HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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SUBMITTED MATERIAL

HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

MONDAY, MAY 20, 2013

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 4:02 p.m., in room 2123, Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, Burgess, Scalise, Harper, Olson, Griffith, Johnson, Long, Ellmers, Barton, DeGette, Schakowsky, Butterfield, Castor, Green, and Waxman (ex officio).

Staff Present: Sean Bonyun, Communications Director; Matt Bravo, Professional Staff Member; Karen Christian, Chief Counsel, Oversight; Andy Duberstein, Deputy Press Secretary; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Brad Grantz, Policy Coordinator, O&I; Debbee Hancock, Press Secretary; Sydne Harwick, Staff Assistant; Brittany Havens, Staff Assistant; Sean Hayes, Counsel, O&I; Andrew Powaleny, Deputy Press Secretary; Tom Wilbur, Digital Media Advisor; Phil Barnett, Minority Staff Director; Stacia Cardille, Minority Deputy Chief Counsel; Elizabeth Letter, Minority Assistant Press Secretary; Stephen Salsbury, Minority Special Assistant; Roger Sherman, Minority Chief Counsel; and Matt Siegler, Minority Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good afternoon. I convene this hearing of the Subcommittee on Oversight and Investigation to examine the impact the Patient Protection and Affordable Care Act will have on the premiums of every American.

Today we are joined by several witnesses. Cori Uccello. Did I say it correctly?

Ms. UCCELLO. Uccello.

Mr. MURPHY. Uccello? I see. Uccello like—yes, we are good—is a senior health fellow at the American Academy of Actuaries. Chris Carlson—I think I got that right—is an actuarial principal with the Oliver Wyman Group. Daniel Durham is executive vice president for Policy and Regulatory Affairs with America's Health Insurance Plans. And Topher Spiro is the vice president for Health Policy at

the Center for American Progress. I thank the witnesses for joining us today.

Today's hearing will focus on a question that many Americans are concerned about: Will the Affordable Healthcare Act increase the cost of my health insurance? Based on information provided by some of the Nation's largest insurance companies and by outside analysts, the answer to that question is yes.

Two months ago the Subcommittee on Oversight and Investigation sent a letter to 17 insurance companies, including 15 of the Nation's largest insurers. We asked them for very basic information. What do you expect the Affordable Care Act will do to the premiums of Americans? Will they, in fact, be more affordable? We didn't ask them to create new material and we did not ask them to exclude or to focus on certain information or certain States. Instead, we simply asked them for the material they already had created to estimate the impact of the health care law on their consumers.

Nearly all the material the insurers submitted showed that Americans can expect massive premium increases. As one insurer told the committee, consumers in 90 percent of all States would likely face significant premium increases. Another wrote to the committee, "The bottom line is that the PPACA does not contain many provisions that will reduce costs and improve affordability, especially in the short term."

Now, to be clear, some individuals in a few States may see premium decreases. As identified by the insurers, these States are typically the ones that are already highly regulated, such as New York, Massachusetts, Maine, Vermont and others, but some of the materials submitted by the insurance industry show that even individuals in those States may still get a premium increase. And this still only represents five States. The other 45 can expect, as the insurers told us, significant premium increases. Forty-five States get premium increases and five may see a slight decrease.

On the day this law was signed, the President said it would, "lower costs for families and businesses." It seems remarkable that a law that was passed on the basis of affordability will instead bring Boston prices to a small town of Pennsylvania that otherwise would have been successful.

So why are costs going up? According to the materials provided by the companies, the Affordable Care Act mandates insurers provide a number of services regardless of consumer want or need, and then limits the ability for insurers to charge more or less depending on the likelihood of an individual using that insurance. We can easily predict those individuals who will be the hardest hit by these coming premium increases: young and healthy adults and some other age groups as well.

Furthermore, based on the materials provided by the insurers, the provisions in the Affordable Care Act that were supposed to mitigate the premium price increases are not going to be enough. For example, we have heard that those who can afford it the least will get subsidies if they earn less than 400 percent of the Federal poverty line, which is nearly $46,000 for an individual. Yet one insurer told this committee that the subsidies would cover only 40

percent of the premiums. So after doubling your premiums, the Affordable Care Act pays for less than half of it.

And what if you aren't eligible for a subsidy? If you are an individual making more than $46,000 or a family of four making more than $94,000, you won't be getting any help from the Federal Government. This health care plan was passed on the promise of lowering costs for everybody.

Supporters of the law often point out that women can no longer be charged a different amount because of their gender, but this benefit actually stops as women get closer to retirement. Several insurers told the committee these women will actually face higher premium increases than older men because of the end of gender rating. So as women get older and will inherently need more health care coverage, this health care bill makes it even more expensive.

We have also heard about the free services people get under the law, but these services are not free. Many insurers provided us with material showing that these free services were simply added to the premiums. So instead of paying for these services as they actually use them, everyone gets to pay for this in their premium regardless of whether you benefit from it.

Now, our investigation has heard from the insurers, so today we hope to hear from those before us. We will hopefully be able to get the perspective of the actuaries before us as well as the industry representatives. Thank you again for joining us today.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

I convene this hearing of the Subcommittee on Oversight and Investigations to examine the impact the Patient Protection and Affordable Care Act will have on the premiums of every America. Today we are joined by several witnesses: Cori Uccello is a Senior Health Fellow at the American Academy of Actuaries, Chris Carlson is an Actuarial Principal with the Oliver Wyman Group, Daniel Durham is the Executive Vice President for Policy and Regulatory Affairs with America's Health Insurance Plans, and Topher Spiro is the Vice President for Health Policy at the Center for American Progress.

I thank the witnesses for joining us today.

Today's hearing will focus on a question that many Americans are concerned about: will Obamacare increase the cost of my health insurance?

Based on information provided by some of the nation's largest insurance companies and by outside analysts, the answer to that question is yes.

Two months ago, the Subcommittee on Oversight and Investigations sent letters to 15 of the nation's largest insurers. We asked them for very basic information: what do you expect the Affordable Care Act will do the premiums of Americans? Will they in fact be more affordable? We didn't ask them to create new material and we didn't ask them to exclude or focus on certain information. Instead, we simply asked them for the materials they had already created to estimate the impact of the health care law on their consumers.

Nearly all of the material the insurers submitted showed that Americans can expect massive premium increases. As one insurer told the committee, consumers in 90 percent of all states would likely face significant premium increases. Another wrote to the committee: "The bottom line is that the PPACA does not contain many provisions that will reduce costs and improve affordability, especially in the short term."

To be fair, some individuals in a few states may see premium decreases. As identified by the insurers, these states are typically the ones that are already highly regulated: New York, Massachusetts, Maine, Vermont. But some of the materials submitted by the insurance industry show that even individuals in those states may still get a premium increase. And this still only represents five states. The other 45 can expect, as the insurers told us, significant premium increases. 45 states get premium increases, five may see a slight decrease. On the day this law was signed,

the president said it would "lower costs for families and businesses." It seems remarkable that a law that was passed on the basis of affordability will instead bring Boston prices to small town Pennsylvania, it would have been successful.

Why are costs going to go up? According to the materials provided by the companies, the Affordable Care Act mandates insurers provide a number of services regardless of consumer want or need, and then limits the ability for insurers to charge more or less depending on the likelihood of an individual utilizing that insurance. We can easily predict those individuals who will be the hardest hit by these coming premium increases: young and healthy adults.

Furthermore, based on the materials provided by the insurers, the provisions in the Affordable Care Act that were supposed to mitigate the premium price increases are not going to be enough. For example:

We have heard that those who can afford it the least will get subsidies if they earn less than 400 percent of the federal poverty line, which is nearly $46,000 for an individual. Yet, one insurer told this committee that the subsidies would only cover 40 percent of the premium. So, after doubling your premiums, Obamacare pays for less than half of it.

And what if you aren't eligible for a subsidy? If you're an individual making more than $46,000, or a family of four making more than $94,000-you won't be getting any help from the federal government. Obamacare was passed on the promise of lowering costs for everybody.

Supporters of the law often point out that women can no longer be charged a different amount because of their gender-but this "benefit" actually stops as women get closer to retirement. Several insurers told the committee these women will face higher premium increases than older men because of the end of gender rating-so as women get older and will inherently need more health care coverage, Obamacare makes it more expensive.

We have also heard about the "free" services people get under the law- but these services are not free. Many insurers provided us with materials showing that these free services were simply added to premiums—so instead of paying for these services as they actually use them, everyone gets to pay for this in their premium, regardless of whether you benefit from it.

Our investigation has heard from the insurers, so today we hope to hear from those before us. We will hopefully be able to get the perspective of the actuaries before us, as well as the industry representatives.

Thanks again for joining us today.

# # #

Mr. MURPHY. I now recognize Ranking Member DeGette for her opening statement.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you so much, Mr. Chairman. Mr. Chairman, last week for the 37th time the House voted to repeal the Affordable Care Act. And I suppose someone—I think you told me that we are all going to get little diamonds on our member pins when we hit 40 votes to repeal, but I am really mystified at the zeal to repeal the law, because I think we have made a lot of progress in the last 3 years, and as the law continues to be implemented, I think we will make a lot more progress.

Some of the worst abuses of the insurance industry, like rescissions of coverage for those who became ill, and the refusal to provide care for children with pre-existing conditions are no longer allowed. Tens of millions of Americans are already receiving better health insurance coverage, benefiting from free preventative care, and the elimination of lifetime coverage limits. States are taking advantage of new rate review tools, helping to slow the outlandish rates at which insurance premiums were increasing before the Af-

fordable Care Act. And I would point out those who are complaining that insurance rates are still rising in some areas need to look at how much they have been rising in the last 10 or 15 years in this country.

Other things in the Affordable Care Act that are helping, over 3 million young adults under the age of 26 have been able to retain health insurance coverage on their parents' plan. Medicare coverage has gotten even better. Over 6 million seniors are benefiting from the Affordable Care Act closure of the part D doughnut hole. They have saved over $6 billion in prescription drug costs. Tens of millions of seniors have received free preventative care under the Affordable Care Act.

And, Mr. Chairman, the early results seem to indicate that the Affordable Care Act's provisions design to reduce overall health care costs, which is what this hearing is about, are encouraging more coordinated care, moving away from payment systems that discourage unnecessary care, and paying more for quality than for quantity are working.

The National Health Expenditure Survey released in January found that health expenditures are increasing at their slowest rate in 50 years. The Congressional Budget Office reported what one analyst called "a sharp and surprisingly persistent downward slow"—let me try that again—"a sharp and surprisingly persistent slowdown in health care costs" since passage of the Affordable Care Act.

And last week, largely because of these changes, CBO reported a drop in deficit productions of hundreds of billions of dollars. And I think, Mr. Chairman, that these success stories are only the beginning.

In January 2014, the ACA will be fully in effect. When that happens, all Americans will, for the first time, have access to affordable health coverage regardless of age, gender or whether they have a pre-existing health condition. Millions of low income Americans will be able to sign up for Medicaid. Others, who do not receive coverage from their employer, will be able to shop for insurance on the competitive and transparent environment of health care exchanges, and most will qualify for tax credits to help pay for this coverage. According to the CBO, 86 percent of individuals who receive coverage through the ACA exchanges will receive tax credits, with the average credit reducing costs by over $5,000 a year.

So, Mr. Chairman, I think the ACA represents a real and enduring improvement in quality of life. We have a lot of work to do, and that's why I am really glad that we are having this second hearing on implementation of the ACA. And I would urge the entire Energy and Commerce Committee to spend less time fighting about whether we should have this important legislation and more time talking about how we can make it work better.

We have heard people complaining that there are going to be massive premium increases, but the Affordable Care Act's tools to help cut costs, from rate review, to tax credits, to the availability of lower cost catastrophic plans for young people will ensure that health insurance is affordable.

Now, later this week, we are going to learn about the ACA premiums in my State in Colorado, but we already had more insurers

than we expected, 19 of them, line up for enrollment in the exchange, so we think this should only benefit competition in Colorado. In States like Rhode Island, Washington State, and Vermont, they show no evidence that the worst-case scenario of rate increases, the rate shock that we hear so much about, will happen.

And so I hope that we can really take it—take time in this hearing and as we go forward in this subcommittee, look at the good things the law is doing for the American people and figuring out how we can make health care even more available for all Americans and more cost-effective.

With that, Mr. Chairman, I yield back.

Mr. MURPHY. Thank the gentlelady.

Now turn to Dr. Burgess for his opening statement, 5 minutes.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Well, thank you, Mr. Chairman. And I appreciate the fact that we are having this hearing today. It's important, and I think we need to have this discussion.

You know, the summer of 2009 is a time that I will never forget. The town halls that summer, my little town of Denton, Texas, which normally if I could get 2 dozen people to show up, I thought I was doing a good job, we had 2,000 people show up for the town hall. And why? Because they were concerned about what they saw just over the horizon with the President's effort to take over the administration of health care in the entire country.

They weren't asking us to do that. They were saying, be careful. Do not disrupt the system that is arguably working well for 60 to 65 percent of the people in this country, but if you are going to do anything at all, could you please help us with costs?

Now, I think January 1st of 2014, we will begin to see how disruptive this law has been to the system in the country. We will—we will have to wait on that day and see if I am right on that premise, but we do know today about the effects on cost, and they have not been good.

The President, in the heady days leading up to the passage and the signing of the Affordable Care Act, said 2,500 bucks is what you are going to save once this law comes into effect and online. Today, nobody's talking about saving $2,500. In fact, most people are worried that they are going to spend that amount more. Now, it's all well and good to say that, hey, that costs would have gone up even more without the Affordable Care Act, but that's a pretty difficult premise to prove, but what people are—do know, that they see when they open their cost of their insurance for the coming year is that it's going up significantly.

I had a youngster in my district over the weekend, mid 30s, single, he teaches school, his premiums have doubled this year. And, like many young men, he is questioning whether or not he even should continue the insurance, because after all, there is no real penalty, and if he gets sick, don't they have to take care of him anyway? That is a problem that is on the horizon that really has been poorly addressed, but this committee, in doing its work, sent out a number of letters to 17 of the Nation's largest health insurance companies requesting analysis of the effect of the Affordable

Care Act's policies, the mandates, the taxes and fees on health insurance premiums.

The results demonstrate exactly what some of us have felt all along, that the Affordable Care Act fails to lower costs, and instead exacerbates the very problems it was sent to correct.

The greatest effects of the increase in costs from the Affordable Care Act will be felt by the very individuals that the President claimed it would help the most, that is, people in the small group market, people in the individual market, and people who lack health insurance.

Insurers in our survey reported that not only would premiums increase across almost all 50 States, but they also reported that these premiums will increase between 1 and 400 percent. Even more troubling is that the premium increases are not just contained to the individual market, but will also be felt by consumers in the small group market and the large group market. Small businesses purchasing these plans can expect premiums to go up by 50 percent on average.

Many employers in the large group markets choose to self-insure, and even these plans reported that the taxes and fees embedded in the Affordable Care Act could increase premiums from 15 to 20 percent on average.

Now, there has always been this notion that we will tax an insurance policy and that money will somehow come out of the salaries of the executives in the insurance company. Well, I tell you, that's a fantasy. Those charges do not come out the salaries of the executives. They are passed on to the rate payer, they are passed on to the premium payer of those insurance policies, and that effect is going to be felt in a very profound way beginning next year.

The central promise of the Affordable Care Act is the component of the law that was supposed to hold costs down is in fact going to be very detrimental to consumers, to job creators, and to health care providers.

One of the most offensive things that I hear people—when I hear people talk about the Affordable Care Act is things are going to be free. Let me just tell you, practicing medicine for 25 years, there is nothing free that happens in a doctor's office or a hospital. You are either stealing something, even if it's just the intellectual property of the doctor or nurse who provides that care, it's paid for somewhere by someone. Unfortunately, those people aren't represented today.

I will yield back the balance of the time.

Mr. MURPHY. The gentleman yields back. I now recognize the ranking member of the full committee, Mr. Waxman, for an opening statement.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman. Our hearing today is supposed to discuss insurance coverage and insurance premiums under the Affordable Care Act. This is a—not a new topic. When the Democrats, and I chaired this committee, adopted this legislation, we looked at that issue very, very carefully. We did numerous

investigations of the health insurance market, and we found that premiums were rising very fast and in an incomprehensible way. Millions of Americans who had pre-existing conditions either couldn't get insurance at all or they were charged a very high extraordinary price for insurance coverage. And we also found out that even conditions where a woman might get pregnant or was the victim of domestic abuse wouldn't qualify for insurance or would have to pay more for her insurance.

Americans were paying for inadequate insurance. People were buying insurance that didn't really cover their health care needs, but it wasn't very expensive, so they thought they were covered. We learned Americans were paying very high amounts for deductibles and they had stringent annual and lifetime limits on the coverage. People didn't realize this, but a lot of the policies the insurance companies were selling were very, very limited.

So what we learned was that the market was broken. A lot of people who needed insurance badly couldn't afford it or couldn't even get it. If people had insurance, they lived with a great deal of insecurity about whether they would be able to continue to afford it.

And the Act, the Affordable Care Act, requires insurers to provide quality, secure coverage that is there for people when they need it. That's why the law contains numerous tools to make coverage affordable. So I was surprised last week when the Republicans on this committee ignored these provisions when they released an analysis warning of high premiums under the Affordable Care Act. This is what they are warning about. I think this is what they are hoping for, but they are going to be wrong.

The Republicans' report presented large premium increases as a certainty, but it only reached this faulty conclusion by cherry-picking data, ignoring the cost saving programs in the Affordable Care Act, ignoring the value of improved coverage available under the law.

The report, Mr. Chairman, ignored the fact that under Obamacare, the 85 percent of Americans with employer or public coverage will see little change in premiums or coverage because of this law. They will be able to keep that coverage. The report also ignored the impact of the Affordable Care Act's tax credits to help cover the cost of insurance premiums. And according to the CBO, 86 percent of the people that go to the marketplace for these individual policies will be getting tax credits, reducing the cost by an average of $5,000 per year. These tax credits will help make insurance coverage affordable for millions.

The report, of course, ignored the impact of the small business tax credits that can cut the cost of insurance by 50 percent. It ignored the impact of competition, because when you go into that marketplace, you will have a number of insurance policies competing for your business. When there is competition, it will lower the cost, and CBO says in this case, by as much as 10 percent.

The Republican report ignored the fact that because of this Act, many women, older Americans and those with pre-existing conditions are likely to see their premium costs fall, because if they have insurance coverage and they are paying for it, they are paying a lot more for that coverage and they are no longer going to be re-

quired to pay more for that coverage in the future, starting in January.

The report the Republicans put out ignored the fact that many Americans pay higher premiums, but they will also be paying higher premiums because they are going to actually get better coverage.

In recent weeks, we have received some actual premium data that we can use to protest the Republicans' prediction of doom, and today my staff released an analysis of the States where insurers have submitted their premiums for 2014, five States, Vermont, Oregon, Washington, Rhode Island and Maryland, and there is little evidence in those States of a rate shock that Republicans have been predicting. In many cases, Americans will actually pay less for comparable coverage.

I would like to ask that this staff memo and a memo released last week be made part of the record, Mr. Chairman.

Mr. MURPHY. Without objection.

[The information appears at the conclusion of the hearing.]

Mr. WAXMAN. This is going to be the true story of premiums under the ACA: Better coverage, affordable rates, and protection from insurance company abuse. We need to begin to focus on the facts so we can stop misleading the American people. Thank you, Mr. Chairman.

Mr. MURPHY. The gentleman's time has expired and now we will be continuing on with our other comments here. Now, we are going to talk about our witnesses here. Let me introduce each one. Our first witness is Ms. Cori Uccello. Got it right this time. She is a senior health fellow at the American Academy of Actuaries. She is the actuarial profession's chief policy liaison on health care issues. Ms. Uccello has prepared testimony and has authored, co-authored and contributed to several academy publications on various health-related issues. She was appointed to the Medicare Payment Advisory Commission, otherwise known as MedPAC, in May of 2010.

Our second witness is Chris Carlson. He is an actuary in the health care field working at Oliver Wyman. He provides consulting services to help insurers, health providers employers and State regulators. Previously, Chris worked in the industry as a pricing actuary at a Blue Cross/Blue Shield. Lately, Mr. Carlson has been assisting health care plans in developing premium rates in preparation of the market changes in 2014. He has written several reports that quantify the impact of the health insurance fees that have been widely accepted by the actuarial profession, and recently published an article describing the effect of age ratings compression in the American Academy of Actuaries magazine.

Our third witness, again, is Daniel Durham. He is currently the executive vice president for Policy and Regulatory Affairs for America's Health Insurance Plans, where he leads health care reform implementation efforts and policy activities. He has served in high level policy positions in the private sector as well as in the Federal Government at the U.S. Department of Health and Human Services, the Social Security Administration and the Office of Management and Budget.

And our final witness is Topher Spiro. He is the vice president for Health Policy at American Progress. Prior to joining American Progress, Spiro worked on health care reform at both the Federal

and State levels. He served as deputy staff director for health policy for the U.S. Senate Committee on Health, Education, Labor and Pensions under Senator Edward M. Kennedy and Senator Tom Harkin.

I will now swear in the witnesses.

You are aware that the committee is holding an investigative hearing, and when doing so has a practice of taking testimony under oath. Do any of you have any objections to giving testimony under oath? All the witnesses responded no.

So the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today? And all the witnesses have said no.

In that case, if you would please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. You are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code. Each of you may now give a 5-minute opening statement.

Ms. Uccello, you are first.

STATEMENTS OF CORI E. UCCELLO, SENIOR HEALTH FELLOW, AMERICAN ACADEMY OF ACTUARIES; CHRIS CARLSON, ACTUARIAL PRINCIPAL, OLIVER WYMAN GROUP; DANIEL T. DURHAM, EXECUTIVE VICE PRESIDENT, POLICY AND REGULATORY AFFAIRS, AMERICAS HEALTH INSURANCE PLANS; AND TOPHER SPIRO, VICE PRESIDENT, HEALTH POLICY, CENTER FOR AMERICAN PROGRESS

STATEMENT OF CORI E. UCCELLO

Ms. UCCELLO. Good afternoon, Chairman Murphy, Ranking Member DeGette and members of the subcommittee. I am Cori Uccello, senior health fellow at the American Academy of Actuaries, which is the nonpartisan association for actuaries in the U.S. We provide objective information as policymakers and regulators work to formulate public policy. Thank you for inviting me to speak today.

New health insurance rules that apply to the individual and small group markets will go into effect in 2014. The new rules will affect average premiums, but premium changes will differ across States and individuals. The academy has not done a projection of premiums in 2014, either on a national basis or for any subgroups of the population; rather, my goal today is to provide a framework for understanding premium changes by discussing the factors that will affect premiums. I will focus most of my remarks on changes in the individual market.

First I will discuss the factors that affect average premiums. As a reminder, premiums are set to cover the medical claims and administrative costs of the pool of individuals with insurance. In other words, premiums reflect the underlying demographics and health status of the insured population. The underlying composition of the insured population could change in 2014, due to several factors. One is the guaranteed issue provision that will prohibit insurers from denying coverage based on pre-existing conditions. In-

creasing the ability of high cost people to purchase coverage could put upward pressure on premiums. The individual mandate and premium subsidies will mitigate this effect by providing incentives for younger and healthier people to obtain coverage.

It's also important to consider whether individuals will shift between different types of coverage. If employers drop coverage and workers shift to the individual market, the impact on individual market premiums will depend on the demographics and health status of those shifting.

Individuals moving out of high risk pools and into the individual market will put upward pressure on premiums. Offsetting this effect in the near term will be the temporary re-insurance program.

Premiums also reflect a plan's benefit design, with more generous plans coming with higher premiums. New essential health benefit and actuarial value requirements could mean that plans will be more generous. While this could put upward pressure on premiums, it will also lower out-of-pocket cost sharing.

Premium changes will vary across individuals based on age, gender and health status. In most States, the compression of premiums due to the new age rating restrictions will increase the relative premiums for younger adults and reduce them for older adults. Prohibiting different premiums by gender will shift costs between men and women depending on age, and prohibiting health status rating will increase the relative premiums for healthy individuals and reduce them for those in poor health.

Although young adults not eligible for premium subsidies may be most at risk for premium increases, they will have access to catastrophic plans. The premiums for these plans can be set lower to reflect a younger enrollee population.

Premium changes will also vary by State. In States that already limit the extent to which premiums can vary across individuals, especially among those with guaranteed issue requirements, average premiums could decline as lower-cost individuals obtain coverage due to the individual mandate and the premium subsidies. In States with no or few rate restrictions, premiums are more likely to go up to reflect an influx of higher-cost individuals.

My remarks have focused primarily on the individual market. There will be premium changes in the small group market as well, but likely to a lesser extent. Insurers are already prohibited from denying coverage to small groups and small group plans are already more likely to meet most of the plan generosity requirements.

Most States, however, currently allow insurers to vary premiums across groups. The new rate restrictions will cause different premium changes across—across groups. In general, the groups with the greatest increases will be the low cost groups, while those with the greatest decreases will be the high cost groups. And premium changes across groups will vary by State.

In closing, I want to, again, highlight that when examining how premiums will change beginning in 2014, it's important to understand the various factors underlying these changes. These include the effectiveness of the individual mandate and premium subsidies, the new benefit requirements, employer decisions to offer coverage,

each State's current market rules, and each individual's characteristics.

Thank you, and I look forward to your questions.

Mr. MURPHY. Thank you.

[The prepared statement of Ms. Uccello follows:]

AMERICAN ACADEMY *of* ACTUARIES

Committee on Energy and Commerce
Subcommittee on Oversight and Investigations
U.S. House of Representatives

Hearing on
Health Insurance Premiums Under the Patient Protection and Affordable Care Act

May 20, 2013

Statement of
Cori E. Uccello, MAAA, FSA, MPP
Senior Health Fellow
American Academy of Actuaries

The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

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Executive Summary

This testimony is submitted on behalf of the American Academy of Actuaries, which is the non-partisan professional association representing all actuaries in the United States. Our mission is to serve the public by providing independent and objective actuarial information, analysis, and education to help in the formation of sound public policy.

On Jan. 1, 2014, the Affordable Care Act's (ACA) health insurance issue and rating rules that apply to the individual and small group markets will go into effect. These rules will affect not only overall average premiums, but also the specific premiums that people will face. Premium changes due to the ACA health insurance market reform rules will vary across states and among individuals and will reflect many factors, including:

- The effectiveness of the individual mandate and premium subsidies at attracting low-cost enrollees,
- New benefit requirements which may increase plan generosity but reduce out-of-pocket costs,
- Employer decisions to offer coverage and the demographics and health status of any employees shifting to coverage in the individual market,
- How each state's current issue and rating rules compare to those beginning in 2014, and
- Each individual's demographic characteristics and health status (and income when determining premiums net of subsidies).

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Testimony

Chairman Murphy, Ranking Member DeGette, and distinguished members of the subcommittee—thank you for the opportunity to appear before you today to address how certain provisions in the Affordable Care Act (ACA) could affect health insurance premiums in 2014 and beyond.

My name is Cori Uccello, and I am the Senior Health Fellow at the American Academy of Actuaries. I am providing this testimony on behalf of the Academy, which is the non-partisan professional association representing all actuaries in the United States. Our mission is to serve the public by providing independent and objective actuarial information, analysis, and education to help in the formation of sound public policy.

On Jan. 1, 2014, the ACA health insurance issue and rating rules that apply to the individual and small group markets will go into effect. These rules will affect not only overall average premiums, but also the specific premiums that individuals will face. It is important, however, to highlight that premium changes will differ across states and among individuals.

Much uncertainty still remains regarding how premiums will change. My testimony, which focuses primarily on the individual health insurance market, is intended to examine the various factors that can affect premiums. In doing so, it can help Congress and the public better understand the drivers of any premium changes in 2014. Although this testimony focuses on gross premiums—before any premium subsidies are taken into account—I will note the impact

of premium subsidies on individual decisions to purchase coverage and the resulting effects of those decisions on gross premiums.

I will begin with an overview of the basic concepts underlying premium calculations, and then highlight various ACA-related provisions and how premiums may change as a result.

Premiums reflect many factors

Premiums are set to cover the medical claims and administrative costs of the pool of individuals or groups with insurance.

Who is covered—the composition of the risk pool. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable and stable premiums can be. But the composition of the risk pool is also important. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher. If a risk pool disproportionately avoids those with higher expected claims, premiums will be lower.

Projected medical costs. The majority of premium dollars goes to medical claims.

Other premium components. Premiums must cover administrative costs, including those related to product development, enrollment, claims adjudication, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as profit.

Laws and regulations. Laws and regulations can affect risk pools, projected medical spending, and other premium components.

Factors driving medical claims

The total costs of medical claims reflect unit costs, utilization, the mix and intensity of services, and plan design. These categories can overlap because the underlying drivers of health spending can affect more than one of these categories. The interaction between categories is also important.

Unit cost drivers. Prices for medical goods and services reflect inflation, the relative negotiating power between insurers and health care providers, and the costs of new medical technology.

Utilization drivers. Utilization trends depend on the underlying demographics and health status of the population. On the provider side, they also will reflect incentives in the payment system. For instance, the fee-for-service system encourages greater utilization. On the consumer side, they also will reflect plan generosity—plans covering a wider array of services with lower cost-sharing requirements likely will incur greater utilization.

Intensity drivers. The introduction of new technology and more widespread use of existing technology can lead to the use of more intense and costly medical services. An example of technology-induced intensity increases is the shift from X-rays to more advanced imaging such as CT scans and MRIs. Greater disease severity also can increase treatment intensity.

ACA rules affecting premiums

Premiums will change under the ACA due to provisions beginning in 2014 that affect the composition of the risk pool, benefit coverage rules, administrative cost rules, and limits on premium variations.

Rules affecting the risk pool. Guaranteed-issue requirements will prohibit insurers from denying insurance coverage to those with high-expected health costs, which will tend to increase premiums in states that formerly allowed medical underwriting. On the other hand, the individual mandate and premium subsidies will provide incentives for individuals in good health to obtain coverage, mitigating premium increases due to guaranteed issue.

Benefit coverage rules. Plan generosity may increase due to essential health benefit and actuarial value requirements, thus increasing premiums, but lowering out-of-pocket costs.

Administrative cost rules. Medical loss ratio (MLR) requirements, already in effect beginning in 2011, limit the share of premiums that can be used for expenses other than medical claims and quality improvement activities.

Limits on premium variations. Premiums charged to older adults are limited to three times those charged to younger adults. Aside from age, premiums will be allowed to vary only by family size, tobacco status, geographic area, and metal tier. Premiums will not be allowed to vary by health status or gender.

Single risk pool. Insurers must use a single risk pool for each of the individual and small group markets when developing insurance premiums. This means insurers cannot separate their insured populations into different pools, with higher premiums charged to one segment and lower premiums charged to another.

Potential premium changes in 2014 and beyond

When projecting and examining premium changes, it is important to distinguish between changes in average premiums and the drivers of those changes from changes in premiums faced by particular individuals and the drivers of those changes. Notably, premium changes will vary by state depending on how each state's pre-ACA rules compare to those under the ACA.

Changes in average premiums. Changes in overall premium averages will depend on changes in the composition of the risk pool, which is the underlying demographics and health status of the insured population. This in turn will reflect the effectiveness of the individual mandate and premium subsidies designed to increase coverage among young and healthy individuals, combined with the increased ability of high-cost individuals to purchase coverage due to the guaranteed-issue requirement. In addition, average premiums could increase due to plan generosity requirements. Note that while increases in plan generosity can increase average premiums, they also can reduce consumer out-of-pocket costs.

In addition to previously uninsured individuals obtaining coverage, an important consideration is whether and how individuals will shift between different types of coverage. Such shifts can affect the composition of the risk pool. For instance, if employers drop coverage and the workers

instead obtain coverage in the individual market, the impact on premiums in the individual market depends on the demographics and health status of those shifting coverage. If those shifting coverage are young and healthy, the result would be downward pressure on average premiums in the individual market. If those shifting coverage are older and less healthy, the result would be upward pressure on average premiums.

Individuals moving out of high-risk pools and into the individual market also will impact premiums. Presumably, these individuals will have high costs and put upward pressure on premiums. Offsetting this effect, at least in the near term, will be the temporary reinsurance program in effect from 2014 to 2016. This reinsurance program will provide payments to plans with individuals who incur high medical costs. These payments have the effect of subsidizing premiums in the individual market. Although the payments will phase down between 2014 and 2016, the individual mandate penalties will increase during this period, which may increase the mandate's effectiveness at encouraging low-cost individuals to obtain coverage.

Changes in premiums faced by individuals. Different individuals will face different premium changes based on their age, gender, health status, and, as discussed below, state. In most states, the compression of premiums due to the age rating restrictions will increase the relative rates for younger adults and reduce them for older adults. The prohibition on the ability to charge different premiums by gender will shift costs between men and women, depending on age. In states that currently allow premiums to vary by gender, premiums typically are higher for younger women than younger men and for older men than younger women. Premiums will shift between men and women accordingly so that these gender-related differences will be eliminated.

The prohibition of health status rating will increase the relative premiums for healthy individuals and reduce them for those in poorer health.

The distribution of individuals by health costs is skewed, with more low-cost individuals than high-cost individuals. If the low-cost individuals, who are vulnerable to the largest gross premium increases, elect to leave (or not join) the individual market after the ACA 2014 rules take effect, upward pressure on premiums will result. The premium subsidies and individual mandate could reduce this effect.

Premium changes will vary by state. How premiums change, on average and among individuals, will vary by state based on how each state's pre-ACA rules compare to those under the ACA. In states that already limit the extent to which premiums can vary among individuals, especially those with guaranteed-issue requirements, average premiums potentially could decline as lower-cost individuals obtain coverage due to the individual mandate and premium subsidies. In states with no or few rate restrictions, premiums are more likely to go up, to reflect an influx of higher-cost individuals. In addition, premium changes will vary depending on each state's distribution of the population by income and insurance status (including access to employer coverage) and regional differences in utilization rates and provider prices. Among individuals, the largest premium increases for younger adults, and the largest reductions for older adults, will occur in states that don't currently restrict premium variations by age.

Factors mitigating rate shock/adverse selection. Premium subsidies will directly lower the net premium costs for individuals with incomes less than 400 percent of the federal poverty level. As

a result of these lower premiums, more individuals will obtain coverage, regardless of health status. The individual mandate also provides an incentive to obtain coverage, regardless of health status. Taken together, these provisions will help mitigate premium increases caused by the guaranteed-issue provision. Although young adults not eligible for premium subsidies are most at risk for premium increases, they will have access to catastrophic plans. The premiums for these plans can be adjusted for expected enrollee spending, meaning premiums could be lower to reflect a younger enrollee population.

Options to further address rate shock/adverse selection. Although the ACA includes provisions aimed to mitigate premium increases and rate shock, more can be done. Strengthening the individual mandate would help mitigate premium increases due to a less healthy enrollee population. Approaches could include less frequent open enrollment periods, penalties for late enrollment, more generous premium subsidies, and enhanced public outreach and consumer education. Another option would be to extend and/or increase the reinsurance program subsidies.

Premium changes in the small-group market

Much of the focus on premium changes has been in the individual market. In the small-group market, however, premiums are likely to change as a result of the ACA as well. And, as in the individual market, the premium changes will vary across states and across groups.

Currently, insurers in all states are required to offer guaranteed issue for small groups, meaning that they cannot be denied coverage.[1] Nevertheless, in most states, insurers are allowed to vary rates across groups, depending on the group's demographics, health status, group size, and industry. Beginning in 2014, small-group insurers will be required to use the same limited set of premium-rating factors as used in the individual market—age (limited to a 3:1 variation), family size, tobacco status, geographic area, and metal tier. Premiums will not be allowed to vary by health status, gender, or other small-group characteristics. As a result, premiums could go up in small groups with a disproportionately higher share of young and/or healthy workers and down in small groups with a disproportionately higher share of old and/or unhealthy workers. The smallest groups, which are currently often charged higher premiums than larger groups, could see premium reductions, while larger groups could see premium increases. Again, however, the degree to which small-group premiums will change due to ACA premium-rating restrictions will vary according to a state's current rating rules. The changes will be largest in those states that currently allow the greatest flexibility in rating and much lower in those states with existing rating rules similar to those required by the ACA.

In general, the small groups that will experience the greatest increases will be the lower-cost groups, while the groups experiencing the greatest decreases will be the higher-cost groups. Just as the distribution of individuals by health costs is skewed, the distribution of groups by health care costs is skewed, with more low-cost groups than high-cost groups. If the low-cost groups,

[1] The Health Insurance Portability and Accountability Act (HIPAA) prohibits insurers from denying coverage to small employers based upon health conditions of the employees. However, HIPAA does allow insurers to enforce minimum participation and employer contribution requirements. Under the ACA, insurers will continue to be able to enforce minimum participation and employer contribution requirements, but only for small groups enrolling outside of the designated month-long annual open enrollment period. The prohibition on minimum participation and employer contribution requirements within the one month open enrollment period could result in some upward pressure on premiums.

which are vulnerable to the largest premium increases, elect to leave the small-group market after the ACA 2014 rules take effect, upward pressure on small-group premiums would result.

The ACA's essential health benefit and actuarial value requirements also could impact premiums in the small-group market, but likely to a much lesser extent than in the individual market. Small-group plans are more likely than individual market plans to already cover most, but perhaps not all, of the required essential health benefits. In addition, the level of plan generosity (i.e., actuarial value) of small-group plans typically is above that of plans in the individual market. As a result, the increases in small-group premiums due to essential health benefit and actuarial value requirements will likely not be as substantial as those in the individual market.

Conclusion

ACA market reform provisions beginning in 2014 will affect premiums. Examining only average premium changes, however, will mask the underlying reasons for the changes and how premiums will change across individuals and groups. How premiums will change depends on many factors, including the effectiveness of the individual mandate and premium subsidies at attracting low-cost enrollees into the insurance market, the new benefit requirements that may lead to higher premiums but lower out-of-pocket costs, employer decisions regarding whether to continue offering insurance and the health status of those whose coverage is dropped, how each state's current issue and rating rules compare to those beginning in 2014, and each individual's demographic characteristics and health status (and income when determining premiums net of subsidies).

Mr. MURPHY. Mr. Carlson, you are recognized for 5 minutes.

STATEMENT OF CHRIS CARLSON

Mr. CARLSON. Thank you. Mr. Chairman and members of the subcommittee, thank you for this opportunity to testify on premium rates under the ACA. My testimony will focus on factors that are affecting premium rates that have been filed for 2014, and have been made available for public review. I will also discuss the professional responsibility of actuaries that are involved in preparing and certifying these rates.

There are three specific actuarial factors of the rate filings that I would like to address, which are, the impact of changes in the population on morbidity, changes in the value of benefits, and the impact of the transitional re-insurance program.

Recall that the CBO estimated the change in premium rates in their November 2009 letter to Senator Evan Bayh. Overall, the CBO expected premium rates to increase between 10 and 13 percent. Now that filings are available, we can discuss what is actually happening to premium rates.

I reviewed the 2014 rate filings in three States: Oregon, Maryland and Vermont. In each State, I identified the top health insurers and pulled from their filings the factors described above.

First, in Oregon, we reviewed the filings for the top three health insurers. We found that the expected change in morbidity due to new enrollees in the non-group market is between 27 percent and 46 percent. Although we note that the Oregon market also includes a merger with the high risk pool, which constitutes a very costly population. We also found the change in premiums due to average value of benefits ranged from an increase of 2 percent to a decrease of 17 percent.

Finally, the re-insurance program is expected to decrease rates by 10 to 12 percent. Overall, the average premium rate in these filings represents an increase of 36 to 53 percent over current premium rates.

The publication of these rates and the transparency of the process have had an immediate effect. One carrier has already expressed interest in revision to their rate filings due to concern about their rates relative to their competition and has produced reducing their rates by 15 percent.

The second State we reviewed is Maryland. We looked at the rate filings for two companies in the State and found the results to be quite divergent. One company has proposed rates that include 25 percent increase for morbidity for new enrollees, a 2 percent increase for benefits and a 4 percent reduction for re-insurance. Overall, they proposed a rate increase of 25 percent relative to current rates. The second company proposed an increase of 65 percent due to morbidity, a 6 percent increase for benefits and an 8 percent decrease for re-insurance. Overall, they proposed rates that are 120 percent higher than the current rates.

The final State we reviewed is Vermont, where there are only two health insurers that filed rates. Overall, the rates are expected to be consistent with the current premium rates in the market; however, it is worth noting that Vermont is already a community-

rated State with guarantee issue, thus we would not have expected an increase, and in fact, some may have expected lower premiums in the State.

The factors I discuss in each of these filings do not include the impact of age rating, therefore, for younger individuals that are affected by the age rating compression, the increases would be higher.

It is important to understand that these rates are before any consideration of the premium subsidies available in the exchanges. For the individuals that are expected to be eligible to receive premium subsidies, the amount they pay will be less, and sometimes substantially less.

Finally, I would like to add a few comments about the actuaries that have developed the rates described herein. The actuarial profession has a strong reputation of professionalism and independence. While many actuaries work and consult with insurance companies, we also work with regulators and consumer advocacy groups, and our high standards of professionalism always come first. This is illustrated in our code of professional conduct which, among other things, requires actuaries to act honestly, with integrity and competence, not be influenced by conflicts of interest, and only perform work where we are properly qualified.

The rates that actuaries are proposing require certification, which has components that are relevant in this discussion. The rates must be reasonable in relation to the benefits to be provided and must be neither excessive nor unfairly discriminatory. These provisions, in addition to minimum loss ratio requirements, protect consumers to ensure that they are receiving fair value and benefits for the premiums they pay.

The purpose in mentioning these issues is to help the public understand that the rate proposals that have been prepared in support of premium rates beginning in 2014 are done with the utmost of care. As actuaries, we do not take lightly the responsibility that has given us, and strive to maintain a high level of integrity and professionalism.

Mr. Chairman, again, I thank you for the opportunity to speak and look forward to answering any questions.

Mr. MURPHY. Thank you.

[The prepared statement of Mr. Carlson follows:]

Health Insurance Premiums under the Patient Protection and Affordable Care Act

by

Christopher Carlson
Principal and Consulting Actuary
Oliver Wyman

for the
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations

May 20, 2013

Mister Chairman and members of the subcommittee, thank you for this opportunity to testify on premiums rates under the ACA.

My testimony will focus on factors that are affecting premium rates that have been filed for 2014 and have been made available for public review. I will also discuss the professional responsibility of actuaries that are involved in preparing and certifying these rate filings.

There are three specific actuarial factors of the rate filings that I would like to address which are:

- The impact of changes in the population on morbidity or claims costs
- Changes in the value of coverage due to the requirement to provide essential health benefits, and
- The impact of the transitional reinsurance program

Recall that the CBO estimated the change in premium rates in their November 2009 letter to Senator Evan Bayh. Their projection was based on three factors. First, they estimated that the changes in the population being covered in the nongroup market would reduce premium rates by seven to ten percent. As we will see, it is unlikely that this expectation will be realized as the new enrollees are expected to have higher than average morbidity. Second, the CBO estimated that

the amount of insurance would increase by 27 to 30 percent. Finally, they estimated that the price would be reduced by seven to ten percent for other factors, primarily changes in the rules governing the nongroup market. We could say that this last factor can be considered competition and efficiency, although I did not try to quantify this factor in reviewing the publically available rate filings. Overall the CBO expected premium rates to increase between 10 percent and 13 percent.

Now that actual filings are available, we can move beyond talking about what may happen with premium rates, and discuss what is happening. I reviewed the 2014 rate filings in three states, Oregon, Maryland and Vermont. In each state, I identified the top two or three health insurers and pulled from their filings the factors described above.

First, in Oregon we reviewed the filings for the top three health insurers. We found that the expected change in morbidity due to the new enrollment in the nongroup market is between 27 percent and 46 percent. Although we note that the Oregon market also includes merger with the high risk pool which constitutes a very costly population. We also found that the change in premiums due to the average value of benefits ranged from an increase of two percent to a decrease of 17 percent. Finally, the transitional reinsurance program is expected to decrease

rates by 10 to 12 percent. Overall, the average premium rate in these files represents an increase of 36 to 53 percent over current premium rates.

The publication of these rate filings and the transparency of the process have had an immediate effect due to competition. One carrier has already expressed interest in a revision to their initial filings due to concern about their rates relative to their competition and has proposed reducing their rates by 15 percent.

The second state we reviewed is Maryland. We looked at the rate filings for two companies in the state and found the results to be quite divergent. One company has proposed rates that include a 25 percent increase for morbidity of the population, a two percent increase for benefits and a four percent reduction for the transitional reinsurance. Overall, they proposed a rate increase of 25 percent relative to current rates. The second company proposed an increase of 65 percent due to morbidity of the population, a 6 percent increase for benefits, and an 8 percent decrease for reinsurance. Overall, they propose rates that are 120 percent higher than the current rates in the market.

The final state we reviewed is Vermont, where there are only two health insurers that filed rates. Both carriers assumed no change in the morbidity due to the population to be covered and only small changes in benefits. Finally, they assumed a reduction in premiums of between eight percent and ten percent for the

transitional reinsurance. Overall, the rates are expected to be consistent with the current premium rates in the market. However, it is worth noting that Vermont is already a community rated state with guarantee issue, thus we would not have expected an increase due to new, less healthy enrollees and in fact, some would have expected lower premiums in the state.

The factors I discussed in each of these filings do not include the impact of age rating. Therefore, for younger individuals that are affected by the age rating compression, the increases would be higher. It is important to understand that these rates are before any consideration of the premium subsidies available on the exchange. Therefore, for the individuals that are expected to be eligible to receive premium subsidies in the exchanges, the amount they actually pay may be less, and sometimes substantially less.

Finally, I would like to add a few comments about the actuaries that have developed the rates described herein. The actuarial profession has a strong reputation of professionalism and independence. While many actuaries work and consult with health insurance companies, we also work with regulators and consumer advocacy groups, and our professions high standards of professionalism always come first. This is illustrated in our code of professional conduct which, among other things, requires actuaries to act honestly, with integrity and

competence, not be influenced by conflicts of interest, and only perform work where we are properly qualified.

The rates that actuaries are proposing require certification, which has components that are relevant in this discussion. The rates must be "reasonable in relation to the benefits to be provided" and must be "neither excessive nor unfairly discriminatory." These provisions, in addition to minimum loss ratio requirements, protect consumers to ensure that they are receiving fair value in benefits for the premiums that they pay.

The purpose of mentioning these issues is to help the public understand that the rate proposals that have been prepared in support of premium rates beginning in 2014 are done with the utmost of care. As actuaries, we do not take lightly the responsibility that is given us and strive to maintain a high level of integrity and professionalism.

Mister Chairman, again I thank you for the opportunity to speak and look forward to answering any questions of the committee.

Mr. MURPHY. Now to Mr. Durham. You are recognized for 5 minutes.

STATEMENT OF DANIEL T. DURHAM

Mr. DURHAM. Good afternoon, Chairman Murphy, Ranking Member DeGette and members of this committee. I am Dan Durham, executive vice president for Policy and Regulatory Affairs at AHIP. I appreciate this opportunity to testify regarding the Affordable Care Act's impact on health insurance premiums.

Our members are focused on implementing all the new changes required by the ACA in 2014 in a manner that will be least disruptive and least costly to consumers and employers, and we have been working closely with Federal regulators and State regulators to identify challenges and offer constructive solutions. Health plans are committed to ensuring implementation as smooth and possible, and are doing their part to be ready to go when open enrollment begins.

Our written testimony focuses on factors that are driving health insurance premiums, including specific provisions in the ACA, and strategies that we support for bringing down health care costs. A broad range of studies, including several commissioned by AHIP, provide insights into the likely impact the ACA will have on premiums beginning in 2014.

An April of 2013 report by Milliman provides a comprehensive overview of ACA provisions that will impact individual market premiums next year. This report explains that covering pre-existing conditions, requiring a broader benefit package, and covering more uninsured Americans who have gone without medical costs, will benefit millions of people while increasing the cost of coverage. It further emphasizes that the new health insurance tax and other fees will also increase premiums.

At the same time, Milliman indicates that other ACA provisions will make coverage more affordable, including premium and cost-sharing subsidies and the transitional re-insurance program, which will help offset the impact of high cost enrollees in the individual market.

Premiums for specific individuals will vary significantly depending on their age, gender, location, health status, income level, and what coverage they have today.

Additional studies estimate the impact on several specific ACA provisions. The new health insurance tax, the age rating restrictions, and the minimum benefit requirements that will directly impact premiums.

The ACA insurance tax begins in 2014 and will exceed $100 billion over 10 years. While the tax is assessed on health plans, it will increase costs for individuals and small businesses, Medicare Advantage beneficiaries, and State Medicaid programs. CBO has stated that this tax will largely be passed through to consumers in the form of higher premiums. An Oliver Wyman analysis estimates that the tax will increase the cost of family coverage in the individual market by $270 in 2014, and by an average of $5,080 over 10 years.

We strongly support bipartisan legislation to repeal this tax introduced by Congressmen Boustany and Matheson.

Regarding the age band compression, beginning in 2014, the ACA will allow health insurance rates to vary based on an enrollee's age by a ratio of no more than three-to-one. This is a dramatic change from the age bands of five-to-one or more currently effective in 42 States. We are deeply concerned that the ACA's restrictive age band will cause premiums to increase dramatically for younger people.

An Oliver Wyman study concludes that young single adults age 21 to 29 with incomes beginning at about 225 percent of the Federal poverty level can expect to see higher premiums than would be the case absent the ACA, even after accounting for the presence of premium assistance. We thank Congressmen Gingrey and Matheson for introducing bipartisan legislation to address this concern.

Beginning in 2014, the ACA will require health plans to offer essential health benefits package covering a broad range of mandated benefits, some of which typically are not included in current individual and small group policies. This will require consumers to buy up coverage beyond what they have today. A variety of studies commissioned by State departments of insurance and State exchange boards have found that the EHB requirements will result in higher premiums.

In conclusion, additional challenges are raised by the underlying cost of medical care. Recognizing the need to reduce costs, our members have been very proactive in advocating solutions to this problem. AHIP's board of directors recently approved a series of strategies to bring down costs and to make coverage more affordable by tackling barriers to transparency, facilitating benefit modernization, and advancing bold structural reforms.

Thank you again for this opportunity to testify.

Mr. MURPHY. Thank you, Mr. Durham.

[The prepared statement of Mr. Durham follows:]

Health Insurance Premiums Under the Affordable Care Act

by

Daniel T. Durham
Executive Vice President, Policy and Regulatory Affairs
America's Health Insurance Plans

for the
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations

May 20, 2013

I. Introduction

Chairman Murphy, Ranking Member DeGette, and members of the subcommittee, I am Dan Durham, Executive Vice President for Policy and Regulatory Affairs at America's Health Insurance Plans (AHIP), which is the national trade association representing health insurance plans. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate this opportunity to testify on the impact the Affordable Care Act (ACA) will have on health insurance premiums in 2014. Our members are strongly committed to competing in the new Exchanges and offering high quality, affordable coverage options under the framework established by the new health reform law. At this stage of the ACA implementation process, many of our members already have submitted applications for qualified health plans (QHPs) they will be offering in the federally-facilitated health insurance Exchanges in 2014. Others have or are preparing to offer coverage in the state-based Exchanges, state partnership Exchanges, and in the outside market. All across the nation, our members are working hard to provide value to individuals and families, employers, and beneficiaries in government programs.

Our members are focused on implementing all of the new changes required by the ACA in 2014 in a manner that will be least disruptive and least costly for consumers and employers, and we have been working closely with federal and state regulators to identify challenges and offer constructive solutions. Health plans are committed to ensuring implementation is as smooth as

possible and are doing their part to be ready to go when open enrollment begins. Companies have dedicated teams working around the clock to implement all of the changes, and we will continue to work constructively with federal and state regulators.

Our testimony today will focus on two broad areas:

- Factors that are driving health insurance premiums, including specific provisions of the ACA and underlying medical costs; and

- Strategies we support for bringing down health care costs and our participation in a diverse stakeholder group that has developed recommendations for decelerating health care costs and improving quality.

II. Factors Driving Health Insurance Premiums

A broad range of studies, including several commissioned by AHIP, provide insights into the likely impact the ACA will have on health insurance premiums beginning in 2014. Additional studies examine the role that underlying medical costs play in increasing the cost of coverage.

Comprehensive Analysis of ACA by Milliman

In late April, AHIP released a report[1] from Milliman that provides a comprehensive overview of ACA provisions that will impact individual market health insurance premiums in 2014. This

[1] Milliman, Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014, April 25, 2013

study highlights how some provisions will increase premiums while others will make coverage more affordable.

The Milliman report explains that covering pre-existing conditions, requiring a broader benefit package, and covering uninsured Americans who have gone without medical care will benefit millions of people while increasing the cost of health care coverage. It further emphasizes that the new health insurance tax and other fees will also increase premiums. At the same time, Milliman indicates that other ACA provisions will make coverage more affordable, including premium and cost-sharing subsidies and the transitional reinsurance program, which provides funds to help offset the impact of high-cost enrollees.

The impact on specific individuals will vary significantly depending on their age, gender, location, health status, income level, and what coverage they have today. The Milliman report found that "young, healthy males could see substantial increases due to the combination of the overall rate change and the age/gender rating requirements" while "older, less healthy individuals could see rate reductions."

Individuals and families with household incomes up to 400 percent of the federal poverty level (FPL), or approximately $94,200 for a family of four or $45,960 for an individual, will be eligible for financial assistance to help lower total out-of-pocket insurance costs. The Milliman report estimates that those eligible for subsidies will receive financial assistance in 2014 to cover, on average, 40 percent of the premium for the "Silver" plan, and as much as 94 percent for those with the lowest incomes. "Bronze" plan premiums after the subsidy could be as low as $0 for certain low-income individuals.

The report also notes that millions of people will not be eligible for subsidies and that the amount of the subsidy declines significantly as incomes rise. The Congressional Budget Office (CBO) estimates that persons with incomes between 250-300 percent of the FPL will receive subsidies sufficient to cover 42 percent of their premium and those with incomes between 350-400 percent of the FPL will receive assistance to coverage 13 percent of the premium.

Milliman explains that new innovative benefit designs developed by health plans will lead to more affordable coverage options than would otherwise be available. These include wellness programs that encourage healthy living, prescription drug formularies that incentivize patients to choose lower-cost generic drugs when they are available, and the availability of "high-value networks" that are limited to providers with a track record of providing the highest quality care at the lowest cost.

The report also highlights the importance of bringing younger and healthier people into the system to help keep coverage as affordable as possible. Milliman states: "When faced with high premiums, younger and healthier individuals may choose to forgo purchasing health insurance until they need it, which will only serve to increase costs for all other individuals in the healthcare system… For the individual insurance market risk pool to remain stable in 2014 and beyond, it is vital that young and healthy individuals enter and remain in the insurance market in addition to individuals with an immediate need for healthcare services."

Focusing on numerous aspects of ACA implementation that will impact premiums, the Milliman report includes the following estimates:

- **Health Insurance Tax:** The ACA's new health insurance tax is estimated to increase premiums in 2014 by about **2 percent** on average.

- **Exchange User Fees:** The user fee that applies to insurers participating in the federally-facilitated Exchanges is estimated to increase premiums by an average of **1.4 percent**. Although the user fee is set at 3.5 percent, the estimate by Milliman is based on insurers selling coverage both inside and outside of the Exchanges.

- **Transitional Reinsurance Assessment:** The fee to support the ACA's transitional reinsurance program is estimated to increase premiums for all consumers by an average of **1 to 2 percent**. However, the subsidy the transitional reinsurance provides in the individual market for high cost claims is estimated to reduce premiums for consumers in the individual market by **6 to 12 percent**.

- **Benefit Buy-Up:** Beginning in 2014, the ACA will require health plans to provide coverage for an essential health benefits (EHB) package covering a broad range of mandated benefits, some of which typically are not included in current individual and small group policies. As noted in the Milliman report, individuals will receive more comprehensive benefits which could reduce out-of-pocket costs, but at a higher pre-subsidy premium level. Milliman estimates that the EHB requirements will increase premiums in the range of **3 to 17 percent**. Additional studies, requested by various state departments of insurance and state Exchange boards, also have found that the EHB requirements will result in higher premiums.

- **Minimum Actuarial Value Requirement:** The ACA requires that coverage sold through the new Exchanges must be at one of four actuarial value levels: 60% (Bronze); 70%

(Silver); 80% (Gold); and 90% (Platinum). Most people will be required to buy coverage with a minimum actuarial value requirement of at least 60 percent (i.e., the "Bronze" plan). Milliman notes that a study[2] recently published in *Health Affairs* estimates that this requirement will increase premiums by an average of **8.5 percent**.

- **Age Rating Restrictions:** Beginning in 2014, the ACA will allow heath insurance rates to vary, based on an enrollee's age, by a ratio of no more than 3 to 1 (3:1). This is a dramatic change from the **"age bands"** of 5 to 1 (5:1) or more that are currently effective in 42 states where state policies recognize that utilization of health care services is correlated with age and that health insurance only works if younger and healthier consumers are part of the risk pool. These states, relying on decades of expertise in setting rules that balance the needs of different age groups, provide protection to older consumers without making coverage unaffordable for younger consumers. We are deeply concerned that the ACA's restrictive age band, by overriding these state policies, will cause premiums to increase dramatically for younger people. Milliman estimates that the new age rating restrictions will increase premiums for people under the age of 35 by **19 to 35 percent**, while reducing premiums for people age 55 and older by **4 to 9 percent**. Similarly, a study conducted by Oliver Wyman found that young, single adults aged 21 to 29 and with incomes beginning at about 225 percent of the federal poverty level, or roughly $25,000, can expect to see higher premiums than would be the case absent the ACA – even after accounting for premium subsidies.[3] As a result, this issue may have implications for the broader population of health care consumers. If higher premiums cause younger and healthier people to delay purchasing coverage until

[2] Gabel, J. et al. (2012). More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014, *Health Affairs* 31 No. 6
[3] Kurt Giesa and Chris Carlson. "Age Band Compression under Health Care Reform." *Contingencies;* Jan/Feb 2013.

after they are sick or injured, the overall pool of people purchasing health insurance will be weighted more heavily with older and less healthy people – thereby driving up premiums for everyone and destabilizing the market. Reps. Phil Gingrey (R-GA) and Jim Matheson (D-UT) have introduced bipartisan legislation, H.R. 544, which addresses this concern by allowing states to set their own age rating rules and by establishing a 5:1 age rating band in states that do not take action.

- **Changes in Risk Pool Composition / Adverse Selection:** Milliman notes that the ACA will result in many people entering the individual health insurance market, including those who previously were uninsured and who were enrolled in state high-risk pool programs or the Federal Preexisting Condition Insurance Plan (PCIP) program. The entrance of these new enrollees into the market will impact premiums because their average health status differs from that of current enrollees in the individual market. Milliman also discusses several additional factors – including the ability of consumers to choose plans based on their expected health needs, and the elimination of underwriting and preexisting condition exclusions – that will lead to adverse selection. Overall, Milliman estimates that changes in the composition of the risk pool and adverse selection will cause premiums to increase by **20 to 45 percent**.

- **Pent-Up Demand:** Milliman estimates that as the uninsured gain health coverage in 2014, there will be a temporary surge in the utilization of health care services by people seeking preventive care or treatment for minor health issues for which they otherwise would not seek medical care. Milliman estimates that this will cause premiums to increase by **up to 5 percent**.

- **Market Competition:** Milliman estimates that market competition in the new Exchanges will reduce premiums by **0 to 5 percent**.

- **Innovation in Benefit Design:** New innovative benefit designs developed by health plans will lead to more affordable coverage options than otherwise would be available. These include wellness programs that encourage healthy living; prescription drug formularies that incentivize patients to choose lower-cost generic drugs; and the availability of high-value networks. Milliman estimates that these innovative strategies could reduce premiums by up to **10 percent**.

- **Premium Assistance Tax Credits:** Milliman estimates that the ACA's premium assistance tax credits will cover, on average, about **40 percent** of the "Silver" plan premium in 2014 in the individual market. As we noted earlier, Milliman estimates that premium subsidies for those eligible would cover about 40 percent of the cost of "Silver" plan coverage – a substantial benefit that will make coverage more affordable. At the same time, according to the Congressional Budget Office, more than 40 percent of individuals purchasing individual market coverage are not eligible for subsidies and the generosity of the subsidies scales back significantly for moderate-income families.

- **Catastrophic Plans:** The ACA allows for the availability of "catastrophic plans" to individuals under the age of 30 and anyone who is exempt from the individual mandate due to lack of affordable coverage options. Catastrophic plans are intended to provide lower premiums and more affordable coverage options – particularly for price-sensitive, younger adults. Milliman estimates that premiums for catastrophic plans will be lower than those available for "Bronze" plans.

The findings of the Milliman report are reinforced by studies conducted by other research organizations, including the American Academy of Actuaries and the Society of Actuaries.

A May 2013 issue brief[4] by the American Academy of Actuaries identifies several factors that will determine premium levels in 2014: the effectiveness of the individual mandate and premium subsidies at attracting low-cost enrollees into the insurance market; new benefit requirements that may lead to higher premiums but lower out-of-pocket costs; decisions by employers about whether to continue offering coverage and the health status of employees whose coverage is dropped; how each state's current market rules compare to the ACA reforms that take effect in 2014; and the demographic characteristics and health status of consumers purchasing coverage through the new Exchanges.

A March 2013 report[5] by the Society of Actuaries concludes that changes driven by the ACA could increase underlying claims costs in the individual market by an average of 32 percent nationally by 2017. This report also predicts wide variation across the states, with as many as 43 states experiencing a double-digit increase in claims costs.

The New ACA Health Insurance Tax

The health insurance tax established by the ACA – which we mentioned above in our review of the Milliman report – is scheduled to begin in 2014 and will exceed $100 billion over the next ten years. The tax is set at $8 billion in 2014, $11.3 billion in 2015 and 2016, $13.9 billion in

[4] American Academy of Actuaries, How Will Premiums Change Under the ACA?, May 2013
[5] Society of Actuaries, Cost of the Future Newly Insured under the ACA, March 2013

2017, and $14.3 billion in 2018. In subsequent years, the tax will increase annually based on premium growth.

The health insurance tax will be imposed broadly on health insurance providers, based on their market share, and will impact the following: (1) businesses and public employers that purchase health insurance on a fully insured basis, including small businesses that provide coverage; (2) all individuals and families who purchase coverage in the individual market or through an Exchange; (3) Medicare beneficiaries who enroll in Medicare Advantage health plans or Medicare Part D prescription drug plans; and (4) state Medicaid programs that contract with managed care organizations.

While the ACA health insurance tax is assessed on health plans, experts agree that it will impact consumers and employers that purchase coverage directly from health insurance plans in the individual and group markets as well as beneficiaries in public programs. The Congressional Budget Office (CBO) has stated that this tax will be "largely passed through to consumers in the form of higher premiums."[6]

The magnitude of the expected premium increase is addressed by a pair of actuarial studies that have been conducted by the Oliver Wyman firm and commissioned by AHIP. The first study[7] examined the impact the premium tax will have – from a nationwide perspective – on individual

[6] CBO letter to Sen. Even Bayh. "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." 30 November 2009.
[7] Carlson, Chris. "Estimated Premium Impacts of Annual Fees Assessed on Health Insurance Plans." Oliver Wyman. October 2011.

market consumers, employers, Medicare Advantage enrollees, and state Medicaid programs. A second study[8] provides state-by-state data on the impact of the tax in all 50 states.

The Oliver Wyman analysis concluded that the health insurance tax alone will increase the cost of family coverage in the individual market by $270 in 2014 and by an average $5,080 over the ten-year period of 2014-2023. The study also estimated that the health insurance tax will increase the cost of family coverage in the small group market by $360 in 2014 and by an average of $6,830 over the same ten-year period. These findings are reinforced by Congress' Joint Committee on Taxation (JCT)[9], which has estimated that repealing the health insurance tax could decrease the average family premium in 2016 by $350 to $400.

The health insurance tax is particularly burdensome not only because of its size, but also because it is not deductible for income tax purposes. This means that health plans must pay the tax and then also pay federal, state, and local taxes on the taxed amount. The Oliver Wyman study notes that because the ACA health insurance tax is not deductible, the potential impact of the tax on premiums will be $1.54 for each $1.00 paid toward the tax by insurers.

Focusing specifically on the Medicare Advantage (MA) program, the Oliver Wyman study found that the health insurance tax will increase costs for MA enrollees by $16 to $20 per month in 2014 and by $32 to $42 per month by 2023. The average expected increase in the cost of MA coverage over ten years is $3,590. This number represents a direct reduction in the resources that will be available to support the health care benefits of 14 million seniors and persons with disabilities who value the improved quality of care, additional benefits, and innovative services

[8] Carlson, Chris. "Annual Tax on Insurers Allocated by State." Oliver Wyman. November 2012.
[9] See JCT Letter to Senator Jon Kyl. 12 May 2011.

their MA plans provide. Additional costs will be imposed on Medicare Part D plans, for which the health insurance tax will increase premiums by an estimated $9 in 2014 and $20 in 2023 for a total increase of $161 over 10 years.

We also are deeply concerned by estimates in the Oliver Wyman study that the health insurance tax will put greater pressure on state Medicaid budgets by increasing the average cost of Medicaid coverage by an estimated $1,530 per enrollee between 2014-2023. In several states (see chart on next page), the impact on the cost of Medicaid coverage will exceed $2,200 per enrollee over ten years. Taking such a significant level of resources away from Medicaid at a time when many states are implementing major expansions in Medicaid eligibility is a shortsighted move that may compromise access to health care services for millions of vulnerable people.

Oliver Wyman's state-by-state findings provide additional information showing which states will be most severely impacted by the ACA health insurance tax. The charts below highlight the top 20 states with the highest per-person cost impact in each market segment. These charts show, for example, that families purchasing coverage in the individual market will be hit the hardest in New York while those getting coverage from a small employer will be most impacted in West Virginia. With respect to public programs, Medicare Advantage enrollees in New Jersey and the Medicaid managed care program in Washington, DC will be hardest hit by the new tax.

Individual Market

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Family Coverage Purchased in the Individual Market (2014 - 2023)

#	State	Ten-Year Impact (per family)
1	New York	$9,942
2	Massachusetts	$9,937
3	Rhode Island	$8,308
4	Connecticut	$6,339
5	New Hampshire	$5,736
6	Georgia	$5,539
7	Maine	$5,429
8	Minnesota	$5,245
9	District of Columbia	$5,187
10	Delaware	$5,007
11	Wisconsin	$4,961
12	California	$4,909
13	Florida	$4,881
14	Alaska	$4,855
15	West Virginia	$4,844
16	Washington	$4,843
17	Texas	$4,833
18	New Mexico	$4,805
19	New Jersey	$4,796
20	Pennsylvania	$4,772
20	Virginia	$4,772

Small Employers

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Family Coverage Offered Through Small Employers (2014 - 2023)

#	State	Ten-Year Impact (per family)
1	West Virginia	$9,221
2	New York	$9,046
3	New Hampshire	$8,555
4	Nebraska	$7,995
5	Massachusetts	$7,895
6	District of Columbia	$7,613
7	Connecticut	$7,454
8	Rhode Island	$7,414
9	Delaware	$7,345
10	Illinois	$7,293
11	Florida	$7,136
12	Alaska	$7,124
13	New Mexico	$7,051
14	New Jersey	$7,038
15	Colorado	$7,005
16	Maryland	$6,985
17	Texas	$6,971
18	Wyoming	$6,960
19	Wisconsin	$6,932
20	California	$6,916

Medicare Advantage

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Medicare Advantage Beneficiaries (2014 - 2023)

#	State	Ten-Year Impact (per person)
1	New Jersey	$4,182
2	Florida	$4,181
3	Louisiana	$4,111
4	New York	$4,074
5	Texas	$4,033
6	Maryland	$4,022
7	Massachusetts	$3,962
8	District of Columbia	$3,919
9	Connecticut	$3,895
10	California	$3,847
11	Michigan	$3,838
12	Mississippi	$3,746
13	Illinois	$3,728
14	Pennsylvania	$3,708
15	Delaware	$3,660
16	Ohio	$3,618
17	Rhode Island	$3,555
18	Tennessee	$3,523
19	Oklahoma	$3,513
20	Indiana	$3,458

Medicaid Managed Care

Top 20 States with Highest Average Aggregate Impact of Health Insurance Tax on Medicaid Managed Care Programs (2014 - 2023)

#	State	Ten-Year Impact (per person)
1	District of Columbia	$2,518
2	New York	$2,466
3	Rhode Island	$2,360
4	New Jersey	$2,276
5	Minnesota	$2,257
6	Massachusetts	$2,219
7	North Dakota	$2,093
8	Pennsylvania	$2,038
9	Maryland	$2,026
10	New Hampshire	$1,921
11	Missouri	$1,790
12	Wisconsin	$1,789
13	Wyoming	$1,763
14	Kansas	$1,748
15	Oregon	$1,727
16	Ohio	$1,685
17	Nebraska	$1,671
18	Delaware	$1,637
19	Kentucky	$1,622
20	New Mexico	$1,615
20	Virginia	$1,615

To avoid the increased costs that would result from the ACA health insurance tax, we strongly support legislation, H.R. 763, which would repeal the tax. This bipartisan bill, the "Jobs and Premium Protection Act," was introduced in February 2013 by Reps. Charles Boustany (R-LA) and Jim Matheson (D-UT). To date, 182 House members have cosponsored this bill, including 27 members of the House Energy and Commerce Committee.

Underlying Medical Costs

Additional challenges are raised by the underlying costs of medical care, which are driving up the cost of coverage, taking up a greater share of federal and state budgets, and threatening the long-term solvency of our nation's public safety net programs.

A September 2012 study[10] by the Health Care Cost Institute found that "higher prices were the primary driver of per capita health spending in 2011." This study found that unit prices increased by 9.7 percent for outpatient surgery, 9.1 percent for emergency room visits, 7.4 percent for mental health and substance abuse admissions, 6.5 percent for surgical admissions, and 6 percent for deliveries and newborns.

Another study[11], published by the *American Journal of Managed Care,* provides new data on trends in hospital prices across the country. This study, conducted by researchers at AHIP, found that from 2008 to 2010 inpatient hospital prices increased 8.2 percent annually, while also highlighting common medical procedures that experienced the highest growth in prices during the period studied. Overall, the price for a spinal fusion increased the most (15.2 percent annually) between 2008 to 2010. The next highest price increases were for bronchitis and

[10] Health Care Cost Institute, Health Care Cost and Utilization Report: 2011, September 2012
[11] AJMC.com, Trends in Inpatient Hospital Prices, 2008 to 2010, March 6, 2013

asthma treatment (10.3 percent annually) and uterine laparoscopic procedure for non-malignancy (9.8 percent annually).

Our study also found wide variation in hospital prices across states and localities. Among the states examined by this study, New York experienced the largest increase in hospital prices from 2008 to 2010 (10.5 percent annual growth). Texas (9.3 percent annual growth) and Tennessee (8.8 percent annual growth) also saw higher-than-average increases in hospital prices. Hospital prices also varied significantly among metropolitan areas within a state.

Another AHIP study[12] highlights the exorbitant fees that some out-of-network physicians are charging for services. This study found that some physicians who choose not to participate in health insurance networks are charging patients fees that are 10 times – and in some cases, close to 100 times – Medicare reimbursement for the same service in the same geographic area. The following are just a few examples of the unreasonable charges consumers sometimes face when receiving care from out-of-network providers:

- $19,000 for a colonoscopy and biopsy – 33 times more than Medicare pays;
- $29,998 for an upper GI endoscopy biopsy – 73 times more than Medicare pays; and
- $12,000 for a tissue exam by a pathologist – 93 times more than Medicare pays.

In addition to showing how much patients who seek out-of-network care are being charged by some physicians, these findings also illustrate the value of the physician networks that are

[12] AHIP, Survey of Charges Billed by Out-of-Network Providers: A Hidden Threat to Affordability, January 2013

established by health plans to ensure that patients have affordable access to a wide choice of high quality health care providers, and that consumers receive savings when they visit contracted providers who have agreed to lower rates.

Similar concerns are raised by data[13] on hospital prices recently released by the Centers for Medicare & Medicaid Services (CMS). These data show significant variation across the nation and within communities in the amount hospitals charge for common inpatient services. For example, among all hospitals nationwide, CMS reported that the average hospital inpatient charges for services provided in connection with a joint replacement range from a low of $5,300 to a high of $223,000. Additionally, the CMS data show that average hospital inpatient charges for services provided in connection with treating heart failure range from a low of $21,000 to a high of $46,000 in Denver, Colorado and from a low of $9,000 to a high of $51,000 in Jackson, Mississippi.

Provider consolidation is a significant factor contributing to growth in underlying medical costs. A recent study[14] from the Robert Wood Johnson Foundation reports that hospital consolidation generally results in higher prices, stating: "When hospitals merge in already concentrated markets, the price increase can be dramatic, often exceeding 20 percent." The study further cautions that "physician-hospital consolidation has not led to either improved quality or reduced costs" and, additionally, points out that consolidation "is often motivated by a desire to enhance bargaining power by reducing competition."

[13] CMS Press Release, Administration Offers Consumers An Unprecedented Look At Hospital Charges, May 8, 2013
[14] Robert Wood Johnson Foundation, The impact of hospital consolidation – Update, June 2012

In an effort to help inform the public about the impact of rising medical costs, AHIP has developed a new iPad app[15] that consolidates fifty years of federal health care spending data into a series of easy-to-use, interactive charts. Users of this app can view historical and projected health care spending data at the national level, state-by-state, on a per capita basis, or as a percent of GDP. The app also provides a detailed breakdown of how much the nation is spending on different aspects of the health care system, such as hospital care, physician services, prescription drugs, and health plan administrative costs, and how each of these components contributes to health care cost growth.

III. Bringing Down Health Care Costs

Our members are very pro-active in advocating solutions to rein in the costs of health care. AHIP's Board of Directors recently approved a statement recommending a series of strategies to bring down costs and make health care coverage more affordable. These strategies complement the innovative delivery system and payment reform initiatives health plans are spearheading all across the country.

Our Board has recommended three strategies for reducing health care costs:

1. **Tackling Barriers to Transparency:** We call for the elimination of barriers that prevent stakeholders from understanding how markets are (or are not) working. Increased transparency – with a concurrent focus on quality – will give consumers and purchasers a

[15] http://ahip.org/Issues/US-HC-Spending101-App.aspx

clearer perspective on the drivers that are contributing to higher health care costs in their community, as well as an understanding of how dynamics such as provider consolidation affect the costs they pay.

2. **Facilitating Benefit Modernization:** Recognizing that a range of legal, regulatory, or operational barriers often prevent health plan innovations from being adopted in local communities, we believe that cost containment strategies must modernize these "rules of the road" to ensure that innovative plan designs – aimed at decreasing costs while ensuring safe, high quality care – can thrive. This includes re-evaluating scope of practice requirements, accelerating the use of health information technology, promoting preventive care and wellness programs, promoting laws or regulations that support innovative delivery structures, and eliminating excessive network requirements that prevent plans from forming lower cost, high quality networks.

3. **Advancing Bold, Structural Reforms:** Strategies to address rising health care costs need to include fundamental, structural changes in the health care system. Further, action needs to be grounded where health care is delivered today – at the state and local levels. A state-federal shared savings, or "gain-sharing," initiative could be implemented that would allow states to keep a portion of any health care cost savings they generate. This would direct hundreds of billions in needed incentives to cash-strapped states, while at the same time bending the total cost curve and having a productive impact on the economy as a whole, as well as family, corporate, and government budgets.

Building upon the strategies in our Board statement, we have proposed a policy agenda, recently published[16] by the *American Journal of Managed Care* (AJMC), outlining policies that would support and encourage delivery system reform. This agenda includes proposals in the following areas: providing greater transparency on what providers are charging for services; aligning public and private quality measures; promoting administrative simplification and meaningful data exchange; investing in research on what works; promoting scope of practice laws to allow doctors and other clinicians to practice to the "top of their license"; and encouraging states to play a greater role in expanding private-public efforts to bring costs under control.

On another front, AHIP recently joined a diverse stakeholder group, the Partnership for Sustainable Health Care, in releasing a report[17] that outlines recommendations for decelerating health care costs and improving quality. This partnership includes organizations that play a prominent role in the hospital, physician, business, and consumer sectors. We were supported in our work by a grant from the Robert Wood Johnson Foundation.

Our report proposes a set of integrated, system-wide approaches involving both the public and private sectors that will significantly curb the growth in health care spending and enhance the delivery of care. Specifically, we outline a seven-part vision for a transformed health care system: (1) health care that is affordable and financially sustainable for consumers, purchasers, and taxpayers; (2) patients who are informed, empowered, and engaged in their care; (3) patient care that is evidence-based and safe; (4) a delivery system that is accountable for health outcomes and resource use; (5) an environment that fosters a culture of continuous improvement and learning; (6) innovations that are evaluated for effectiveness before being widely and rapidly

[16] AJMC.com, Health Plan Innovations in Delivery System Reforms, April 16, 2013
[17] Partnership for Sustainable Health Care, Strengthening Affordability and Quality in America's Health Care System, April 2013

adopted; and (7) reliable information that can be used to monitor quality, cost, and population health.

The Partnership for Sustainable Health Care report includes recommendations in five key areas:

- **Transforming the current payment paradigm.** We encourage the accelerated adoption of payment approaches that demonstrate their effectiveness in improving both quality and cost. These value-based payment approaches include a range of models that include incentives for patient safety, bundled payments, accountable care organizations, and global payments.

- **Paying for care that is proven to work.** We recommend that public programs and the private sector reduce payments for services that prove to be less effective or of lesser value than alternative therapies.

- **Incentives for greater consumer engagement in care.** We encourage the use of high-value services and providers through tiered cost-sharing and related financial incentives. The goal of such tiered cost-sharing is to create financial incentives for consumers to make better use of their discretionary care choices, leading to savings from improved adherence to preventive measures and evidence-based care, lower utilization of unnecessary services, and the use of more efficient, higher-quality providers.

- **Improving health care infrastructure.** We call for reforms aimed at strengthening the foundational infrastructure of America's health care system so that cost- and quality-related innovations can be implemented more effectively. Specific initiatives include:

- Accelerating research on treatment effectiveness to give patients and providers more information on which to base health care decisions;
- Speeding the adoption and the use of electronic health records and health information exchanges to improve care for patients;
- Ensuring that there is an adequate and diverse health care workforce;
- Reducing and resolving medical malpractice disputes;
- Promoting greater transparency in health care costs; and
- Encouraging competitive markets.

- **Incentives for states to partner with public and private stakeholders to transform the health care system.** We propose a gain-sharing system that would enable states to receive fiscal rewards for successfully meeting cost- and quality-related goals. States would have flexibility to use different combinations of strategies that fit their specific cultures and political environments, ranging from working with private and public payers to collaboratively implement major payment reforms, to modifying scope of practice restrictions, to providing incentives for improvements in care coordination to promote quality and patient safety.

IV. Conclusion

Thank you again for considering our perspectives on these important issues. Our members remain strongly committed to working with Congress, the Administration, and other stakeholders to expand access to high quality, affordable coverage options.

Mr. MURPHY. Mr. Spiro, you are recognized for 5 minutes for your opening statement.

STATEMENT OF TOPHER SPIRO

Mr. SPIRO. Mr. Chairman, Ranking Member DeGette, thank you for the opportunity to testify today about the premium impact of the Affordable Care Act.

When thinking about this issue, it is important to be clear about who will be affected by reforms and how. Nearly 90 percent of insured Americans are covered by employer plans, Medicare, Medicaid or other government programs. These Americans will not be affected by reforms to non-employer coverage under the ACA.

Now consider the remaining 10 percent of the population. Concern is focused on the premium impact for young adults with higher incomes who will not be eligible for full subsidies, but the fraction of the population that now has non-employer coverage is between the ages of 19 and 29 and has income above 250 percent of the Federal poverty level is 0.5 percent.

By contrast, the Affordable Care Act will benefit tens of millions of Americans, who have been offered Swiss cheese insurance, who were priced out of the market or who were denied insurance all together. All Americans will benefit from the security and peace of mind of knowing that if misfortune strikes, they will not suffer financial catastrophe.

Studies on this topic always omit key factors that greatly influence the costs people would pay out of pocket. While some of the studies take into account some of the factors, none of them take into account all, or even most of the following factors.

First, of course, most important, premium tax credits. According to the Urban Institute, 70 percent of young adults who now have non-employer coverage will be eligible for Medicaid or exchange subsidies; the availability of parents' coverage for young adults up to age 26; the availability of catastrophic plans for young adults up to age 30; insurance for insurers that incur high costs, known as re-insurance. For example, in California, re-insurance is projected to lower premiums by 9 percent. Administrative savings. For example, in California, administrative savings are projected to lower premiums by 4.5 percent. Finally, the medical cost trend that would occur anyway in the absence of the Affordable Care Act. For example, in California, the projected premium increase in the absence of the ACA is 9 percent.

Because these studies are not reliable, it is instructive to compare some of them with actual rate filings and analyses by independent experts. A recent report by the Lewin Group and Optum projects that the pool of insured people will become less healthy overall, increasing average costs by 32 percent, but the independent Congressional Budget Office came to a different conclusion on this point, finding that the influx of new enrollees will actually lower premiums by 7 to 10 percent on average. This huge discrepancy seems to be driven by the Lewin report's assumption that there will be an influx of unhealthy people from large employers.

To illustrate how the Lewin report is speculative and incomplete, consider actual rate filings in Washington. The Lewin report pro-

jected an average cost increase of 14 percent, but we now know that many Washingtonians will actually see lower premium rates. The average proposed premium increase is 7 percent, less than the projected medical cost trend that would occur anyway in many States.

The experience in Washington is noteworthy, because just last year the executive vice-president of the Blue Cross insurer warned that premiums would increase by 50 to 70 percent. In other words, the hysteria did not match up with the reality.

One recent development that is encouraging is that competition is already lowering premiums, because consumers can more easily shop for and compare plans. In Oregon, when premium proposals were posted publicly online, two insurers immediately lowered their proposed rates by 15 percent and more to remain competitive. Clearly these insurers had been inflating their projected costs. One insurer said its actuarial projections had been too pessimistic.

Finally, it is important not to lose sight of the benefits of insurance market protections and improved coverage. Exchanges will offer brand-new, modernized products. Comparing their prices to the prices of old, Swiss cheese insurance products is like comparing the price of an iPhone to the price of a Sony Walkman. It is not a meaningful comparison.

Nor should we focus exclusively on premiums, which are not consumers' only costs. While providing more coverage increases premiums, it lowers out-of-pocket costs. A narrow focus on premiums also ignores the millions of Americans who have been shut out of a dysfunctional market.

Furthermore, premiums reflect a snapshot in time. Just because you are young and healthy now does not mean you will always be.

In the current dysfunctional market, premiums can spike for both individuals and small businesses——

Mr. MURPHY. The gentleman's time has expired. Can you just summarize the rest of your——

Mr. SPIRO. I am almost done.

Mr. MURPHY. OK.

Mr. SPIRO [continuing]. As a result of many factors that are totally beyond their control. In the modernized market when people get sick or are diagnosed with a medical condition or just grow older, they will not experience rate shock.

Mr. Chairman, this concludes my testimony. I am happy to answer questions.

[The prepared statement of Mr. Spiro follows:]

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY & COMMERCE
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS

"HEALTH INSURANCE PREMIUMS UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT"
MAY 20, 2013

STATEMENT OF
CHRISTOPHER J. SPIRO, J.D.
VICE PRESIDENT FOR HEALTH POLICY
THE CENTER FOR AMERICAN PROGRESS

Mr. Chairman, Ranking Member, and members of the Committee—thank you for the opportunity to testify today about the premium impact of the Affordable Care Act. My testimony will make five key points:

1.) Concern has focused on the premium impact for young adults. But young adults who now have non-employer coverage and higher incomes are a small fraction of the population.

2.) Recent studies by health insurance companies and actuaries affiliated with the insurance industry lack transparency, are self-serving, and omit key factors.

3.) These studies do not measure up when compared with actual rate filings and analyses by independent experts.

4.) Emerging evidence indicates that the Exchanges are working as intended—competition among plans and providers is already lowering premiums.

5.) Premiums should not be the exclusive focus of investigation. In the new, modernized market, consumers will get a lot more for their money.

Young adults who now have non-employer coverage and higher incomes are a small fraction of the population

First, it is important to be clear about who will be affected by reforms and how. Among Americans with health insurance coverage, nearly 90 percent are covered by employer plans,

Medicare, Medicaid, or other government programs.[1] These Americans will not be affected by reforms to non-employer coverage under the Affordable Care Act.

Now consider the remaining 10 percent of the population. Concern has focused on the premium impact for young adults with higher incomes, who will not be eligible for full subsidies. But the fraction of the population that now has non-employer coverage, is between the ages of 19 to 29, and has income above 250 percent of the federal poverty level is **0.5 percent.**[2]

That fraction is even smaller after excluding women, who will see premium savings from the elimination of gender rating. And the fraction is smaller still after excluding young adults who will be eligible for their parents' coverage: Among young adults who will not be eligible for subsidies, **two-thirds** will be eligible for their parents' coverage.[3] Finally, the fraction is even smaller after excluding young adults who now have non-employer coverage that is "grandfathered"—in other words, that is exempt from reforms. For example, in Maryland, 60 percent of CareFirst's enrollees in non-employer coverage are grandfathered.[4]

By contrast, the Affordable Care Act will benefit millions of Americans who have been offered Swiss cheese insurance, who were priced out of the market, or who were denied insurance altogether. Tens of millions of Americans will gain health insurance coverage. All Americans

[1] Author's calculation based on data from the U.S. Census Bureau.
[2] Maura Calsyn and Lindsay Rosenthal, "How the Affordable Care Act Helps Young Adults," The Center for American Progress, May 2013.
[3] Linda J. Blumberg and Matthew Buettgens, "Why the ACA's Limits on Age Rating Will Not Cause 'Rate Shock': Distributional Implications of Limited Age Bands in Nongroup Health Insurance," The Urban Institute, March 2013.
[4] Jay Hancock, "Maryland Offers Glimpse at Obamacare Insurance Math," Kaiser Health News, April 24, 2013.

will at long last benefit from the security and peace of mind of knowing that, if misfortune strikes, they will not suffer financial catastrophe.

Studies lack transparency, are self-serving, and omit key factors

Second, these types of studies are not new, but they have always suffered from a lack of transparency. Health insurance companies are happy to disclose their conclusions, but refuse to disclose their assumptions and underlying data. It is unclear why members of Congress would want to take insurance companies at their word, or rely exclusively on actuaries who are affiliated with the insurance industry. It should go without saying that insurance companies have every incentive to pad their premium proposals.

These studies always omit key factors that greatly influence the costs people would pay out of pocket. In fact, one of the insurer submissions to this Committee acknowledged these omissions: "The analyses are not a comprehensive summary of all PPACA-related premium impacts."[5] While some of the studies take into account some of these factors, none of them take into account all (or even most) of the following factors:

- Premium tax credits. For example, in California, people who make less than 400 percent of the federal poverty level will get tax credits that reduce their average premium costs by

[5] U.S. House of Representatives Committee on Energy and Commerce Majority Staff, "The Looming Premium Rate Shock," May 13, 2013.

more than 65 percent.[6] According to the Urban Institute, 70 percent of young adults who now have non-employer coverage will be eligible for Medicaid or Exchange subsidies.[7]

- The availability of parents' coverage for young adults up to age 26.
- The availability of catastrophic plans for young adults up to age 30. Because premiums for these plans can reflect the expected costs of younger enrollees, they will be lower than premiums for Bronze plans.
- Insurance for insurers that incur high costs, known as "reinsurance." For example, in California, reinsurance is projected to lower premiums by 9 percent.[8]
- Administrative savings. The independent Congressional Budget Office projected that administrative savings will lower premiums for non-employer coverage by 7 to 10 percent.[9] Some administrative tasks currently performed by insurers can be performed by Exchanges, taking advantage of economies of scale. Some tasks, like medical underwriting, can be eliminated. In California, administrative savings are projected to lower premiums by 4.5 percent.[10]
- The medical cost trend that would occur anyway. For example, in California, the projected premium increase in the absence of the Affordable Care Act is 9 percent.[11]
- The extent to which individuals are enrolled in "grandfathered" plans that are exempt from reforms.
- Savings from competition among plans and providers, as explained more fully below.

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[6] Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.
[7] Linda J. Blumberg and Matthew Buettgens, "Why the ACA's Limits on Age Rating Will Not Cause 'Rate Shock': Distributional Implications of Limited Age Bands in Nongroup Health Insurance," The Urban Institute, March 2013.
[8] Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.
[9] The Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.
[10] Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.
[11] Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

Studies do not measure up when compared with actual rate filings and independent analyses

Because these studies are not reliable, it is instructive to compare some of them with actual rate filings and analyses by independent experts.

A recent report by the Lewin Group and Optum projects a 32 percent average cost increase for non-employer coverage nationwide.[12] Under this analysis, because the Affordable Care Act guarantees all sick people access to insurance, the pool of insured people could become less healthy overall, increasing expected costs.

But the independent Congressional Budget Office came to a different conclusion on this point, finding that the influx of new enrollees will actually *lower* premiums by 7 to 10 percent, on average.[13] This huge difference seems to be driven by the Lewin/Optum report's assumption that there will be an influx of unhealthy people from large employers. Note that the CBO did not see fit to change its analysis in its most recent estimates.

To illustrate how the Lewin/Optum report is speculative and incomplete, consider actual rate filings in Washington. The Lewin/Optum report projected an average cost increase of 14 percent.[14] But we now know that many Washingtonians will actually see lower rates. For example, a 21-year old could buy a similar Blue Cross plan—except with a lower deductible—

[12] Randy Haught and John Ahrens, "Cost of the Future Newly Insured under the Affordable Care Act," March 2013.
[13] The Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.
[14] Randy Haught and John Ahrens, "Cost of the Future Newly Insured under the Affordable Care Act," March 2013.

for 15 percent less next year.[15] The average proposed premium increase is 7 percent—less than the projected medical cost trend that would occur anyway in many states.[16]

The experience in Washington is noteworthy because just last year, the executive vice president of the Blue Cross insurer warned that premiums would increase by 50 to 70 percent.[17] The hysteria did not match up with the reality.

Finally, consider California. According to the majority staff report, one insurer projected a premium increase of 23 to 66 percent.[18] But an independent analysis projected that the Affordable Care Act will *lower* total health care costs by more than 40 percent, on average, for most people who now have non-employer coverage.[19]

Competition among plans and providers is already lowering premiums

When the independent Congressional Budget Office projected premiums under the Affordable Care Act, it theorized that competition in Exchanges would lower premiums.[20] Consumers would be able to more easily shop for and compare plans. Now that theory is becoming reality.

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[15] Mike Baker, "Some may see lower rates under Obama health law," The Associated Press, May 14, 2013.
[16] Washington State Office of the Insurance Commissioner.
[17] Mike Baker, "Some may see lower rates under Obama health law," The Associated Press, May 14, 2013.
[18] U.S. House of Representatives Committee on Energy and Commerce Majority Staff, "The Looming Premium Rate Shock," May 13, 2013.
[19] Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.
[20] "The exchanges would enhance competition among insurers in the nongroup market by providing a centralized marketplace in which consumers could compare the premiums of relatively standardized insurance products. The additional competition would slightly reduce average premiums in the exchanges by encouraging consumers to enroll in lower-cost plans and by encouraging plans to keep their premiums low in order to attract enrollees." The Congressional Budget Office, Letter to the Honorable Evan Bayh, November 30, 2009.

In Oregon, when premium proposals were posted publicly online, two insurers immediately lowered their proposed rates to remain competitive.[21] One insurer lowered its proposed rate by 15 percent and another lowered its proposed rate by even more. Clearly, these insurers had been inflating their projected costs; one insurer said its actuarial projections had been too pessimistic.

Competition is also lowering the prices that hospitals charge. Some insurers are demanding and receiving price discounts of 10 percent or more from hospitals in exchange for a larger volume of new patients.[22] In California, provider price discounts are projected to lower premiums by 6 percent.[23] The potential premium savings from provider price discounts are particularly significant in Exchanges that will offer Medicaid managed care plans.

Consumers will get a lot more for their money

When comparing premiums before and after the Affordable Care Act, it is important not to lose sight of the benefits of insurance market protections and improved coverage. The law's market protections guarantee access to insurance to people who are ill or who have pre-existing conditions, and they prohibit insurers from charging them higher rates. They also limit how much more insurers can charge older people versus younger people. Other reforms require coverage of prescription drugs, mental health care, maternity care, and other essential benefits.

[21] Nick Budnick, "Two Oregon insurers rethink 2014 premiums as state posts first-ever rate comparison," The Oregonian, May 9, 2013.
[22] Anna Wilde Mathews and Jon Kamp, "Another Big Step in Reshaping Health Care," The Wall Street Journal, February 28, 2013; Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.
[23] Milliman, "Factors Affecting Individual Premium Rates in 2014 for California," March 28, 2013.

Exchanges will therefore offer brand new, modernized products. Comparing their prices to the prices of old Swiss cheese insurance products is like comparing the price of an iPhone to the price of a Sony Walkman. It is not a meaningful comparison.

Nor should we focus exclusively on premiums. Premiums are not consumers' only costs; they also pay deductibles, co-insurance, and co-payments. While providing more coverage increases premiums, it lowers out-of-pocket costs. A narrow focus on premiums also ignores the millions of Americans who have been shut out of a dysfunctional market.

Furthermore, premiums reflect a snapshot in time. Just because you are young and healthy now does not mean you will always be. In the current dysfunctional market, premiums can spike uncontrollably for both individuals and small businesses, as a result of many factors that are totally beyond their control. In the modernized market, when people get sick or are diagnosed with a medical condition, or just grow older, their premiums will remain stable.

Finally, it is important to keep in mind the reforms that are at issue here, and their purpose. Repealing these reforms would increase premiums for women, older people, sick people, and people with pre-existing conditions. These premium impacts must be part of the discussion.

Mr. Chairman, this concludes my testimony, and I am happy to answer any questions members of the Committee may have.

Mr. MURPHY. I appreciate all of—the testimony from all of the witnesses today. We will go on to some questions here, and I will start off with 5 minutes for myself here. Although I am reminded sometimes, like when we have economists in front of us, they all talk about you don't see a one-handed economist because they always say, "On the other hand." So this will be important to get some information from you all.

Mr. Carlson, today Mr. Waxman released a staff memo we had put in the record saying that the customers in Rhode Island, Vermont, Maryland, Oregon and Washington can expect large rate decreases. In your testimony, however, you note that you reviewed the actual rate filings in some of these States, Oregon, Maryland and Vermont. Am I correct?

Mr. CARLSON. Yes, that's correct.

Mr. MURPHY. And your testimony States an average premium rate in these files represents an increase of 36 to 53 percent over current premium rates. Can you elaborate on this?

Mr. CARLSON. Well, that information was from the—several—I believe that was the Oregon rate filings that I was mentioning there. And based on all the factors that they have in their filing, including trend rates, all of the assumptions due to the changes in the market, market rules, all those factors combined resulted in rates for a similar benefit package of 36 to 53 percent increases. So having not——

Mr. MURPHY. That's for Oregon? That's for Oregon, you are saying?

Mr. CARLSON. I believe that was Oregon, yes.

Mr. MURPHY. OK.

Mr. CARLSON. Having not seen the report that was put out today, I can't comment how those numbers relate.

Mr. MURPHY. I see. But I just want to make sure I understand. In Oregon, you said there's probably going to be a premium increase?

Mr. CARLSON. Yes. That's correct.

Mr. MURPHY. Right. Now, in Maryland you note that one insurance proposed an overall rate increase of 25 percent. Am I correct?

Mr. CARLSON. That's correct, yes.

Mr. MURPHY. And another insurance proposed rates that are 120 percent higher than the current rates in the market?

Mr. CARLSON. Yes.

Mr. MURPHY. Correct, too? Can you elaborate on these findings? Basically you said Maryland's going to see a premium increase, but can you elaborate on——

Mr. CARLSON. Well, I think the important point to take from there is that the rate increases are going to differ substantially based on what State you are in, what kind of market you are in, the level of benefits that you currently have, and, you know, other factors as far as, you know, the insurer that is showing a very high rate increase, they may have been able to enroll a much healthier population in the past, therefore, when they get a normal mix of membership, they end up with a much higher rate increase than if they had started with an average population.

So, no individual is going to get the same rate increase. It's going to differ greatly from one individual to the next.

Mr. MURPHY. I see. All right. Mr. Durham, last week the committee released its findings on the investigation we conducted in the internal analysis of how premiums will be impacted by the Affordable Care Act, and after reviewing the internal analysis of the nation's largest insurers, we saw that massive premium increases are likely. Can you provide your view on the likelihood of this?

Mr. DURHAM. Well, I read the report from the committee and looked at the great degree of variability in premiums depending on the individual's age, their location, their health status, and it's similar to what we find in our Milliman report that I described in my testimony. Again, a great degree of variability here in terms of how plans are building their premiums in 2014. There are certain things that are sure to include increases in premium costs, and those include the health insurance premium tax, other fees and assessments, the benefit buy-up, since many, particularly in the individual market, have coverage that is less generous than coverage that's required under the ACA, and also the age band compression, where younger individuals are likely to face much higher——

Mr. MURPHY. So it's safe to say in States that already have a number of these restrictions, they—they will not see a lot of movement, in the States that do not have those, they will see a lot of upward movement——

Mr. DURHAM. That's correct.

Mr. MURPHY [continuing]. In general? Thank you.

Mr. DURHAM. And on the other side of the coin, the Milliman report also goes into detail about the premium tax subsidies that will help lower income individuals, which—which are very important, and also other things that will lower premium costs, such as competition in the marketplace that was mentioned earlier.

Mr. MURPHY. Sure. Competition helped lower things in the Medicare Part D plan, which is often bashed, which—by 41 percent below, I think it is.

But let me ask this real quickly, Ms. Uccello and Mr. Durham, because you both stated in your testimony—you talked about the individual mandate effect on this, Ms. Uccello, and Mr. Durham, you made a reference to people between 21 and 29.

Are a lot of these estimates based upon the assumption that all those people will sign up or do they also take into account if people see rates go very high for themselves, regardless of subsidies, they may not show up, may not sign up, and then that will affect rates as well?

Ms. Uccello, can you comment on that?

Ms. UCCELLO. I can't comment directly on the different projections, but I assume that each of those projections makes assumptions regarding participation in the market. And as you were alluding to, key to the viability of this program is attracting the lower cost people into the pool to help offset the higher costs of the—of those other people.

Mr. MURPHY. Thank you. I am out of time, but if I could ask, Ms. Uccello, if you could provide a little more information to this committee on what means, and Mr. Durham, elaborate on those two points, that's very important to us, in terms of the assumptions with regard to people signing up by the mandate.

I now recognize—I am out of time—Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Ms. Uccello, just like Mr. Carlson, you are also an actuary. Is that correct?

Ms. UCCELLO. That is correct.

Ms. DEGETTE. And you—you testify—it sounds to me like the gist of your testimony is we are going to have sort of a rebalancing of rates, because in the exchanges at least and in these plans, we are going to be covering everybody. Is that right?

Ms. UCCELLO. Yes.

Ms. DEGETTE. So right now what happens is if an individual with a pre-existing condition, or a woman, or somebody who's older, people like that, if they choose to get insurance, their insurance will be more expensive, because the pool is smaller. Is that right? So cheaper people aren't in those pools right now. I think you said that, too, Mr. Durham, as a matter of fact.

Mr. DURHAM. I think the concern is——

Ms. DEGETTE. For some people, for some people, insurance is much more expensive now because health care costs more for them, right?

Ms. UCCELLO. There are some people—depending on what State and the rules that apply in that State, some people with pre-existing conditions may not have access to coverage at all——

Ms. DEGETTE. Right. But what I am saying is——

Ms. UCCELLO [continuing]. They may be paying more.

Ms. DEGETTE. What I am saying is so when you put everybody into the pool, some people will pay higher insurance rates, some people—like young people.

Ms. UCCELLO. Yes.

Ms. DEGETTE [continuing]. And some people will pay lower insurance rates. Is that right?

Ms. UCCELLO. Yes.

Ms. DEGETTE. And that's because the pool is bigger, right?

Ms. UCCELLO. It's more about the distribution of who's in the——

Ms. DEGETTE. OK. Right. And so there are going to be a lot of people who are paying lower insurance rates under the Affordable Care Act, correct?

Ms. UCCELLO. Depending on the certain—the particular circumstance, premiums go down for some people——

Ms. DEGETTE. For some people.

Ms. UCCELLO [continuing]. And for others go up.

Ms. DEGETTE. And in addition, other people, in fact, the majority of people who will now be going into these exchanges will be subsidized, will be eligible for the tax credits, correct?

Ms. UCCELLO. I don't know the specific share, but the people who are eligible will indeed see downward pressure on their net premium.

Ms. DEGETTE. Spoken like a true actuary.

Mr. Durham, I wanted to ask you, because I think you would agree, since you have been looking at these issues, health insurance premiums have increased about 10 percent a year on average for the last 10 years from 1999 to 2009, correct?

Mr. DURHAM. Yes. Premiums reflect the average cost of care, and so if——

Ms. DEGETTE. Right. They have been going up on an average of about 10 percent per year for the last 10 years or so. Is that right?

Mr. DURHAM. Right.

Ms. DEGETTE. Correct?

Mr. DURHAM. Reflecting the average cost——

Ms. DEGETTE. Yes or no.

Mr. DURHAM. Yes.

Ms. DEGETTE. Thank you. And so you wouldn't expect to see a dramatic reversal of this trend right now, would you?

Mr. DURHAM. Oh, we have seen some reversal because of reduced utilization due to the downturn in the economy.

Ms. DEGETTE. Oh, OK. OK. So that's because people aren't buying insurance, right?

Mr. DURHAM. Or they are not using insurance as much. But we have seen——

Ms. DEGETTE. Yes. So they are—they are not—so for once, and don't hold me to this, I actually agree with Mr. Burgess, which is, nothing is ever totally free, so if somebody doesn't get insurance and they get sick, somebody is still paying for their care. Is that correct?

Mr. DURHAM. There is some payment through uncompensated care, yes.

Ms. DEGETTE. Yes. Yes. Someone's still paying for it. And that's often the taxpayers, right?

Mr. DURHAM. Right. And it often gets shifted to private plans as well, which increases premium costs.

Ms. DEGETTE. So if it gets shifted to private plans, that increases the premium costs for those people, right?

Mr. DURHAM. Correct.

Ms. DEGETTE. Yes. So I wanted to ask you a question, Mr. Spiro. Have you looked at—have you looked at the memo that the Democratic staff released this morning about the results from Oregon, Washington, Maryland, Vermont, and Rhode Island?

Mr. SPIRO. I have not, but I am broadly familiar with the rate filings in those States.

Ms. DEGETTE. So what they found out was in Oregon, rates for people who stay in comparable plans offered by their current insurance are expected to fall by about 7 percent, and in Washington, consumers will see average reductions by 25 percent, and in Vermont, a similar result. What is your reaction to this kind of a finding?

Mr. SPIRO. I think, number one, it shows that some of the concerns have been inflated, in that in some of these States, the insurance executives, as I mentioned, were projecting increases of 50 to 70 percent, and it turned out not to be the case, so their concerns were overblown.

Second, I think it shows that there is—despite actuaries making it seem like a science, there is a lot of flexibility and fudge room in what they do, and that projected costs based on very minor changes in assumptions can vary wildly.

Ms. DEGETTE. Just one last question. You would expect competition to give a more apt competitive insurance price, right?

Mr. SPIRO. Yes. I think the interesting thing in Oregon, as I mentioned is, immediately after the rates were posted online, and

not every State is as transparent as Oregon but that is something to be encouraged, but once the competitors saw those rates being posted, they immediately requested to the insurance commissioner that they be able to propose lower rates.

Ms. DEGETTE. Thank you.

Mr. SPIRO. And those are just the proposed rates, so they haven't even been reviewed by the insurance commissioner yet.

Mr. MURPHY. Thank you. Time has expired.

Now recognize Dr. Burgess for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman. Mr. Durham, I wasn't going to go here, but since I was provoked by the ranking member, let's go here for just a moment. Cost of people who show up with no insurance does cost those who have insurance something, doesn't it?

Mr. DURHAM. Yes, sir.

Mr. BURGESS. But the greater amount of cross-subsidization that occurs is between the public plans, Medicare, Medicaid, and what they don't pay in covering the cost of the care rendered. Is that a fair statement?

Mr. DURHAM. Correct. And that is often again passed through to practice.

Mr. BURGESS. And what is the larger group? People who show up in the emergency room without an insurance policy or Medicare and Medicaid that show up in the emergency room of the hospital?

Mr. DURHAM. Medicare and Medicaid.

Mr. BURGESS. Yes, absolutely. That is the 9 percent cross-subsidization. We like to push that off onto the uninsured, but in fact, it is the Federal Government not paying their fair share of the note; is that not correct?

Mr. DURHAM. Correct.

Mr. BURGESS. Well, look, Mr. Spiro, let me just ask you, I have got your biography, I guess, in front of me. You are not a physician; is that correct?

Mr. SPIRO. That is correct.

Mr. BURGESS. But you did serve some time in the Senate Health, Education, Labor, and Pensions Committee?

Mr. SPIRO. Correct.

Mr. BURGESS. Was that time that you served there while a law that is now known as Affordable Care Act was under consideration?

Mr. SPIRO. Yes.

Mr. BURGESS. This is a good day for me because you may recall that the House had hearings and marked up a bill called H.R. 3200, and do you recall what happened to H.R. 3200?

Mr. SPIRO. I was a staffer on the Senate side.

Mr. BURGESS. Well, the correct answer is it vaporized. It went off into the ether. No one has seen it since November of 2009 because the law that we are talking about, the Affordable Care Act, was actually a Senate bill; is that not correct?

Mr. SPIRO. It was a Senate bill, but it was very much informed by——

Mr. BURGESS. OK. Yes or no. It was a Senate bill.

Mr. SPIRO. But to finish my answer, there was——

Mr. BURGESS. The point I—I control the time.

Mr. SPIRO. May I finish?

Mr. BURGESS. The point I need to make here is that there are some things that many of us have wondered about over here on the House side. Now, we have just been told that the House has voted to repeal all or a part of the Affordable Care Act some 37 times, but there was one part of the Affordable Care Act that everybody agreed with, the 1099 provision. Do you remember the 1099 provision, the business-to-business transaction greater than $600 that was going to generate the issuance of a 1099 form?

Mr. SPIRO. Yes.

Mr. BURGESS. Was that part of the work you did in your Senate committee?

Mr. SPIRO. No. Part the work I personally did, I was not a tax counsel, but I am familiar with the provision.

Mr. BURGESS. So that is a portion of the Affordable Care Act that again there was broad bipartisan agreement that this was an onerous burden on—as a paperwork requirement on the businesses of this country, correct? And the President signed it into law. The President agreed with the Congress when that repeal portion came through

Now, there is another bill that was voted on January 1st of this year called the—we called it a fiscal cliff bill. I actually voted against it, but one of the parts of it that I actually liked was the repeal of something known as the Class Act.

Now, that was one of Senator Kennedy's projects. Did you work on the Class Act when you were on the Committee of the Health, Education, Labor and Pensions?

Mr. SPIRO. I did not, but I am familiar with it.

Mr. BURGESS. Well, the Class Act was again one of those aspects of the Affordable Care Act where there was broad agreement between Republicans and Democrats that this was something that would be better off repealed. And again, I guess the President agreed because the President signed that, did he not?

Mr. SPIRO. I think there was an acknowledgment that as structured, the Class Act, because it did not have an individual mandate, that it would spiral out of control, so——

Mr. BURGESS. Well, I think the language that the chief actuary used, because we heard him here in this very committee, that it was the classic insurance death spiral that the Class Act was fixing to inaugurate.

Well, we have talked a lot today about pre-existing conditions. Were you part of the committee that worked on the pre-existing conditions——

Mr. SPIRO. Yes.

Mr. BURGESS [continuing]. Program? Well, do you know what has happened to the Federal pre-existing conditions program since January or February of this year?

Mr. SPIRO. A lot of things have happened with——

Mr. BURGESS. Well, they are out of money, and so people who were hoping to age into that system, and we have heard from them in this—already in the health subcommittee, they are now frozen out. There is no—they cannot be taken into that system, so they are basically on their own between February 1st and January 1st of 2014. Were you aware of that?

Mr. SPIRO. Do you want to provide more appropriations for that program?

Mr. BURGESS. Well, I was hoping to move all of the money from the prevention fund into the pre-existing plan, but I haven't quite been able to do that, and therein is the problem. You knew, when this part of the law was drafted in committee, you knew that it was woefully underfunded. There is no one in the world who thought $5 billion was going to be enough to do what you said it was going to do.

Mr. MURPHY. Gentleman's time has expired.

Mr. BURGESS. Do you have a thought on that?

Mr. SPIRO. The bill was designed in such a way so that it would reduce the deficit, and it met that test. Now, could it have provided more funding for the PCIP program? Yes. Would you have supported the program and the bill if it had done so?

Mr. BURGESS. Sir, with all due respect——

Mr. MURPHY. Time has expired.

Mr. BURGESS. I didn't support a single part of this, but I will save my followup questions for a second round.

Mr. MURPHY. Time has expired.

Mr. Waxman is recognized for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

It is interesting that my colleague talked about the things for there was a bipartisan consensus like to take away the burden on businesses to file 1099s, but where was the bipartisan consensus to protect people from being charged more money or denied insurance because of pre-existing conditions?

Mr. BURGESS. Waiting on you——

Mr. WAXMAN. Mr. Chairman, it is my time. There was no bipartisan consensus for that. All they wanted was to protect the industry, the businesses. Fine. We all agreed to do that, and we are going to make other changes in this law.

Mr. Carlson, I want to ask you about your testimony. We looked it over, and I think that you got this to us very late. We just got it today. The rules require you to put it in earlier, but—so we are at somewhat of a disadvantage, but your testimony contains a review of premiums in three States recently released filings of proposed premiums, and you state that the average premium rates of the top three insurers in Oregon represent an increase of 36 to 53 percent over current premium rates. I would like to ask you a few questions about that.

Did you separate out the bronze, silver, and other levels of plans from your calculations of the average premium and changes in premiums?

Mr. CARLSON. What I looked at was kind of the base rate. So as——

Mr. WAXMAN. In other words, you didn't. You looked at a base rate, but there are several different kinds of plans under the Affordable Care Act. Did you do any comparison of the currents rates of plan with comparable actuarial value to silver and bronze plans to the proposed rates of silver and bronze plans that will be available in the marketplace?

Mr. CARLSON. I relied upon what was in the filings.

Mr. WAXMAN. But the law requires that there be several plans, a silver and a gold plan and a bronze plan, and they all have to provide basic services but they relate to how much are the out-of-pocket costs. Did you look at those different plans in a different way or you treat them all the same?

Mr. CARLSON. Well, I looked at the average plan, so, obviously, each of those plans are——

Mr. WAXMAN. You didn't look at an analysis then if people switched to the lowest cost silver and bronze plans offered in the marketplace; is that right?

Mr. CARLSON. Well, if they were to do so, they would also, their benefits would be reduced as well as their premium.

Mr. WAXMAN. Yes, but you didn't look at that. Some people would choose to do that. They want a lower premium, so they are willing to take a lower plan. That is a reasonable thing to do, isn't it, have a choice?

Did you make any attempt to calculate the savings individuals might see because their improved coverage would lead to a reduction in out-of-pocket spending?

Mr. CARLSON. No, I didn't consider the out-of-pocket spending.

Mr. WAXMAN. Did you estimate the impact of premium tax credits available in the marketplace on effective premiums in Oregon?

Mr. CARLSON. Well, I mean, I am just looking at what the premium rate the insurance company is going to charge, not what the consumer is going to actually pay.

Mr. WAXMAN. Well, I think what this hearing is supposed to be all about is what consumers might expect. So you didn't look at what a lot of consumers will appreciate, which is a lower cost to them because of the premium tax credit.

Your testimony also differs in many important ways from the supplemental report that we put out. I know you haven't had a chance to do it, but our memo found that the average consumer currently enrolled in a bronze comparable plan would see a rate decrease of 11 percent and save $470 annually if they stay with the same insurer. If they switch to a lower cost bronze plan, consumers would save an average of 32 percent or over $1,300 annually. I want to just bring this to your attention because there is a more complete analysis.

Mr. Durham, you represent the insurance industry. Does the insurance industry support the full repeal of healthcare reform that the Republicans have voted on 37 times?

Mr. DURHAM. We are focused like a laser on implementation. This is the law of the land, and our plans are working around the clock to——

Mr. WAXMAN. Does your industry support repeal of the law?

Mr. DURHAM. We haven't taken a position on repeal. We are focused on implementation.

Mr. WAXMAN. What you don't like is the tax on insurance companies.

Mr. DURHAM. We would like to see——

Mr. WAXMAN. You would like to see that changed.

Mr. DURHAM. Yes, because——

Mr. WAXMAN. You don't want the whole law thrown out.

Mr. DURHAM [continuing]. Adds to the cost of premiums and makes premiums less affordable.

Mr. WAXMAN. I think your position shows how out of the mainstream my Republican colleagues are with their continuing push for full repeal of healthcare reform. I don't understand why Republicans would continue to vote for healthcare repeal that would cost 25 million Americans to lose health insurance coverage, increase the cost for millions of Medicare beneficiaries and increase the Federal deficit. My time is expired. I yield back.

Mr. MURPHY. Gentleman's time is expired.

Now recognize Mr. Harper for 5 minutes.

Mr. HARPER. Thank you, Mr. Chairman.

And thank each of you for taking your time to be here. This is something we are dealing with in every State, in every district. And for me, the calls began even before Obamacare was passed back in 2010 because people were worried about what was going to happen with their premiums, how they were going to be able to pay either the fine or provide health insurance when some of their businesses were on a very marginal rate.

And Mr. Spiro, listening to some of the information brings back a lot of memories, but when we were calculating the price on this, the plan did not include SGR, did it? That was the cost to fix the doc fix, that was not a part of the plan, was it? That was not included in the calculation for the price.

Mr. SPIRO. The SGR is still part of current law.

Mr. HARPER. OK. My point is we didn't solve that because it would have driven up the cost, the price tag. I mean, it wasn't included in the law that came out, was it?

Mr. SPIRO. No, it was not.

Mr. HARPER. OK. You know, when you talked and you said something about additional money to fund preexisting, how do you feel about doing away with the preventive care slush fund that Sebelius has and using that money to help with preexisting?

Mr. SPIRO. How do I feel about that?

Mr. HARPER. Yes. I mean, you are sitting there talking about it. Do you support doing away with the preventive care fund and moving that money over to help those that need it most in preexisting?

Mr. SPIRO. As you may know, I worked for Chairman Harkin, so I support the prevention public health fund.

Mr. HARPER. OK. Even though that is being used for things that truly are not for preventive care. You have seen some of that already.

Mr. SPIRO. Being used for evidence-based practices to lower the cost of healthcare and improve——

Mr. HARPER. OK.

Mr. SPIRO [continuing]. Quality of healthcare.

Mr. HARPER. So the money used for lobbying for soda tax that came out of preventive care fund or that that was used for pet neutering programs, those are not—you consider that part of importance for preventive care?

Mr. SPIRO. I don't know what you are referring to.

Mr. HARPER. OK. Well, it is there.

And if I may, Mr. Chairman, I am going to yield to Dr. Burgess.

Mr. BURGESS. I thank the gentleman for yielding.

Mr. Durham, let me ask you a question on preexisting conditions. Because we were told in the run up to pass the Affordable Care Act that there were 8 to 12, 15 million people who had preexisting conditions and as a consequence could not get insurance. As of January 1st or January 30th when the program closed to new folks, do you know how many people were receiving insurance through the preexisting pool?

Mr. DURHAM. I believe it was around 135,000.

Mr. BURGESS. So how do you explain the discrepancy between 8 to 12 to 15 million people who we were told in the run up to this law, and 100,000, 150,000 that were actually in the pool when the doors closed?

Mr. DURHAM. I don't have an explanation for that?

Mr. BURGESS. Well, wouldn't part of the explanation be in the large group market, under ERISA regulations, there are periods called open enrollment periods, where people who are hired onto say a large telecommunications company, they are hired on, they get on the insurance, if they have a preexisting condition, are they what, are they fired, are they turned down or what, what happens to them? They get insurance, don't they?

Mr. DURHAM. Yes, through their employer.

Mr. BURGESS. And that is one of the issues. All of the debate leading up to the passage of the Affordable Care Act conveniently ignored that, yes, here is a group of people who have a problem, people in the individual market. They have a preexisting condition, they get frozen out of market, but people in the large group market, because of some existing Federal regulations, some of which I have a problem with, to be perfectly honest, but nevertheless, they get coverage when they get hired onto one of the multi-State corporations; is that not correct?

Mr. DURHAM. That is correct.

Mr. BURGESS. So, the problem with preexisting conditions was actually one that perhaps was quite manageable, I would submit. It never required a new Federal agency to be stood up, and that is where most of the dollars in the PCIP program were wasted setting up a new Federal agency. It would have been far better served to help those States that already had risk pools of reinsurance or some other novel approach to help someone in the individual market who didn't have coverage, but for whatever reason, we decided that we needed a new Federal agency because I guess we didn't have enough already; is that right?

Mr. DURHAM. I can't comment on the specific administrative side of the PCIP program.

Mr. BURGESS. Well, Mr. Spiro may have some recollection about that from his time on the committee, but we have already visited about that, so I will yield back. I did want to make that point, though. There is—the folks who have preexisting conditions are rarely in the large group market. They tend to be in the small group market and the individual market, and that was a fixable problem——

Mr. MURPHY. Time expired.

Mr. BURGESS [continuing]. Had the Congress had the will to do that.

Mr. MURPHY. OK. Gentleman's time expired.

I recognize Mr. Butterfield for 5 minutes.

Mr. BUTTERFIELD. Thank you very much, Mr. Chairman.

Thank all of you for your testimony today. We have heard a lot today about premiums under ACA may actually increase, and a lot of these claims aren't accurate, in my opinion, because they don't take into account factors like the tax credits that will be available to many enrollees to reduce the cost of coverage. But some of this discussion simply misses the point.

Under ACA, millions of Americans will have access to much better coverage, so even if they pay higher premiums, they will get a lot more for their money. Let me start off with Mr. Durham, if I can.

Your testimony puts this in what I call clinical terms. It refers to the Affordable Care Act's minimal actuarial value requirements. In plain English, what does this mean?

Mr. DURHAM. That is the percent of total healthcare cost that is paid by the plan versus the insured, so a minimum of 60 percent actuarial value means the plan picks up 60 percent of the total cost. The beneficiary pays the other 40 percent.

Mr. BUTTERFIELD. Has your industry projected with any certainty about how many more people will have insurance as a result of the Affordable Care Act?

Mr. DURHAM. We have seen CBO projections in terms of——

Mr. BUTTERFIELD. Do you accept that projection as valid for planning purposes within your industry?

Mr. DURHAM. Generally, yes.

Mr. BUTTERFIELD. And how many people do you project will get insurance?

Mr. DURHAM. Well, let me see. I have got the latest CBO projections here with me. They estimate that—it looks like, in 2014, there will be 9 million additional Medicaid and SCHIP; 2 million will lose nongroup coverage; 7 million will gain coverage through the exchange.

Mr. BUTTERFIELD. But the industry is preparing for a large influx of new enrollees in the—in the exchange.

Mr. DURHAM. Well, that is our hope. And our main concern is that if premiums are not affordable, then those younger and healthier will opt not to purchase coverage, stay out, and that will deteriorate the risk pool.

Mr. BUTTERFIELD. And that is why you focused on implementation. You want this thing to work, don't you?

Mr. DURHAM. Yes. Our plans are competing in this new marketplace and have been working on implementation round the clock to get ready for the October 1 open enrollment.

Mr. BUTTERFIELD. And the tax credits that you will be getting to assist with these premiums, that is money. That is real money that your companies will spend and use to—for your overhead and for other things that you do.

Mr. DURHAM. Those tax credits will not reduce the premium cost, but they will help lower-income individuals pay for premiums, that is correct. But they do—they do phase out rapidly, so by the time you get up to around, according to CBO, about 250, 300 percent of Federal poverty level, those premium tax cuts are only paying for 40 percent of the premium, and so that is worth to note as well.

Mr. BUTTERFIELD. Do you have any idea what the average premium will be, let's say for a 35-year-old single healthy adult in the average State?

Mr. DURHAM. The average premium, I don't have that in front of me. I think for CBO's estimate, it is $5,200.

Mr. BUTTERFIELD. And Ms. Ucello, do you have any projection on the average premium cost for a single adult?

Ms. UCCELLO. No, and I would argue that there is no such thing as average.

Mr. BUTTERFIELD. I think Kaiser comes out with like $330 a month, which is $4,000 a year or something. You are saying——

Ms. UCCELLO. We have not done any projections.

Mr. BUTTERFIELD. Because of the variations between the States and the different——

Ms. UCCELLO. Across individuals and States, exactly.

Mr. BUTTERFIELD. All right. So back to you, Mr. Durham. So, under the Affordable Care Act, plans on the exchange must offer policies that cover at least 60 percent of healthcare costs; is that correct?

Mr. DURHAM. That is correct. That is the minimum actuarial value.

Mr. BUTTERFIELD. But it can go up from there to 90 percent of the cost.

Mr. DURHAM. That is correct.

Mr. BUTTERFIELD. We have heard a lot of furor from my friends on the other side in this hearing and in previous hearings about potential large increases in premiums, but Mr. Spiro, your testimony walks through why some of these concerns seem to be overblown. For starters, people who currently have employer coverage, like Medicare and Medicare and other public coverage, are unlikely to be affected by premium changes; is that correct?

Mr. SPIRO. That is correct. It is almost 90 percent of the American population.

Mr. BUTTERFIELD. And much of the remaining population, women and older people and people with preexisting conditions are likely to see lower premiums and not higher premiums. Would that be correct?

Mr. SPIRO. Correct. It depends, as Cori has mentioned, it depends on a lot of different factors. The group of concern would be young adults with higher incomes who don't qualify for full subsidies, and in my testimony, I said that the estimated fraction of the population that that is 0.5 percent.

Mr. BUTTERFIELD. Mr. Spiro, if this act was completely repealed, what would happen to the number of uninsured people in our country?

Mr. SPIRO. Relative to the act being in place, I believe CBO's latest estimate, if I can borrow this——

Mr. DURHAM. Sure.

Mr. SPIRO. Is that, you know, within 10 years, the Affordable Care Act will reduce the number of uninsured by 25 million. Now, it would be much higher if all States expanded their Medicaid programs, so——

Mr. BUTTERFIELD. That was going to be my final question.

Mr. SPIRO. And I expect that to be the case. Over time, States will realize what a good deal it is, how good it is for their economies, so I expect every State will eventually take up the expansion. And when the CBO estimated on that basis, the reduction in the number of uninsured was over 30 million.

Mr. BUTTERFIELD. When you served on the Senate committee that helped put the finishing touches on this thing, did you ever imagine that States would decline to expand their Medicaid program to cover poor people within their States?

Mr. SPIRO. Well, first, I never imagined that the Supreme Court would make that expansion a voluntary option. Now, I don't think it is wise for States not to expand. One reason, since we are talking about premium impact, is that actually, in States that do not expand their Medicaid programs, premiums will rise in the exchanges.

Now, why is that connected? It is because on average people who are lower income are sicker, it is a less healthy population, so if they are being covered under the exchanges, rather than under Medicaid, premiums are going to rise slightly in the exchanges, so I think it is an unwise policy——

Mr. MURPHY. Gentleman's times has expired.

Mr. SPIRO [continuing]. Not to extend Medicaid program.

Mr. MURPHY. Mr. Long is recognized for 5 minutes.

Mr. LONG. Thank you, Mr. Chairman.

Mr. Spiro, you worked on the Hill up here and were a staffer. If you were a staffer today and wanted to get information on what your healthcare was going to cost you January 1st of next year, were would you suggest I go?

Mr. SPIRO. I am sorry, can you repeat the question?

Mr. LONG. My 5 minutes will be up. If you were working on the Hill today and you go to the Member of Congress—you worked for Senator Kennedy; is that right?

Mr. SPIRO. Right.

Mr. LONG. And you go to Senator Kennedy and you say, what is my health insurance? They have got this new Affordable Care Act coming in and Members of Congress and their staff are going to be under the exchanges, how much is my healthcare?

Mr. SPIRO. Yes.

Mr. LONG. Where would you go to get that information? Where can I—because these are the questions my staff has asked for.

Mr. SPIRO. Yes.

Mr. LONG. We are talking about the increased healthcare cost, so where can I get that information? I have been trying since January and I haven't been able to get it from anybody. Where would you suggest I go with your experience up here?

Mr. SPIRO. This is the beauty, Congressman, of the exchanges. Each State is going to have its own exchange, whether it chooses to establish its own exchange. If it doesn't——

Mr. LONG. Missouri is not going to—I mean, Missouri is not going——

Mr. SPIRO. If it does not, then the Federal Government will facilitate an exchange in that state and consumers can go online.

Mr. LONG. Today?

Mr. SPIRO. When the exchanges are functioning.

Mr. LONG. May 20th?

Mr. SPIRO. October 1st.

Mr. LONG. They go—OK, October 1st.

Mr. SPIRO. Yes. They can go online and see the rates and compare them, apples-to-apples comparison, makes it much easier to shop for and compare plans and that you will be able to see what your premium tax credit would be.

So, we won't be talking about all these studies that don't take into account your premium tax credits. Consumers will actually be able to see how much they will actually have to pay out of pocket.

Mr. LONG. So that is October 1. So if you are a young—how old are you?

Mr. SPIRO. I am 38.

Mr. LONG. 38. OK. You look younger than that. If you—but if you are a young staffer up here living three and four deep in an apartment, as you know they do, trying to make a living and staffers back home that have one or two children, young family starting out, they are going to need to wait till October the 1st before they can then find out what their insurance is going to cost January 1st, so they are going to have October, November, December to make a decision on whether they want to stay employed here in public service or whether they need to find another job where they will have better coverage, correct? About three months.

Mr. SPIRO. The open enrollment period is 6 months, and it starts on October 1st, so it is a long period of time for people to enroll.

Mr. LONG. When you were talking to Mr. Butterfield there about the—repeat that about the 90 percent; 90 percent of the people will not see premium increases? Was that a category or something, or did I—surely that is not 90 percent of the public.

Mr. SPIRO. What Mr. Butterfield was pointing out was that the vast majority of Americans who have health insurance today, they either have it through their employers or through Medicare or Medicaid or the Veterans Health Administration, other government programs, and when you add up all those people, that's 90 percent.

Mr. LONG. And you are saying that their premiums are not going to rise.

Mr. SPIRO. I am saying that because we are focussing today on the impact of reforms to the non-employer market, the nongroup market, we are not talking about that 90 percent of the population.

Mr. LONG. I thought we were talking about the health insurance premiums under the Patient Protection and Affordable Care Act.

Mr. SPIRO. Correct. And the reform——

Mr. LONG. OK. Let me move on to another question. I had a CEO come to me, and he said, I am coming to you, I am coming to Senator McCaskill, Senator Blunt because I want you to realize how devastating this Affordable Care Act is to our company. We provided great healthcare.

This is a local company in my town.

Mr. SPIRO. Yes.

Mr. LONG. They have 53,000 employees. To quote him, he said, we had great health insurance for our people. They loved it. It was affordable for us.

Mr. SPIRO. Yes.

Mr. LONG. If we comply with Affordable Care Act, it is not affordable. We cannot do it. The only thing we can rationalize is cut everybody back to under 29 hours a week, which that is not feasible. So what would you suggest to someone like that?

I am talking to you and not them. What do you suggest to somebody like that? What do I tell a CEO that comes to me, 53,000 employees, started out with one store in Springfield, Missouri, now, obviously, they have stores around the country, has built this company up and they are not able to keep the insurance they were promised, that they were promised, what do you tell somebody like that?

Mr. SPIRO. The first point I would make is that it was an option to grandfather their plan, so it was an option for them to keep their——

Mr. LONG. Are they past that deadline now?

Mr. SPIRO. Now, the second thing is that a lot of——

Mr. LONG. They don't think they can keep their plan, sir. If they can, I need the information out so I can get to them quick.

Mr. SPIRO. They had the option to keep their plan.

Mr. LONG. They can keep what they had exactly.

Mr. SPIRO. When the Affordable Care Act was enacted, they had the option to keep their plan, and they would be grandfathered or exempt from these reforms.

Now, a lot of employers were finding, are talking about cost increases and blaming the Affordable Care Act. Well, as we discussed earlier, there has been a trend for 10 years of premiums increasing.

Mr. MURPHY. Gentleman's time has expired.

Mr. LONG. Is that clock not working or what?

Mr. MURPHY. Well, we gave you extra time on that.

Mr. LONG. Very well. Yield back.

Mr. SPIRO. Their policies not necessarily——

Mr. MURPHY. Mr. Spiro, we are going into the next—I would appreciate it if you could try to keep your comments under time.

Mr. Green recognized for 5 minutes.

Mr. GREEN. Thank you. Thank you, Mr. Chairman, and I guess I have had a whole line of questions, but in an earlier life, I actually managed a business and part of our employees were under a union bargaining agreement and part of the office personnel were not, but—and one of my jobs was to negotiate for a small firm for their insurance premiums. In the years that I did that, I never had my insurance company come in and say, we are not going to increase your premiums 10 percent, sometimes even 25 and 30 percent.

So, for us to say that we cannot guaranty insurance premium increases, didn't happen in the real world for the last 30 years because I know they went up. I know they went up on my business. I know they went up on even large businesses. And so that is what boggles my mind because, frankly, we have this huge pool of people who are not paying into anything right now. And so my hospitals have to cover them by Federal law, and we are not going to change that. Why shouldn't we have some type of mandate to go in there?

And frankly, I am familiar with my colleague from Missouri's company because I am a customer of that company, and it is a retail operation, and I think they would qualify. But in all honesty,

I want to compliment you, Mr. Spiro, my colleague from Missouri has never told me I look younger than I am.

But let me talk about some of things, though, that were in the bill that, for example, the preexisting conditions. My colleague from Texas, Dr. Burgess talked about it, that it is mainly in the smaller groups, and it is right. Under ERISA, you have certain rules that once you are an employee—and mostly yours only covers very large employers, you got that coverage. But I can tell you in the smaller group, in State government policies, which were individual and smaller group, they weren't coming under multi-State requirements. They did not have that, and so they could actually write people out for preexisting, and I will give you my example.

When I was negotiating with a company, for an insurance company for our 13 employees, they came to me after 3 years and said, we can lower the increase in your premiums if you would exclude this person in there and later go to the individual market because she just happened to have a double mastectomy, and it was only my job to negotiate. I wasn't the owner of the company. And I said, well, I appreciate that, but that lady had a double mastectomy, she works here and she is the wife of the owner. I will share that information with them because that is what happens in the real world and that is why the preexisting condition is so important in the Affordable Care Act.

And by the way, that is not the only thing. A lot of my colleagues—I know I didn't like the Senate bill. I am a House Member. I know what the Senate did. They took our House number and amended it. In our House bill, we fixed the SGR. In our House bill, we did not have an iPad in there. In our House bill, we did not include Senator Kennedy's long-term care because we couldn't afford it but we did include preexisting conditions. And yet, to a person on the Republican side, they all voted against those things even though they were in the House bill, and they were added in the Senate bill, and they didn't vote for it either then.

So, to sit here and say we didn't fix SGR, we did, and I still cannot imagine why the United States Senate didn't fix that because I don't think we can find any one of the Senators over there to support the SGR any more than we can found a House Member to do it.

But Mr. Spiro, I appreciate your—and I know my colleague talked about the 90 percent of the Americans—insured Americans have employer covered insurance, and I regret the Supreme Court's decision on Medicaid. I also served as a State legislator, and in Texas, State legislators are not full-time. You get $600 a month, whether you earn it or not. So all of us had other income, and that was part of my management of that printing company that I learned about insurance from a buyer's point of view in small group insurance. But, and again, coming from Texas, we have a huge number of people who are uninsured.

I have one of the largest districts in the country with people who work and yet their employer doesn't provide insurance for them. So, the Affordable Care Act, one of the benefits was Medicaid—we have a lot of working poor because you have to be pretty destitute and poor to get Medicaid in Texas to begin with, but if you are a working poor, you still don't get it now under the Affordable Care

Act. So, and I know that has been discussed, and a lot of legislators all over the country, and I wish we would change that because that was one of the goals is to make sure these folks, if you are making $15 an hour and have three or four children, there is no way you can afford insurance premiums and still be—and still pay for rent and everything else.

Mr. Chairman, I know a lot of the questions have been asked that I already have, but I appreciate my colleagues, and I appreciate your patience today.

Mr. MURPHY. Thank you. Now we will recognize Mr. Olson for 5 minutes.

Mr. OLSON. I thank the Chair, and welcome to our witnesses.

I am the congressman for Texas 22, which is a suburban district right outside of Houston. I go home every week and try to go out to eat a meal with my family at a restaurant one day when I am home because there is no better place in Texas, none, to get the feel of Texans when you are at a restaurant.

They are scared of Obamacare and what it is going to do to the healthcare of their family. Every time I go to eat at a restaurant, whether it is breakfast, lunch or dinner, they tell me stories about the broken promises that have been made by Obamacare. If they provide their own health insurance, it is going to go up somewhere between 5 and 43 percent. That is from a study this committee determined, 5 to 43 percent. That is a broken promise. If their employer provides insurance, it is going up to 23 percent increase of their cost, or they lose it. That is a broken promise.

These people have been hurt by this weak economy. They don't have more money to spend on healthcare. They are tapped out. They are not just afraid of Obamacare. They are terrified of it.

I represent the most diverse district in America, and they express these same fears regardless of ethnicity, religion, gender, or age. It happens all the time back home. At Bob's Taco Station in Rosenberg or barbecue lunch at The Swinging Door in Richmond, Texas, or a steak dinner at Killen's in Pearland, Texas. These good scared Texans agree with Senator Baucus, Obamacare is a train wreck coming down the tracks.

I want to focus on one of these broken promises, is that young American will purchase their healthcare. They won't. They will get it when they need it, as they are driving to the hospital to get their healthcare. I am a former naval aviator. There is a thing in aviation called a death spiral and that is a situation where the aircraft, it starts out benignly enough, but then it starts spinning, spinning spinning and eventually you can't regain control and you can't eject out of the airplane, hence the term death spiral. My questions to you, Mr. Durham, if young Americans don't purchase healthcare, they forego that, does that put Obamacare into a death spiral?

Mr. DURHAM. It could if young Americans, young healthy individuals do not purchase coverage, that could increase cost for everyone who remains in the risk pool and that could have an adverse effect. That compounds over time, so depending on how many younger and healthier individuals opt out and pay the penalty, it could certainly compromise the risk pool, which could lead to that type of situation down the road.

Mr. OLSON. So another broken promise. And we have got some actuarials here. I mean, Ms. Ucello, Mr. Carlson, how about the death spiral? If young people do not get involved in this healthcare bill, like I think is going to happen, is that going to start a death spiral with Obamacare getting more and more people coming into the exchanges because their employers got rid of healthcare insurance, all these things are happening on January 1st. I mean, that sounds to me like a death spiral.

Ms. UCCELLO. As I mentioned earlier, the viability of the market does rely on bringing in lower-cost people to offset the cost of the higher-cost people, and the guaranteed issue provision will provide more incentives to bring in the high-cost people. But the individual mandate and the premium subsidies will help to mitigate that effect by providing incentives to bring in lower-cost people. So it depends on how effective those provisions are at mitigating the other upward pressures on premiums.

Mr. OLSON. Mr. Carlson, you care to elaborate, sir?

Mr. CARLSON. Well, I think I agree with what Ms. Ucello said, and you know, because of the premium tax credits there, there is kind of a floor, but it doesn't minimize the importance of bringing young healthy individuals into the pool.

Mr. OLSON. OK. It is about time.

I yield back the rest of my time, sir. Thank you all.

Mr. MURPHY. Gentleman yields back.

I now recognize Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Mr. Carlson, in reading your testimony, you said, for the individuals that are expected to be eligible to receive premium subsidies in the exchanges, the amount they actually pay may be less and sometimes substantially less. So, your analysis did not take into account the out-of-pocket cost that people are going to pay, given the premium subsidies, right?

Mr. CARLSON. Correct. My report looked at what the insurance company would charge in premium rate.

Ms. SCHAKOWSKY. And following up on the—oh, did Mr. Olson leave? He was talking about young people and getting them in the plans.

Mr. Spiro, isn't it true that when young people have been surveyed, the main reason that they don't get health insurance, my understanding is, is the cost of health insurance, that they would, and isn't it also true that young Americans tend to have lower incomes and could be some of the biggest beneficiaries of the premium subsidies. I wondered if you would reflect on younger people getting in the plan.

Mr. SPIRO. Right. So, as I said, 70 percent of young adults with non-employer coverage would be eligible for Medicaid or the exchange subsidies, and in many cases, those subsidies would be very generous and lower the costs that they see.

I do want to mention that there are three things that this committee could do constructively to mitigate any premium increases. One is, don't scare away young Americans by talking about rate shock all the time. Second is encourage Medicaid expansion, because as I mentioned before, in States that don't expand their Medicaid programs, premiums will be slightly higher in exchanges as

a result. And third, fund consumer assistance and education. The exchanges are there to lower barriers to young Americans, to make it easier to shop for and compare plans. But one thing that you can really do, if you are concerned about rate shock, is to provide more funding for consumer outreach and assistance.

Ms. SCHAKOWSKY. The other thing I was interested in.

Mr. Olson was talking about how fearful people were because of the rate increases that they are experiencing, but only five States have said what the rates are going to be.

Mr. Durham, does anybody know right now what kind of increases—I mean, we know that they have been going up every year as Mr. Green pointed out, but when they talk about, oh, my rates are going to go up this, my rates are going to go up that, do we really know that already?

Mr. DURHAM. We don't yet. We won't know for sure until the rates are actually approved and individuals can start shopping on the exchange Web sites and the like come October 1st, so there is still a long way between now and then. A number of States are still——

Ms. SCHAKOWSKY. So blaming Obamacare for increases in rates at this point is not really accurate, is it?

Mr. DURHAM. Well, I think what we are conveying through the studies that have been talked about this morning is a number of actuarial firms have indicated that there are provisions in the Affordable Care Act that put upward pressure on premiums. It is variable, depending on the age, health status, location and the current coverage the individual has, and so it is more shaping the environment than the——

Ms. SCHAKOWSKY. Well, let me ask—anybody can answer this. But seems to me, for example, that competition is not really taken into account. In Maryland, Blue Cross, the largest carrier in Maryland, and we do have it, proposed a 25 percent average increase for its 2014 individual market. Other plans saw smaller increases, in some cases, below annual trends in years prior to health reform. For example, Kaiser Permanente's average rate increased only by 4.3 percent.

So, wouldn't it make sense, Mr. Spiro, that in a marketplace, that if you could compare rates and go online and find that, that you would take a Kaiser Permanente over a Blue Cross/Blue Shield then?

Mr. SPIRO. Yes. I think the exchanges are working as intended, and there is intense competition among insurers because the premium subsidies are linked to the second lowest cost plan, so they want to be close to that plan.

In Maryland, as it turns out, the original proposal from CareFirst was for a 50 percent increase, and then they lowered it to 25 percent, and that is proposed. So, after the Maryland insurance commissioner reviews that rate, it is probably going to come down even more. And as you said, there are other plans available that will be cheaper and consumers can vote with their feet, with their pocketbooks and choose those plans.

Ms. SCHAKOWSKY. Thank you.

Thank you, Mr. Chairman.

Mr. MURPHY. Thank the gentlelady whose time has expired.

Now recognize the gentlelady from North Carolina, Ms. Ellmers for 5 minutes.

Mrs. ELLMERS. Thank you, Mr. Chairman.

Thank you to our panel for being here today. Ms. Ucello, there has been discussion today about decreases in premium costs, and one of those discussions focuses around reinsurance. Can you very quickly give a description of what reinsurance is?

Ms. UCCELLO. Sure. Reinsurance is that plans who have a high-cost person who spends, you know, has a catastrophic accident or something, that plan is going to be reimbursed for the spending on that person, and so by reimbursing that spending, their costs are, in effect, subsidized so they can lower their premium.

Mrs. ELLMERS. And who pays that subsidy or that reimbursement?

Ms. UCCELLO. So, in this particular reinsurance program, it is for the individual market and it is funded by assessments on all plans.

Mrs. ELLMERS. So all plans will pay an increased cost.

Ms. UCCELLO. It is a——

Mrs. ELLMERS. To pay for the subsidy?

Ms. UCCELLO. Yes, but it's a—Chris, I don't know if you know. It is like it is $5.

Mr. CARLSON. $5.25.

Ms. UCCELLO. $5.25 per member.

Mr. CARLSON. And it includes self-insured plans have to pay it, too.

Mrs. ELLMERS. And I am sorry, $5.25. What—can you——

Mr. CARLSON. Per individual per month. So every member that's enrolled in the plan, whether it is insured or self-insured, they're responsible for paying $5.25 per month for that individual.

Mrs. ELLMERS. $525?

Mr. CARLSON. No, $5.25.

Mrs. ELLMERS. $5.25. Kind of—OK. So it is kind of an insurance on the insurance.

Ms. UCCELLO. Exactly.

Mrs. ELLMERS. And the individual pays that for that premium, the individual pays that.

Ms. UCCELLO. It is incorporated into that——

Mrs. ELLMERS. The cost.

Ms. UCELLO [continuing]. Premium for——

Mrs. ELLMERS. OK.

Mr. Carlson, the subsidies. As far as—I keep hearing about the, you know, the tax subsidies and subsidies. Who pays the subsidies and who benefits from that? What group? Is it income-based, I am assuming.

Mr. CARLSON. It is income based. You know, where those funds come from is the general Treasury basically.

Mrs. ELLMERS. So basically the hardworking taxpayers of America are paying for that.

Mr. CARLSON. Yes.

Mrs. ELLMERS. But we don't really know what that cost is. I mean, overall, do we know what that cost is, how we are going——

Mr. CARLSON. No, I think CBO has made assumptions. I don't know them offhand.

Mrs. ELLMERS. And who would benefit? I mean, is there—when I say income-based, I mean, which individuals will be able to benefit from these subsidies?

Mr. CARLSON. Well, it is everybody up to 400 percent of the federal poverty line, which I believe was $40,000-some for an individual and $80,000, $88,000, I think, for a family of four.

Mrs. ELLMERS. OK. Mr. Durham, part of the discussion today is based on the numbers as they are today and implementation, and you identified that your organization that you are with is headed with this being fully implemented; is that correct?

Mr. DURHAM. That is correct.

Mrs. ELLMERS. OK. Now, has that been—the thought that there are employers who currently cover their employees with healthcare plans, is that being taken into consideration, because many have said that they will not be able to afford this and will have to drop the coverage that they now have on their employees. Has that been taken into consideration?

Mr. DURHAM. In terms of the implementation work that our plans are doing, it is focused on applying to be a qualified health plan through the federally facilitated exchange. So that window just closed and CMS is now reviewing those plans. We are also applying——

Mrs. ELLMERS. But the point is, is that you really haven't projected, yes or no, you have not projected how many plans—how many healthcare plans will be dropped and forced onto exchanges or——

Mr. DURHAM. CBO has projected that. I believe their projections are 6 million in 2016, and that goes up to 7 million in later years.

Mrs. ELLMERS. OK. Mr. Spiro, I have one question for you. You had cited CBO saying that there will be a decrease of 25 million with implementation of Obamacare, that 25 million people who are now uninsured will be insured. Well, I also have a CBO number, and I am wondering if you can explain this to me. May 13th, the CBO came out and said that by 2023, with implementation of Obamacare, there will still be 30 million people left uninsured. Can you describe or explain that discrepancy in about 10 seconds?

Mr. SPIRO. Well, for some people, the cost of insurance will still be too high. For some people, some people are undocumented immigrants.

Mrs. ELLMERS. So this is in accordance with undocumented immigrants; is that how you describe it?

Mr. SPIRO. Undocumented immigrants make up a big chunk of the remaining uninsured, yes.

Mrs. ELLMERS. All right. Thank you, sir. I see my time has expired.

Mr. MURPHY. Thank you.

I recognize the gentlelady from Florida, Ms. Castor 5 minutes.

Ms. CASTOR. Thanks, Mr. Chairman, and thank you for calling this hearing because it is—I appreciate the panel because it is important for all of us to try to cut through some of the political rhetoric right now. I know that is difficult here in the Congress, but you know, when you—when you cut through some of that, that rhetoric, there are some very important reforms and opportunities for small businesses across America and individuals, and you just

have to look at my State of Florida, where about 20 percent—it is actually a little more than that—of individuals in the State of Florida do not have access to health insurance. Over time, it has just been—it has been warped because we kind of kept sick people out, took care of people who were healthy. The large group plans are functioning fairly well, except for these big premium increases over time, but part of the problem is this huge chunk of the uninsured.

So, what the Affordable Care Act does is it gives these folks some important insurance market reforms. It gives them an opportunity to take personal responsibility and come into the market. In Florida, you know, many people in the tourism industry, in retail, the mom and pop restaurant down the street that just didn't have the wherewithal to go out into the individual or small business market and afford insurance. So the Affordable Care Act improves the insurance market in two important ways for these folks.

One, it requires that insurers offer high quality coverage to all without discriminating against people who have preexisting conditions, like cancer, diabetes or asthma. And another way of saying that is that people cannot be denied any longer just because they were sick or had a preexisting condition.

Second, the Affordable Care Act provides some very important tools to make it affordable for small businesses and individuals. Specifically, for small businesses, one of the great secrets that this committee could really to help to spread word on is the fact that we have very substantial tax credits available for our small business owners now. Over 360,000 small businesses across America have already taken advantage of them, and there are millions and millions more small businesses that will be available—that can take advantage of the tax credits.

We also help small businesses by creating this new online marketplace, because what we—what we do, we empower those small businesses now, give them the same negotiating power that the larger employers had in the marketplace by pooling everyone together. So, for small business owners, this is going to be a very positive sea change where they will be able to have that kind of health security and economic security for the owners and their employees.

Now, for individuals, the Affordable Care Act provides very substantial tax credits to families, up to about 400 percent of the poverty level, and people just don't know, that is a good middle class family all the way up to maybe $80,000, $90,000, folks can get some type of tax credit. The medium income in my hardworking district in the Tampa Bay area is about $35,000 per year. A great majority of these folks are going to be able to tap these very robust tax credits.

What I would suggest for people that want to cut through the political rhetoric is they go to the independent Web site of the Kaiser Family Foundation. They set up a calculator to estimate the value of these tax credits for families. It shows that a family of four making the medium national household income of $50,000 will receive tax credits worth up to $6,500.

Mr. Spiro, I wondered, talk to us about how these tax credits will help families afford health insurance coverage. What has been happening in the market prior to this time as these reforms roll in?

Mr. SPIRO. I think one important thing to note about the tax credits is they are advanceable. You can get them right away. You don't have to wait till you file your taxes at the end of the tax year. So it really is an immediate reduction in the costs you would pay out of pocket. You can see it online when you go to the exchanges, what costs you would have to pay. The exchange will automatically determine how much you are eligible for.

And so, for young Americans, this is going to be very important because they disproportionately have lower incomes, and they are the key population, as Cori and others, really the whole panel, I think, agrees, they are the key population that we want to enroll because they are young and healthy and they will keep average premiums low for the whole exchange population.

Ms. CASTOR of Florida. Thank you.

Mr. MURPHY. Gentlelady's time has expired.

Now recognize the gentleman from Ohio, Mr. Johnson, for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

I appreciate the witnesses being here today, by the way. Thank you for taking the time.

For Ms. Ucello and Mr. Carlson, could you identify, please, the aspects of the law that may lead to premium decreases?

Ms. UCCELLO. Did you say decreases?

Mr. JOHNSON. Yes.

Ms. UCCELLO. So the factors that will put downward pressure on premiums, again, include the individual mandate and the premium subsidies, which will help bring in the young and healthy into the insurance market and put, like I said, downward pressure on premiums. In addition, the premium subsidies themselves will directly lower net premiums.

There is also the reinsurance program, which by, again, reimbursing plans for their high-cost enrollees will act as a subsidy to the plan, so that will lower premiums.

There is also the availability of the catastrophic plans for the adults up to age 30 and to those exempt from the mandate, those plans are going to be able to have adjustments to their premiums to reflect the lower expected costs of that population. So those are some of the things that will help put downward pressure on premiums.

Mr. JOHNSON. Any addition to that, Mr. Carlson?

Mr. CARLSON. Well, there were two things I would mention. One, certainly, I would agree that the open competition on the exchanges will, you know, force plans to be careful about their pricing and make sure they have competitive rates. However, on the other hand, you know, they still have a financial responsibility to make sure that they have a premium that is sufficient to cover the claim. So, I think that competition will help there, but on the other hand, you still have to fund the benefits.

And I think the other item that has been discussed is the question of uncompensated care, and the more young individuals and the more enrollment you can get into the program and minimize the uninsured population as much as you can, that will allow plans to get rid of that cost shifting from the uninsured to the commercial market.

The problem is that that will take time for those things to work out and in the system, so that is kind of a longer term goal.

Mr. JOHNSON. Well, these things that decrease a premium, and obviously you've identified some things that would or could, do these items that lower premiums outweigh the items that will increase premiums under the law?

Mr. CARLSON. Certainly not in the short term. I mean, they're——

Ms. UCCELLO. And I think it also depends on for whom you're talking. In certain States, it's possible that there could be premium decreases if they already have market rules that are similar to those that will go into effect in 2014.

Mr. JOHNSON. OK. Mr. Durham, as you are aware, the IRS will be responsible for implementing a great deal of the health care law, mainly enforcement. Have you or your association had any discussions with the IRS about what that role will be, and what the industry can expect from the IRS?

Mr. DURHAM. I have not personally had discussions with the IRS, but other members of my team have had discussions with the IRS. They play a very significant role in implementation, clearly, with regard to the advanced premium tax credits and the system build to ensure that the right information is available to help plans for enrollment.

Mr. JOHNSON. OK. You know, as costs continue to rise, the health care law defenders now say that even though they promised lower costs, that it really doesn't matter if premiums go up, because as Ms. Uccello just pointed out, the subsidies will help. Well, these subsidies phase out after 400 percent of Federal poverty level, which is about $44,000 for an individual, $94,000 for a family of four.

Have you conducted any analysis that has analyzed the impact of the subsidies nationwide, how many individuals will receive them and at what level?

Mr. DURHAM. We have not, but I could look into that for you.

Mr. JOHNSON. OK. My time is almost ready to expire, and I just wanted to end with this comment, Mr. Chairman. You know, the President promised a lot of things in the Affordable Care Act, two very striking things. He said costs will go down, and he said if you want to keep your current health coverage, that you can do so.

I have heard it repeated by my colleagues on the other side several times today that in order to get your premium to go down, you're going to have to take less benefits. That doesn't sound like the promise that the President made to the American people, in my view. And with that, I yield back.

Mr. MURPHY. The gentleman yields back.

I ask unanimous consent for the majority report of March 14th be included in the record. And so ruled.

[The information appears at the conclusion of the hearing.]

Mr. MURPHY. Ms. DeGette, you have——

Ms. DEGETTE. Yes.

I ask unanimous consent for the May 13th Democratic memo, the May 20th Democratic memo, a letter to this committee dated May 20th from Families USA, and a letter dated May 20th to this committee from AARP. And you have all of those, Mr. Chairman.

Mr. MURPHY. Yes. Without objection, they'll also be included in the record.

[The information appears at the conclusion of the hearing.]]

Mr. MURPHY. In conclusion, I'd like to thank our witnesses. Thank you very much. You've given us a lot to think about today and we deeply appreciate your candor and your data. Other questions will be following up.

And I remind members they have 10 business days to submit further questions for the record. And I ask all the witnesses please respond promptly to the questions, because we do appreciate your information on that.

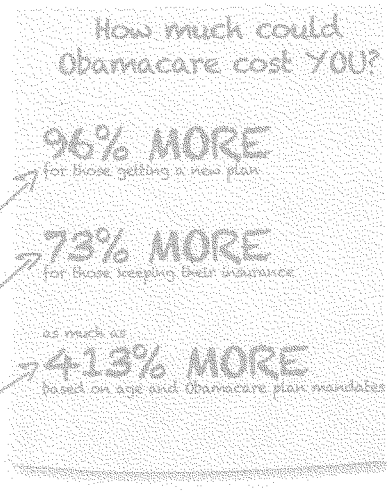
With that, this subcommittee is adjourned.

[Whereupon, at 6:01 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Estimated 2014 Premium Rate Changes due to PPACA

	INDIVIDUAL BUSINESS	
PPACA Item	**New Business**	**Existing Non-Grandfathered Business**
Essential Health Benefits (EHBs) and Cost-Sharing Rules	15.0%	15.0%
Minimum Bronze Level	10.0%	8.0%
Guarantee Issue, Removal of Underwriting Actions	65.0%	10.0%
Insurer Fees	2.3%	2.3%
Reinsurance Recovery*	-10.0%	-10.0%
Risk Adjustment Transfer Payment **	35.0%	35.0%
Reinsurance, Risk Adjustment Fees ($5.33 pmpm)	1.8%	1.8%
Secondary Effect - Small Employer Market Dropout	n/a	n/a
Average Starting Premium Per Member Per Month	$ 158	$ 179
+ Essential Health Benefits (EHB) and Cost-Sharing Rules	$ 182	$ 206
+ Minimum Bronze Level	$ 200	$ 222
+ Guarantee Issue, Removal of Underwriting Actions	$ 330	$ 245
+ Insurer Fees	$ 337	$ 250
+ Reinsurance Recovery*	$ 304	$ 225
+ Risk Adjustment Transfer Payment **	$ 304	$ 304
+ Reinsurance, Risk Adjustment Fees ($5.33 pmpm)	$ 309	$ 309
+ Secondary Effect - Small Employer Market Dropout	$ 309	$ 309
Total Average Change Due to 2014 PPACA-Related Impacts	**96%**	**73%**
Potential Rate Change Ranges* due to:**		
(1) Age Low	-25%	47%	30%
(1) Age High	52%	197%	163%
(2) Minimum Bronze Plan Low	0%	78%	60%
(2) Minimum Bronze Plan High	90%	238%	204%
Both (1) & (2) Low	-25%	33%	20%
Both (1) & (2) High	189%	413%	362%



** Reinsurance recoveries could range from 5% - 15%, with larger variances at the state level based on the block size.*

*** Risk adjustment transfer payment is based on internal data comparisons. While 35% is shown for existing business impact, actual transfer will differ. Additional analysis pending. We expect the risk adjustment transfer to be a payment from Existing Non-Grandfathered Business, since the existing business is largely an underwritten block with lower average morbidity.*

**** Ranges do not account for additional variation due to Area Factor and Underwriting Rating changes.*

***** Premium for Individual book of business is not directly comparable to premium for Small Group book of business in this example due to different inherent benefit levels, geographic mix, and other factors*

Material produced to the U.S. House of Representatives Committee on Energy and Commerce in response to 03/14/13 request. The analyses are not a comprehensive summary of all PPACA-related premium impacts. There may be other factors that impact premiums that are not reflected in the material.

Small Group 2014
Likely Rate Increase Distribution

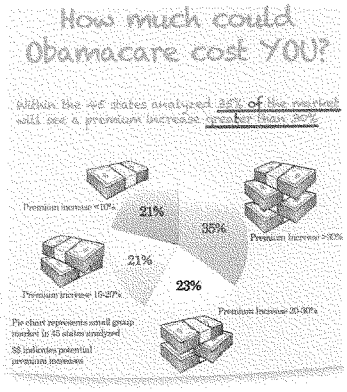
Likely Rate Increase	Community-Rated States	States with Moderate Rating Bands (+/-25% or less)	States with Wide Rating Bands (>+/-25%)	Total Small Group Block
States*	CO, CT, MD, MA, NJ, RI, VT, WA	CA, FL, KY, OR, AL, AR, GA, IL, IA, KS, MN, MS, MT, NE, NC, ND, NM, OK, SC, TX	AZ, DC, DE, ID, IN, LA, MI, MO, NV, OH, PA, TN, UT, VA, WV, WI, WY	
<10%	16%	21%	24%	21%
10-20%	38%	18%	15%	21%
20-30%	32%	23%	17%	23%
>30%	14%	38%	44%	35%

* Excludes NY, AK, HI, ME, NH, SD

Includes: Medical Trend and Demographic Impact (~10%), Insurer Fee & Reinsurance Assessment (3.6%), Product Changes (~3%), Employer Movement (~2%) and Impact of Adjusted Community Rating (includes impact of lacking age, removing gender, industry, group size, and other prohibited adjustments)

Excludes: Impact of risk adjustment (varies by state), impact of re-sloping (revenue neutral but varies by group); and SHOP user fees/assessments.

Material produced to the U.S. House of Representatives Committee on Energy and Commerce in response to 03/14/13 request.
The analyses are not a comprehensive summary of all PPACA-related premium impacts. There may be other factors that impact premiums that are not reflected in the materials.



How much could Obamacare cost YOU?

Examples of actual premium increases projected in the individual and small group markets

One national insurer predicts a 96 percent average increase for new customers in the individual market; Another predicts that small businesses in "nearly all states will see premium increases" in the small group market

Arizona: Potential premium increases ranging from 24 - 35 percent in the individual market and 30 percent in the small group market

California: Potential premium increases from 23 - 86 percent in the individual market and 32 percent in the small group market

Colorado: Potential premium increases from 23 - 55 percent in the individual market and 17 percent in the small group market

Connecticut: Potential premium increases of 36 percent in the small group market

Florida: In the individual market, example of 21-year-old male and female currently enrolled in less comprehensive plans could see increases of 132 and 101 percent respectively; in the small group market, estimated increases ranged from 13 - 23 percent

Georgia: Potential premium increases from 48 - 85 percent in the individual market and 25 percent in the small group market

Idaho: While no overall average was provided, one provider suggested 50 percent of existing customers in the small group market would face premium increases

Indiana: One example provided by an insurer showed a 191 percent increase in the small group market

Illinois: Potential premium increases from 27 - 61 percent in the individual market and 25 percent in the small group market

Maine: Potential premium increases of 55 percent in the small group market

Maryland: Potential premium increases of 18 percent in the small group market

Michigan: Potential premium increases from 23 - 82 percent for males in the individual market, with premiums to vary greatly throughout the state; in the small group market, an estimated 64 percent of plans seeing a decrease and 36 percent seeing an increase

Nevada: Potential premium increases of 31 percent in the small group market

New Jersey: Example of young male and older male in the individual market, premiums could range from 13 and 6 percent increase to 25 and 23 percent decrease, respectively; in the small group market, potential premium increases of 18 percent

Ohio: Potential premium increases from 14 - 20 percent in the individual market and 28 percent in the small group market

Oregon: For one insurer, >35% of existing customers in the small group market will see either no change or an increase of up to 10 percent

Pennsylvania: An average increase of 30 percent in the individual market and 27 percent in the small group market

Tennessee: Potential premium increases from 46 - 54 percent in the individual market and 35 percent in the small group market

Texas: Potential premium increases from 5 - 49 percent in the individual market and 28 percent in the small group market

Utah: For one insurer, ~50% of existing customers in the small group market will see increases from 5 - 45 percent

Virginia: Potential premium increases of 31 percent in the small group market

Washington: For one insurer, >70% of existing customers in the small group market will see either no change or an increase of up to 10 percent; 20% will see an increase from 10 - 20 percent

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May 13, 2013

MEMORANDUM

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Investigation on the Impact on Cost of Coverage of the Affordable Care Act

Today, the Republican staff of the Committee on Energy and Commerce issued a report on the impact of the Affordable Care Act on the cost of coverage in the individual health insurance market. The Republican staff report is deeply flawed. The major methodological error is that the report ignores the provisions of the Affordable Care Act that will reduce costs in the individual market, such as tax credits for individuals and small businesses. The result is a one-sided report full of misleading conclusions that conflict with the findings of independent experts.

Committee Republicans requested information from 17 health insurers on the impact of certain provisions of the Affordable Care Act that could raise premiums in the individual market, such as the requirement of guaranteed issue, community and age rating, the inclusion of essential health benefits, and new taxes on health insurers.[1] The Republicans did not request information regarding the provisions of the Affordable Care Act that would reduce costs in this market, such as the individual tax credits provided in the Affordable Care Act Exchanges and the tax credits for small businesses. The Republicans also did not request information on key cost containment measures, such as the availability of lower-cost catastrophic coverage for young adults.

Because of these data limitations, the Republican report is inherently biased. The majority of Americans receive their coverage as part of a large-employer plan or through

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[1] *See e.g.*, Letter from Chairman Fred Upton et al., to Mark T. Bertolini, President and Chief Executive Officer, Aetna (Mar. 14, 2013). Recipients include Aetna, Blue Cross Blue Shield of Florida, Blue Cross Blue Shield of Michigan, Blue Cross Blue Shield of New Jersey, Blue Shield of California, Cigna Health, Coventry Corp., HCSC, Health Net of California, Highmark, Humana, Independence Blue Cross, Kaiser Permanente, Regence, Unitedhealth, University of Pittsburgh Medical Center, and Wellpoint.

government health insurance programs like Medicare or Medicaid, and they are not affected by changes in the individual market. But some individuals do receive coverage in the individual market. To assess the impact of the Affordable Care Act on the out-of-pocket costs of these individuals, both the provisions that raise rates and well as those that reduce costs need to be taken into account. The Republican report fails this basic test of objectivity.

The Failure to Consider the Impact of Tax Credits and Other Cost Reduction Measures

A review of the documents produced to the Committee show that many insurance companies did not produce analyses that incorporated data on Affordable Care Act programs that were designed to drive down premium costs. This is not surprising as the Republican request to insurers did not seek information on tax credits and other cost containment tools. As a result, many analyses provided to the Committee and released in the Republican report failed to include these factors in the cost of coverage.

It is impossible to determine the impact of the Affordable Care Act in the individual insurance market absent information on the effect of these credits and other cost control measures. According to the Congressional Budget Office, 86% of individuals who receive coverage through the new Affordable Care Act Exchanges will receive tax credits, with the average credit reducing costs by over $5,000 per year.[2] A study of the impact of these tax credits in California estimated that they will reduce premiums by an average of 89% for individuals with an income below 250% of the federal poverty level.[3] Similarly, tax credits available for small businesses will reduce the cost of coverage by as much as 50%.[4]

Some insurers who provided information to the Committee did acknowledge the significant impact of these tax credits. One described the "huge impact" of the subsidies, noting that they are "expected to result in a significant growth in coverage through Individual

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[2] Congressional Budget Office, *CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage* (Feb. 2013) (online at http://cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

[3] Milliman, *Factors Affecting Individual Premium Rates in 2014 for California* (Mar. 28, 2013) (online at http://www.healthexchange.ca.gov/Documents/Factors%20Affecting%20Individual%20Premiums%20FINAL%203-28-2013.pdf).

[4] U.S. Internal Revenue Service, *Small Business Health Care Tax Credit for Small Employers* (2013) (online at http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers).

Exchange."[5] Another identified "Advanced Premium Tax Credits (i.e. Premium Subsidies)" and "Reinsurance Payments" as "Lower cost drivers."[6]

Similarly, many analyses provided to the Committee for the small group market did not take into account tax credits. For instance, one insurer wrote to the Committee that the "small group premium analysis ... does not reflect the effect of any tax credits that may be available for select small employers purchasing through the Small Business Health Options ("SHOP") market place to help cover the cost of coverage."[7]

In addition to the tax credits, the Affordable Care Act established other programs to mitigate any potential premium increases. An Affordable Care Act reinsurance fund will provide funding to insurers to cover costs resulting from the high claims totals of the people they cover.[8] Affordable Care Act risk adjustment provisions protect insurance companies whose plans contain a large number of high-cost enrollees. And Affordable Care Act risk corridors limit insurer losses and gains, reducing incentives for insurers to overestimate beneficiary costs either to protect against losses or to increase profits.[9] While some of the insurance companies took these cost-containment provisions into account, others did not. One insurer that did take these provisions into account provided documents revealing that these three cost containment tools could reduce premiums by 26% in the individual market in one state and by 15% to 19% in other states.[10] Another insurer noted that the reinsurance program alone could decrease projected premium increase by 10% to 13%.[11] A third noted that "Reinsurance is consistently and significantly favorable" in terms of reducing premiums.[12]

Two other key factors not highlighted in the Republican report that must be taken into account when analyzing premiums in the post-reform individual market are transparency and competition. The Congressional Budget Office has estimated that competition and transparency in the new health insurance marketplaces will drive down costs by between 7% and 10%.[13] In

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[5] [Redacted], *The Commercial Market: Public Exchange and other ACA provisions impacting the Small Group and Individual Markets* (Oct. 26, 2012).

[6] [Redacted], *ACA Drivers and Changes in Individual Insurance – Costs for [Redacted] in Our Context* (undated).

[7] Letter from Counsel to Chairman Fred Upton, House Committee on Energy and Commerce (Apr. 1, 2013).

[8] [Redacted], *Pricing Evolution in the context of Health Care Reform* (Dec. 2012).

[9] *Id.*

[10] [Redacted], *2014 pricing methodology and results: [Redacted] Pre-Read* (Mar. 19, 2013).

[11] [Redacted], *2014 HCR Impact Items* (undated).

[12] [Redacted], *[Redacted] Exchange Pricing for 2014* (undated).

[13] Letter from Congressional Budget Office Director Douglas Elmendorf to Senator Evan Bayh (Nov. 30, 2009) (online at http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf).

some states, insurers have indicated that they will significantly lower their proposed rates after seeing the rates proposed by their competitors.[14] In every marketplace, consumers will be able to compare plans with comparable benefits side-by-side and will have the opportunity to select the plan that is right for them.

The Republican report places great emphasis on the rate increases that will be experienced by young, healthy males. But even in this area, the Republican report is one-sided. The report ignores that under the Affordable Care Act, individuals under 30 can purchase low-cost catastrophic coverage. These plans will have higher deductibles and greater cost-sharing than other plans, which will result in lower premiums.[15]

Failure to Account for Improved Benefits

To the extent premiums are increasing, one key factor accounting for this increase is the fact that the health insurance coverage received by millions of people under the Affordable Care Act will be significantly better than the coverage they have now. For example, under the Affordable Care Act, individuals are guaranteed that their plan will pay for between 60% and 90% of the cost of their health care; that their plan will cover a set of essential health benefits such as prescription drugs, maternity care, and mental health care; and that their overall out of pocket costs will be capped. Consumers are eligible for preventive care benefits without copays, co-insurance, or a deductible, and their insurance cannot impose lifetime or annual coverage limits. These benefits will limit out-of-pocket costs and give consumers the security of knowing that their coverage is there for them when they need it.

These increased benefits mean savings for individuals when they need coverage. A fair analysis of the impact of the law on health care affordability would factor these savings into account. The Republican report does not do so.

Premium Rate Decreases in the Individual and Small Group Markets

The documents provided to the Committee reveal that while some consumers in the individual market may see premium rate increases, others will see premium decreases. As one insurer explained in correspondence with the Committee: "the impact of the PPACA is not uniform across all Americans, and ... the impact is likely to vary based on the unique attributes of each state's health care system and market, as well as various demographic factors, such as age."[16]

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[14] *Two Oregon insurers rethink 2014 premiums as state posts first-ever rate comparison,* The Oregonian (May 9, 2013) (online at (www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html).

[15] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review,* 78 Fed. Reg. 39 (Feb. 27, 2013).

[16] Letter from Counsel to Chairman Fred Upton, House Committee on Energy and Commerce (Apr. 1, 2013).

For example, one insurance company document on "HCR Impact" revealed "winners" under the Affordable Care Act: individuals who are "older and/or unhealthy with richer benefits" under their current policies could see a 43% decrease in their premium costs due to the requirements of the law.[17] Another insurer's internal analysis confirms that "[o]lder, sicker populations will have access to coverage and experience some rate relie[f]."[18]

The documents reveal that women in particular are likely to experience reductions in insurance premiums on the individual market. One insurer's internal analysis indicated that as a result of the Affordable Care Act's reforms to gender and age rating, young women in one state would see their premiums decrease by as much as 74%.[19]

The documents provided to the Committee show that many small businesses will also experience rate decreases. One insurance company anticipated premiums to decrease for over 35% of their membership in the small group market in one state and 45% of their small group membership in a different state.[20] Another insurer anticipated premium decreases of as much as 50% for some of their customers.[21]

When analyzing potential premium increases, it is important to note that in the pre-reform individual market, premiums were held down for some policy holders because millions of Americans were either excluded from coverage all together or given an offer of coverage with such unaffordable premiums and cost sharing that they were priced out of the market. When these previously uninsured individuals are allowed into the market, their premiums will be dramatically lower than they would have been if insurers offered them coverage prior to reform.[22]

Most Americans Have Employer Sponsored Coverage or Public Coverage

The majority of Americans receive coverage through their employer or through public programs like Medicare and Medicaid.[23] As the Republican report notes, "most of the insurers

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[17] [Redacted], *HCR Impacts – Front End* (Jan. 31, 2013).

[18] [Redacted], *The Commercial Market: Public Exchange and other ACA provisions impacting the Small Group and Individual Markets* (Oct. 26, 2012).

[19] [Redacted], *Attachment A – Revised April 5, 2013* (Apr. 5, 2013).

[20] *Id.*

[21] [Redacted], *Health Care Reform and Exchanges Transform Employer Markets* (Mar. 2013).

[22] The Henry J. Kaiser Family Foundation, *Why Premiums Will Change for People Who Now Have Nongroup Insurance* (Feb. 6, 2013) (online at http://policyinsights.kff.org/en/2013/february/why-premiums-will-change-for-people-who-now-have-nongroup-insurance.aspx).

[23] The Henry J. Kaiser Family Foundation, *Health Coverage and Uninsured* (online at http://kff.org/state-category/health-coverage-uninsured/).

contacted by the committee had not conducted an analysis on the PPACA's effects on the large group market." No serious analysis has found that large employers will see significantly higher health insurance costs because of the Affordable Care Act. Similarly, public programs are not expected to increase costs to beneficiaries as a result of the Act. Unfortunately, the Republican report glosses over this important limitation on its purported findings.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115

Majority (202) 225-2927
Minority (202) 225-3641

MEMORANDUM

May 18, 2013

To: Subcommittee on Oversight and Investigations Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on "Health Insurance Premiums Under the Patient Protection and Affordable Care Act."

On Monday, May 20, 2013, at 4:00 p.m. in room 2123 of the Rayburn House Office Building, the Subcommittee on Oversight and Investigation will hold a hearing titled, "Health Insurance Premiums Under the Patient Protection and Affordable Care Act."

I. THE HEALTH INSURANCE MARKET PRIOR TO THE AFFORDABLE CARE ACT

Prior to the passage of the Affordable Care Act (ACA), the health insurance market suffered from adverse selection, high administrative costs, and rising premiums. In the decade prior to enactment of the ACA, the percentage of workers receiving health care coverage from their employers declined,[1] premiums increased by 125%, and out-of-pocket health care spending increased by 74%.[2] The number of uninsured was rising rapidly, and many individuals and families with coverage had insurance policies that provided low value and little security if they had a serious accident or illness.[3]

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[1] Kaiser Family Foundation, *Employer Health Benefits Survey 2010 Annual Survey* (online at ehbs.kff.org/pdf/2010/8085.pdf); and Kaiser Family Foundation, *Employer Health Benefits Survey 2011 Annual Survey* (online at ehbs.kff.org/pdf/2012/8345.pdf).

[2] Health Affairs, *A Decade Of Health Care Cost Growth Has Wiped Out Real Income Gains For An Average US Family* (Sept. 2011) (online at content.healthaffairs.org/content/30/9/1630.abstract).

[3] Department of Health and Human Services, *Health Insurance Premiums: Past High Costs Will Become the Present and Future Without Health Reform* (Jan. 28, 2011) (online at www.healthcare.gov/news/reports/premiums01282011a.pdf) and J.R. Gabel et al. *Trends in*

In many states, insurers were permitted to charge individuals dramatically different premiums based on their age, gender, medical history, and other factors. Insurers routinely refused to cover individuals with pre-existing medical conditions and devoted significant resources to the process of medical underwriting – conducting detailed examinations of an applicant's medical history to determine the price at which they could profitably offer coverage to that individual, if at all. In the three years before the passage of health reform the four largest for-profit health insurance companies denied over 600,000 individuals coverage due to pre-existing conditions, with coverage denials increasing significantly each year.[4] As many as 129 million Americans with pre-existing conditions may have been denied coverage prior to reform.[5]

II. AFFORDABLE CARE ACT PROTECTIONS

The ACA established new insurance market consumer protections pertaining to the individual and small group health insurance markets. These provisions only allow premiums to vary based on age, tobacco use, family size, and geography. Beginning in January 2014, insurance companies will no longer be allowed to raise premiums based on any other factors — including pre-existing conditions, gender, and health status. The provisions require a minimum level of coverage and prohibit insurance company abuses like rescissions of benefits when someone gets sick.[6]

In addition to these consumer protections, the ACA creates transparent and competitive marketplaces for high quality insurance to be offered called Exchanges. An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers. Beginning in 2014, individuals who do not have access to employer-based coverage, Medicare, or Medicaid can purchase health insurance on

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Underinsurance and the Affordability of Employer Coverage, 2004-2007, Health Affairs (June 2, 2009) (online at content.healthaffairs.org/content/28/4/w595.full.html).

[4] Memorandum from Chairmen Henry A. Waxman and Bart Stupak to Members of the Committee on Energy and Commerce, *Coverage Denials for Pre-Existing Conditions in the Individual Health Insurance* Market, 111th Cong. (Oct. 12, 2010) (online at democrats.energycommerce.house.gov/Press_111/20101012/Memo.Pre-existing.Condition.Denials.Individual.Market.2010.10.12.pdf).

[5] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *At Risk: Pre-Existing Conditions Could Affect 1 in 2 Americans: 129 Million People Could Be Denied Affordable Coverage Without Health Reform* (Nov. 2011) (online at aspe.hhs.gov/health/reports/2012/pre-existing/index.shtml).

[6] Department of Health and Human Services, *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 77 Fed. Reg. 227 (Nov. 26, 2012) (proposed rule).

either a state-based or, for those who live in states that are not creating their own, a federal Exchange.

The ACA contains an extensive set of tax credits to help small businesses and individuals and families with incomes up to 400% of the poverty level pay for coverage. According to the Congressional Budget Office, 86% of individuals who receive coverage through the new Exchanges will receive tax credits, with the average credit reducing costs by over $5,000 per year.[7] A study of the impact of these tax credits in California estimated that they will reduce premiums by an average of 89% for individuals with an income below 250% of the federal poverty level.[8] Similarly, tax credits available for small businesses will reduce their cost of coverage by as much as 50%.[9]

III. IMPACTS OF HEALTH REFORM ON PREMIUMS

A. Recent Premium Trends

The impact of the ACA on premiums and overall health care costs has been a controversial subject. Although the law has not gone into effect fully, early results appear to indicate that it has been successful at mitigating increases in premiums and increases in overall health insurance costs. The ACA requires insurers to document, submit for review, and publicly justify rate increases of 10% or more. Since this provision of the law went into effect, average health insurance premium increases have declined by more than 30%.[10] The Congressional Budget Office (CBO) has also reported what one analyst called "a sharp and surprisingly persistent slowdown in health care costs" [11] since passage of the ACA, resulting in a significant

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[7] Congressional Budget Office, *CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage* (Feb. 2013) (online at cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

[8] Milliman, *Factors Affecting Individual Premium Rates in 2014 for California* (Mar. 28, 2013) (online at www.healthexchange.ca.gov/Documents/Factors%20Affecting%20Individual%20Premiums%20FINAL%203-28-2013.pdf).

[9] U.S. Internal Revenue Service, *Small Business Health Care Tax Credit for Small Employers* (2013) (online at www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers).

[10] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act* (Feb. 22, 2013) (online at aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.pdf).

[11] *Slower Growth of Health Costs Eases Budget Deficit,* New York Times (Feb. 11, 2013) (online at www.nytimes.com/2013/02/12/us/politics/sharp-slowdown-in-us-health-care-costs.html?_r=0).

drop in deficit projections in CBO's most recent budget update.[12] Similarly, the Health and Human Services Actuary reported earlier this year that health expenditures were growing at their lowest rates in over 50 years.[13]

When the ACA's full set of consumer protections and market reforms go into effect in 2014, the majority of the health insurance marketplace is expected to see limited change in premiums.[14] Plans in the large group insurance market already follow many of the same rules that will be required of the individual and small group markets in 2014, and premiums in that market are expected to be stable. Seniors on Medicare and low income individuals participating in Medicaid will face no changes in premiums. However, questions have been raised regarding what will happen to premiums in the individual and small group market in 2014.

B. Republican Staff Report on 2014 Premiums and Democratic Response

On March 13, 2013, Republican Committee staff issued a report on the impact of the ACA on the cost of coverage in the individual health insurance market.[15] The report, which was based on information provided to the Committee by 17 health insurers, found that "PPACA will increase premiums significantly for most Americans," concluding that the results "definitively contradict the promises that the law will lower costs."[16] Republican staff reported that "consumers purchasing health insurance on the individual market may face premium increases of nearly 100% on average, with potential highs eclipsing 400%."[17]

The Democratic staff produced a memo responding to this report. It found that "[t]he Republican staff report is deeply flawed. The major methodological error is that the report ignores the provisions of the Affordable Care Act that will reduce costs in the individual market, such as tax credits for individuals and small businesses. The result is a one-sided report full of misleading conclusions that conflict with the findings of independent experts."

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[12] Congressional Budget Office, *Updated Budget Projections: Fiscal Years 2013 to 2023* (May 2013) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/44172-Baseline2.pdf).

[13] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services , *National Health Expenditures, Historical Data* (Jan. 2013) (online at www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html).

[14] L.J. Blumberg et al, *Implications of the Affordable Care Act for American Businesses*, Urban Institute (Oct. 2012) (online at www.urban.org/UploadedPDF/412675-Implications-of-the-Affordable-Care-Act-for-American-Business.pdf).

[15] Committee on Energy and Commerce, Majority Staff, *The Looming Premium Rate Shock* (Mar. 13, 2013).

[16] *Id.*

[17] *Id.*

Key flaws in the Republican report that were identified in the Democratic response include:

- The failure to acknowledge that the majority of Americans receive their coverage as part of a large-employer plan or through government health insurance programs like Medicare or Medicaid, and they are not affected by changes in the individual health insurance market.

- The failure to account for the impact of tax credits and other cost reduction measures, described by one insurer as having a "huge impact" in reducing premium costs. According to the Congressional Budget Office, 86% of individuals who receive coverage through the new ACA Exchanges will receive tax credits, with the average credit reducing costs by over $5,000 per year.[18] Tax credits available for small businesses will reduce the cost of coverage by as much as 50%.[19]

- The failure to account for the impact of improved benefits. Under the ACA, individuals are guaranteed that their plan will pay for between 60% and 90% of the cost of their health care; that their plan will cover a set of essential health benefits such as prescription drugs, maternity care, and mental health care; and that their overall out-of-pocket costs will be capped. Consumers are eligible for preventive care benefits without copays, co-insurance, or a deductible, and their insurance cannot impose lifetime or annual coverage limits. These benefits will limit out-of-pocket costs and give consumers the security of knowing that their coverage is there for them when they need it. These increased benefits mean savings for individuals when they need coverage.

- The failure to account for the impact of transparency and competition. The Congressional Budget Office has estimated that competition and transparency in the new health insurance marketplaces will drive down costs by between 7% and 10%.[20] In some states, insurers have indicated that they will significantly lower their proposed rates after seeing the rates proposed by their competitors.[21]

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[18] Congressional Budget Office, *CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage* (Feb. 2013) (online at cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf).

[19] U.S. Internal Revenue Service, *Small Business Health Care Tax Credit for Small Employers* (2013) (online at www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers).

[20] Letter from Congressional Budget Office Director Douglas Elmendorf to Senator Evan Bayh (Nov. 30, 2009) (online at www.cbo.gov/sites/default/files/cbofiles/ftpdocs/107xx/doc10781/11-30-premiums.pdf).

[21] *Two Oregon insurers rethink 2014 premiums as state posts first-ever rate comparison,* The Oregonian (May 9, 2013) (online at (www.oregonlive.com/health/index.ssf/2013/05/two_oregon_insurers_reconsider.html).

- The failure to acknowledge the impact of ACA provisions to mitigate premium increases, such as the reinsurance fund to cover costs resulting from the high claims beneficiaries, risk adjustment provisions to protect insurance companies whose plans contain a large number of high-cost enrollees, risk corridors that limit insurer losses and gains and reducing incentives for insurers to overestimate beneficiary costs, and the availability of lower-cost catastrophic plans for individuals under 30.

- The failure to acknowledge premium reductions for many purchasers of health insurance. The documents provided to the Committee reveal that while some consumers in the individual market may see premium rate increases, others will see premium decreases. One insurance company document on "HCR Impact" revealed "winners" under the ACA: individuals who are "older and/or unhealthy with richer benefits" under their current policies could see a 43% decrease in their premium costs due to the requirements of the law.[22] Another insurer's internal analysis confirms that "[o]lder, sicker populations will have access to coverage and experience some rate relie[f]."[23] Women in particular are likely to experience reductions in insurance premiums on the individual market. One insurer's internal analysis indicated that as a result of the ACA's reforms to gender and age rating, young women in one state would see their premiums decrease by as much as 74%.[24]

IV. WITNESSES

The following witnesses have been invited to testify:

Dan Durham
Executive Vice President, Policy and Regulatory Affairs
American's Health Insurance Plans

Cori Uccello
Senior Health Fellow, American Academy of Actuaries

Chris Carlson
Actuarial Principal, Oliver Wyman

Topher Spiro
Vice President, Health Policy, Center for American Progress

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[22] [Redacted], *HCR Impacts – Front End* (Jan. 31, 2013).

[23] [Redacted], *The Commercial Market: Public Exchange and other ACA provisions impacting the Small Group and Individual Markets* (Oct. 26, 2012).

[24] [Redacted], *Attachment A – Revised April 5, 2013* (Apr. 5, 2013).

May 20, 2013

The Honorable Tim Murphy
Chairman
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Diana DeGette
Ranking Member
House Energy and Commerce Committee
Subcommittee on Oversight and Investigations
United States House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

I write to you on behalf of Families USA, a national nonprofit, non-partisan organization dedicated to the achievement of high-quality, affordable health care for all Americans.

Starting in January 2014, the Affordable Care Act will extend health coverage to millions of Americans. Middle- and low-income Americans will receive premium tax credits to help offset the cost of private health insurance. These tax credits will enable many previously uninsured individuals and families to purchase quality health care coverage through the health insurance marketplaces.

Premium Tax Credits Help Millions of Americans Access Affordable Health Insurance

Families USA commissioned *The Lewin Group* to use its widely respected Health Benefits Stimulation Model to estimate how many people across the country could benefit from the new premium tax credits in 2014. We found that an estimated **25.7 million** people will be eligible for tax credits in 2014. In Pennsylvania, **896,000 people** will be eligible for the tax credits in 2014. More than **466,000 Coloradans** will be eligible for the tax credits in 2014.

Many of the people who will be eligible for the tax credits will be in working families **(about 88 percent)** and will have incomes between two and four times poverty, or between $47,100 and $94,200 for a family of four based on 2013 poverty guidelines. However, because the size of the tax credits will be determined on a sliding scale based on income, those with the lowest incomes will receive the largest tax credits, ensuring that the assistance is targeted to the people who need it most. Young adults are the likeliest age group to be eligible for the credits.

How the Premium Tax Credits Work

The premium tax credits will act like subsidies in that individuals and families will receive help as they buy insurance, rather than having to wait until they file taxes to receive reimbursement through a tax refund.

And the help is available to individuals and families even if they do not owe any taxes. The size of the tax credit is calculated based on one plan offered in the new state marketplaces—the so-called "silver reference plan." However, once the size of the credit is determined, it can be used towards the purchase of any private plan in the marketplace that the individual or family chooses to purchase.

Here is an example of how the tax credit size is calculated:

The Johnsons, a family of four (two adults, two children under age 18), with an annual income of $35,300 (about 150 percent of poverty): If the annual premium for the silver reference plan for family coverage in the state marketplace in the Johnsons' zip code is $12,500, the family's out-of- pocket contribution for premiums for a silver reference plan would be about $1,410 (about $118 a month). The remainder of the family's premium for the silver reference plan would be covered in the form of a tax credit of $11,090. (That amount could also be credited toward premiums for a more or less expensive plan of the family's choice).

National, State and County-Level Premium Tax Credit Data is Available

Premium tax credits will help more than 25 million Americans afford their health insurance premiums and 88 percent of these people are in working families. As we draw closer to the start of the open enrollment period in October, it is essential that states across the country work to inform their residents of this opportunity for assistance. Come January 2014, comprehensive, affordable health coverage will finally become a reality for millions of Americans.

If you would like more information on national, state, or county-level estimates of the number of people eligible for the new premium tax credits, I invite you to read Families USA's *"Help is At Hand Report."* http://www.familiesusa.org/resources/newsroom/press-releases/2013-press-releases/national-tax-credit-eligiblility.html. And, here is a link to the state reports http://www.familiesusa.org/help-is-at-hand/state-reports.html.

Sincerely,

Ron Pollack
Executive Director

May 20, 2013

Chairman Tim Murphy
House Energy & Commerce
Subcommittee on Oversight & Investigations
2125 Rayburn House Office Building
Washington, DC 20515

Ranking Member Diana DeGette
House Energy & Commerce
Subcommittee on Oversight & Investigations
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairman Murphy and Ranking Member DeGette:

Between 1999 and 2009, health insurance premiums rose 131 percent while inflation over that same period was just 28 percent.[1] Such increases have taken a significant toll on Americans and their ability to pay for basic needs or save for retirement. At the same time, the coverage for which people pay has gotten less comprehensive. The Affordable Care Act (ACA) begins to address these challenges. Under the ACA, the coverage offered to all Americans will be better than previously available and critical subsidies and tax credits will be provided to help offset barriers posed by affordability.

We have begun to see evidence in the states of the effect of a transparent marketplace on prices. Last week, Washington State reported that Premera Blue Cross will offer a plan for 21-year-old non-smokers that previously cost $325 per month but will now be available on the exchange for $276, a reduction of 15 percent. And while a plan aimed at Washington's 40 year old non-smokers offered by another carrier will show a small increase of $32 per month, it will provide more benefits because of the ACA and also offer critical prescription drug coverage. In Oregon, we have now seen plans reduce their proposed rates after viewing their competition's prices in the exchanges, with one Oregon carrier requesting their initial proposal be reduced by 15 percent.

Under the ACA, Americans will no longer face coverage that comes with lifetime caps, and no one can be denied coverage due to a pre-existing condition. Coverage will be improved through an essential health benefits package, a limit on out-of-pocket expenses, and a requirement that an insurer spend 80 cents of every dollar on health

[1] *Kaiser Family Foundation And Health Research and Family Trust Annual Survey 2009*, "Employer Health Benefits," page 2: http://kaiserfamilyfoundation.files.wordpress.com/2013/04/7936.pdf

coverage rather than administrative costs. In short, Americans will obtain better coverage for their premium dollar.

Nearly 60 percent of Americans get their health insurance coverage through their employer. About seven percent of non-elderly Americans currently purchase health insurance on the individual market. Older Americans not yet eligible for Medicare are among the fastest growing group of uninsured. These older Americans – as well as other uninsured Americans, will now be eligible for coverage via the competitive insurance marketplaces being established across the nation. For Americans who are uninsured and/or make less than 400 percent of the federal poverty level, tax credits and subsidies will be available to assist in purchasing coverage. Many young American have already received coverage by staying on their parents' coverage. A recent analysis also found, "Over 90 percent of young adults age 21–27 purchasing single non group coverage in the exchanges [will] receive significant subsidies that limit their costs as a share of their income."[2]

AARP also supports efforts to encourage employment, including the elimination of barriers to self-employment. One of those barriers, particularly for older Americans, is often the need for health insurance. We are hopeful that those older entrepreneurial Americans, freed from the need to stay with an employer in order to continue health coverage – a concept known as "entrepreneurship lock" – will be more able to begin their own businesses. In fact, a Kauffman-RAND Institute for Entrepreneurship Public Policy study said the elimination of job lock could increase the number of new U.S. businesses by as much as 33 percent over several years as prospective entrepreneurs feel less constrained to stay in a job simply to keep their health coverage.[3] This is especially important for our members age 50-64, many of whom have considerable professional experience, yet continue to face trouble securing full time employment as well as still need health insurance. The ACA's market reforms and new purchasing options will assist older Americans in protecting their health while, at the same time, allowing them greater freedom to start their own businesses. We see this as a win-win.

Throughout the development of the ACA, AARP was especially concerned about the long-term health prospects of our members age 50-64 who, prior to passage, were ofte either denied coverage outright due to pre-existing conditions or asked to pay prohibitively more in premiums than younger people. We supported limiting age rating i order to protect older Americans from an individual market which often made health insurance either unaffordable or unobtainable. The Urban Institute study found, "use of the 3:1 band ... results in age-based premiums that more accurately match age-related costs among likely purchasers than would a looser rate band. The now-common 5:1

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[2] *Urban Institute*, "Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Rating Bands in Nongroup Health Insurance, Quick Takes, March 2013

[3] Maltby, Emily. "Will Health-Care Law Beget Entrepreneurs?" *The Wall Street Journal* 8 May 2013, www.wsj.com.

age rating tends to undercharge young adults relative to their actual health care expenses and to overcharge older adults relative to theirs..." [4]

As the ACA continues to be implemented, AARP and its members welcome the market reforms contained within the law compelling health insurance companies to offer products protecting policy holders from the financial ravages of unforeseen medical challenges. We applaud the significant payment reforms the ACA brings in terms of affordability and assistance to cover as many Americans as possible. We believe the marketplace improvements will have long-term benefits, both from a healthier citizenry and for the long-term economic outlook of the United States.

Our 38 million members all across the nation find many of the provisions of the ACA to be beneficial for not just older Americans – but also for the entire healthcare system. While much progress has been made, there is still more to be done to tackle high and wasteful health care spending. AARP remains committed to continuing to make our members' voices heard to promote critical health insurance protections, market reforms and affordability programs that help all Americans access the care they need at a price they can afford.

If you have any questions, please feel free to contact me or have your staff contact Ariel Gonzalez of our Government Affairs staff at 202-434-3770 or agonzalez@aarp.org.

Sincerely,

Joyce A. Rogers

Joyce Rogers
Senior VP, Government Affairs

[4] *Urban Institute*, "Implications of Limited Age Rating Bands Under the Affordable Care Act," Timely Analysis of Immediate Health Policy Issues, March 2013.

June 6, 2013

Ms. Cori Uccello
Senior Health Fellow
American Academy of Actuaries
1850 M Street, N.W., Suite 300
Washington, D.C. 20036

Dear Ms. Uccello:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Monday, May 20, 2013, to testify at the hearing entitled "Health Insurance Premiums Under the Patient Protection and Affordable Care Act."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Thursday, June 20, 2013. Your responses should be e-mailed to the Legislative Clerk in Word format at brittany.havens@mail.house.gov and mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

AMERICAN ACADEMY *of* ACTUARIES

June 18, 2013

The Honorable Tim Murphy
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Chairman Murphy:

I appreciate the opportunity to respond to follow-up questions from the subcommittee's May 20 hearing, *Health Insurance Premiums Under the Patient Protection and Affordable Care Act* (ACA), at which I testified on behalf of the American Academy of Actuaries.[1] My responses to the specific questions from you and Representative Butterfield are below.

Chairman Tim Murphy

1. Are premium estimates calculated assuming that all people will sign up for coverage or that some will not obtain coverage?[2]

Premium estimates are typically calculated assuming that not all individuals will obtain health insurance coverage. The 2014 premiums that health insurers currently are submitting for review and consideration are being calculated using assumptions regarding how extensive participation will be and the demographic and health status characteristics of those obtaining coverage. These calculations will consider participation not only from the currently uninsured population but also among those currently with coverage who may shift from one type of coverage to another or drop coverage altogether. These assumptions will reflect many factors including the anticipated effectiveness of the individual mandate and how an individual's anticipation of health care needs (plus any financial penalty for going without coverage) compares with the insurance premium charged (net of any subsidies).

For health insurance markets to be viable, they must attract a broad cross-section of risks. In other words, they must not enroll only higher-risk individuals; they must enroll people who are lower risks as well. If an insurance plan attracts only those with higher than average expected health care spending, otherwise known as adverse selection, then premiums will be higher than

[1] The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.
[2] As requested by Chairman Murphy, this response elaborates on my response given during the hearing.

average to reflect this higher risk. Attracting healthier individuals ultimately will help keep premiums more affordable and stable.

To ensure that people in poor health have access to health insurance, the ACA prohibits insurers from denying coverage or charging higher premiums to those with higher expected costs due to their health status. These prohibitions generally will result in an increase in average health insurance premiums, unless a broad cross-section of people participate in the private health insurance market—the young as well as the old, and the healthy as well as the sick.

The Honorable G.K. Butterfield

1. Will consumers in eastern North Carolina get better value from their insurance premiums under the Affordable Care Act?

This response focuses on the ACA provisions that apply to non-grandfathered plans in the individual market. How the value consumers receive from their insurance premiums under the ACA will compare to that before the ACA depends on several factors, including individual characteristics (e.g., age, gender, health status) and how a state's current issue and rating rules compare to those under the ACA provisions that will commence in 2014. In general, the ACA will impose more restrictive issue and rating rules in states like North Carolina that currently allow insurers to underwrite and vary premiums by health status and other factors. The compression of premiums due to the new age rating restrictions will increase the relative premiums for younger adults and reduce them for older adults. Prohibiting different premiums by gender will shift costs between men and women, depending on age. And prohibiting health status rating will increase the relative premiums for healthy individuals and reduce them for those in poor health. Premium subsidies may lower net premiums for low- and moderate-income individuals and families.

Although young adults not eligible for premium subsidies may be most at risk for premium increases, they will have access to catastrophic plans. The premiums for these plans will be allowed to be set lower to reflect a younger enrollee population.

These new features need to be considered in conjunction with other provisions that will affect the underlying composition of the insured population, and therefore, premiums. ACA's guaranteed issue provision will prohibit insurers from denying coverage based on pre-existing conditions. This increased ability of high-cost people to purchase coverage could put upward pressure on premiums. The individual mandate and the premium subsidies will mitigate this effect by providing incentives for younger and healthier people to obtain coverage. Whether individuals shift between different types of coverage also can affect the risk pool. If employers drop coverage and workers shift to the individual market, the impact on individual market premiums will depend on the demographics and health status of those shifting. Individuals moving out of high-risk pools and into the individual market will put upward pressure on premiums. Offsetting this effect in the near term will be the temporary reinsurance program.

Premiums will reflect a plan's benefit design, with more generous plans coming with higher premiums. New essential health benefit and actuarial value requirements could mean that plans

will be more generous. While this could put upward pressure on premiums, it also will lower out-of-pocket costs.

2. Can you describe some of the additional benefits insurance plans may offer to my constituents due to consumer protections under the Affordable Care Act?

Several ACA provisions offer consumer protections for non-grandfathered plans purchased in the individual and small group markets. Implementation of the ACA guaranteed issue provision means that individuals with pre-existing health conditions cannot be denied health insurance coverage. The prohibition on varying premiums by health status means that individuals with pre-existing health conditions cannot be charged higher premiums than other individuals.

The ACA essential health benefit provision requires plans to offer a comprehensive set of benefits and lists a set of 10 health care service categories that plans must cover. The ACA actuarial value provision requires that, except for catastrophic plans, plans must meet certain thresholds regarding the share of allowed health spending that is paid for by the plan, on average.

Other consumer protections include:

- Standardized information regarding plan benefits and coverage,
- Coverage of certain preventive health services with no cost sharing requirements,
- The prohibition of annual and lifetime benefit limits,[3] and
- The right to appeal health insurance plan decisions.

*****

If you have additional questions or would like more information regarding my responses, I would welcome the opportunity to speak with you further. Please feel free to contact me at 202.223.8196 or Uccello@actuary.org.

Sincerely,

Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

cc: The Honorable Diana DeGette, Ranking Member
The Honorable G. K. Butterfield

[3] The prohibition on lifetime benefit limits also applies to grandfathered plans. The prohibition on annual benefit limits also applies to grandfathered plans in the small group market but not the individual market.

June 6, 2013

Mr. Chris Carlson
Actuarial Principal
Oliver Wyman Group
1166 6th Avenue
New York, NY 10036

Dear Mr. Carlson:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Monday, May 20, 2013, to testify at the hearing entitled "Health Insurance Premiums Under the Patient Protection and Affordable Care Act."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

U.S. SENATE
COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS
"A NEW, OPEN MARKETPLACE: THE EFFECT OF GUARANTEED ISSUE AND NEW RATING RULES"
THURSDAY, APRIL 11, 2013

QUESTIONS FOR THE RECORD

Questions from The Honorable Henry A. Waxman:

Mr. Christopher Carlson

1. Your testimony discusses 2014 insurance premiums in Oregon, stating that, "the average premium rate in these files represents an increase of 36 to 53 percent over current premium rates." This conclusion stands in contrast to the findings other experts who have reviewed the rates. To help understand the differences, we ask that you provide the Committee with a detailed description of the analysis conducted for your testimony, including descriptions of which carriers and plans you included in the analysis, and spreadsheets or other materials showing all comparisons that were made in your analysis.

   Chris Carlson: My analysis was based on the rate filings published by the Oregon Insurance Division at http://www.oregonhealthrates.org/. The three filings I based my review on were the Individual (Major Medical) filings prepared by Kaiser Foundation Health Plan of the Northwest (Kaiser), Providence Health Plans and Regence BlueCross BlueShield of Oregon. These three insurers represent three of the largest health insurers in the state of Oregon.

   The Providence filing explicitly states on the first page (labeled as Exhibit 2, Page 47) that the proposed rate increase is 53.2 percent, on average.

   For the Kaiser filing, I relied upon the exhibit labeled "Development of Rate Change or Base Rate" on page 51 of the PDF document. The calculation of the presumed rate increase is based on "Row (29) – 2014 Premium Requirement" divided by "Row (27) 2013 Premiums (Current)." This calculation is $296.93 divided by $217.63 minus 1, or 36.4%.

   For the Regence filing, we also relied upon the exhibit labeled "Development of Rate Change or Base Rate" on page 9 of the PDF document. The calculation of the presumed rate increase is based on "Row (AH) – Required Revenue" divided by "Row (AD) Earned Premium in the Experience Period." This calculation is $302.91 divided by $211.05 minus 1, or 43.5%. However, I note that this calculation is comparing the rates for calendar year 2012, which represents the experience period. If more recent premiums are considered, the calculation would reflect rate changes since the experience period and the increase would be revised to 32.3% (Row (AH) divided by Row (AF)).

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225-2927
Minority (202) 225-3641

June 6, 2013

Mr. Topher Spiro
Vice President, Health Policy
Center for American Progress
1333 H Street, N.W., 10th Floor
Washington, D.C. 20005

Dear Mr. Spiro:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Monday, May 20, 2013, to testify at the hearing entitled "Health Insurance Premiums Under the Patient Protection and Affordable Care Act."

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Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Center for American Progress

1333 H Street, NW, 10th Floor
Washington, DC 20005
Tel: 202.682.1611 • Fax: 202.682.1867

www.americanprogress.org

June 18, 2013

The Honorable Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Murphy:

Thank you for inviting me to testify at the hearing entitled "Health Insurance Premiums Under the Patient Protection and Affordable Care Act." After the hearing, Members of the Subcommittee submitted additional questions for the record; my responses to these questions are attached.

Please do not hesitate to contact me should you or other Members have additional questions on this topic or other health care topics.

Sincerely,

Topher Spiro
Vice President for Health Policy

Attachment

The Honorable Marsha Blackburn

1. **I am told that a recently published ACA market reform rule will significantly impact the ability of a farmer cooperative program to remain in its own separate risk pool, and will require these farmers to be included as part of a statewide individual or small group pool. Today, over 40,000 farmers, their family members, and employees across 37 states are able to purchase coverage through a farmer-owner program that pools the risks of just its own members. Premium costs for coverage within this farmer cooperative program have been very stable over the past several years and are commonly below the cost of coverage for similar or lesser coverages available in local individual or small group markets. This insurance program is farmer owned and driven to provide for their special health insurance needs. My concern is that if these farmers are no longer able to maintain their own separate risk pool, isn't it very possible that their premiums will increase due to the possibility that the statewide risk pool could prove less stable, and more risky, than their well established, present-day farmer coop pool?**

The farmer cooperative program is likely an "association health plan." If this coverage is self-insured, the ACA market reform rule would not apply. If however this coverage is sold by an issuer, the ACA market reform rule could apply. In most cases, the size of the individual employers (farmers in this case) would determine whether the coverage is offered in the small or large group markets. In rare cases, the association of employers could sponsor a group health plan subject to ERISA, the association itself would be considered the employer, and its size would determine whether the coverage is offered in the small or large group markets. If the farmer cooperative program is one of these rare cases, the coverage would be offered in the large group market, and the ACA market reform rule would not apply. To determine whether this is the case, you should contact the Department of Labor's Employee Benefits Security Administration. Finally, if the coverage is grandfathered, the program could maintain its own separate risk pool.

Note that in general, there is a good reason for applying the ACA market reform rule to association coverage. If the rule did not apply, these plans could continue to "cherry pick" healthy people, driving up premium rates for everyone else enrolled in non-association coverage.

The Honorable G.K. Butterfield

1. **Will consumers in eastern North Carolina get better value from their insurance premiums under the Affordable Care Act?**

Yes. In the current dysfunctional market, many insurance products do not provide real insurance; they are riddled with loopholes and significant coverage gaps. The Affordable Care Act ensures coverage of essential health benefits, guarantees access to coverage, and prevents rate shock when people age or get sick—security that provides real value to everyone. In addition, the "medical loss ratio" ensures more value for your premium dollar by requiring insurers to use at least 80% of your premium for actual health care, not administrative costs.

Finally, the Exchanges will allow consumers to more easily shop for and compare plans, which will have to compete based on value rather than their ability to screen out unhealthy people.

2. Can you describe how tax credits can help a young and healthy male from Warrenton, North Carolina reduce the amount he pays for health insurance?

Suppose that the young and healthy male from Warrenton, NC is age 25 and earns an annual income of $25,000. Further suppose that the annual premium for a plan offered in the non-employer market is $3,030 (CBO's estimate of the national average). This individual would be eligible for a tax credit of $1,301, covering 43% of the premium for a Silver plan and 52% of the premium for a Bronze plan. Keep in mind that this individual could also be eligible for his parents' coverage or could buy a less expensive catastrophic plan. You can calculate these credit amounts for different ages and incomes by using the Kaiser Family Foundation's online subsidy calculator at http://kff.org/interactive/subsidy-calculator/.

3. Can you provide additional examples of insurers lowering premiums through increased competition in the Individual Exchanges?

In California, competition has already resulted in a choice of plans that provide top value. Thirty-three plans competed to offer coverage through the Exchange, called Covered California. As the Washington Post pointed out, "health plans know that they're competing against others for the chance to access millions of customers with tax subsidies"—which put downward pressure on their premium bids. Covered California selected thirteen plans that offered the best value, providing consumers a choice of three to six plans even in rural areas. Four of these plans are new entrants to the market. As a result of this competition, premiums will be lower than actuaries had projected.