup> Oliver Wyman, *Annual Tax on Insurers Allocated by State*, November 2012

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

House and Senate bills proposing to fully repeal the health insurance tax (H.R. 928 / S. 183) have been cosponsored by 230 House members and 35 senators. The bipartisan House bill now claims a majority of House members as cosponsors – a significant milestone in demonstrating widespread congressional support for taking action on this issue. These efforts to repeal the health insurance tax, which our members strongly support, would take an important step toward making health coverage more affordable.

#### **Benefit Mandates**

The ACA requires health plans to provide coverage for an essential health benefits (EHB) package covering a broad range of mandated benefits, some of which typically were not included in pre-ACA individual and small group policies. The health reform law further requires that coverage sold through the Exchanges must be at one of four actuarial value levels: 60 percent (Bronze); 70 percent (Silver); 80 percent (Gold); or 90 percent (Platinum) – meaning that the policy is required to cover a specified percentage of the health care costs of a standard population. The costs associated with these benefits are factored into premiums.

State-mandated benefits also may go above and beyond what is required by the ACA. These additional required benefits add to the cost of coverage and are reflected in insurance premiums.

#### **ACA Premium Stabilization Programs**

The ACA established three premium stabilization programs – risk adjustment, reinsurance, and risk corridors – in an effort to promote competition and affordability for consumers during the early years of the law’s implementation. Our members strongly support these programs as essential tools for helping to create a stable and predictable environment for consumers who are purchasing coverage in the new marketplaces.

While these programs play a critical role in promoting market stability and affordability for consumers, there will be reduced funding for reinsurance next year – \$4 billion in 2016, down from \$6 billion in 2015. This will result in reduced reinsurance payments for 2016, which in turn is likely to place upward pressure on premiums.



#### **ACA Subsidies and Other Factors**

The ACA provides premium assistance tax credits and cost-sharing reduction (CSR) subsidies to make coverage affordable for low-income and moderate-income families. According to the Department of Health and Human Services (HHS)<sup>9</sup>, approximately 85 percent of Exchange enrollees nationwide currently are receiving tax credits, averaging \$272 per month, to cover a portion of their premiums. In addition, 57 percent of Exchange enrollees are receiving CSR payments that reduce the amount they pay for deductibles, coinsurance, and copayments.

Finally, the ACA subsidies are linked to the individual mandate which is enforced through a penalty set at \$325 or 2 percent of household income (whichever is higher) in 2015. This penalty will increase next year to \$695 or 2.5 percent of household income (whichever is higher). Combined with financial assistance and increased consumer awareness of the new marketplaces, the individual mandate penalty is designed to encourage more individuals, particularly younger and healthier individuals, to participate in the Exchanges. This will place downward pressure on premiums by promoting broader participation and more stable markets.

### **III. Avalere Analysis of Premiums for 2016**

A recent analysis by Avalere Health LLC<sup>10</sup> provides insights into the premiums consumers will pay in 2016 for individual Exchange plans in seven states and the District of Columbia.

This analysis found that proposed premium increases are largely stable in 2016, with premiums for all Silver plans increasing by an average of 5.8 percent in Connecticut, Maryland, Michigan, Oregon, Virginia, Vermont, Washington, and the District of Columbia. Avalere further concluded that premiums for the lowest cost Silver plans increased by an average of 4.5 percent, and that premiums for the second lowest cost Silver plans increased by an average of 1 percent.

The Avalere analysis examined premiums for an individual, 50-year-old non-smoker and focused on 2016 rate filings obtained through Department of Insurance websites as of May 29, 2015. State-specific data for the average Silver plan are shown below:

<sup>9</sup> U.S. Department of Health and Human Services, *March Effectuated Enrollment Consistent with Department's 2015 Goal*, press release, June 2, 2015

<sup>10</sup> Avalere Health LLC, *Lowest-Cost Exchange Premiums Remain Competitive in 2016*, June 11, 2015

Average Silver Plan			
State	2015	2016	% Change
CT	\$505	\$525	4.0%
DC	\$393	\$424	7.8%
MD	\$377	\$409	8.5%
MI	\$443	\$419	-5.3%
OR	\$376	\$421	12.0%
VA	\$422	\$469	11.0%
VT	\$455	\$483	6.2%
WA	\$417	\$433	4.0%
<b>Average</b>	<b>\$423</b>	<b>\$448</b>	<b>5.8%</b>

These data are for unsubsidized premiums, not including the ACA's premium assistance tax credits. As we noted above, approximately 85 percent of Exchange enrollees nationwide are receiving tax credits this year – meaning that out-of-pocket premium costs for most consumers will be somewhat lower than the amounts shown in the table above.

#### IV. Conclusion

Thank you for considering our perspectives on issues affecting health insurance premiums. Our members are strongly committed to continuing to work with Congress, the Administration, and other stakeholders to expand access to high quality, affordable coverage options.

