OBAMACARE IMPLEMENTATION: HIGH COSTS, FEW CHOICES FOR RURAL AMERICA

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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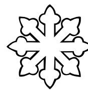

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OBAMACARE IMPLEMENTATION: HIGH COSTS, FEW CHOICES FOR RURAL AMERICA

Monday, November 25, 2013

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
WASHINGTON, D.C.

The Committee met, pursuant to call, at 10:02 a.m., in the Hall County Government Center, Commission Meeting Room, 2875 Browns Bridge Road, Gainesville, Georgia, Hon. Rob Woodall presiding.

Present: Representatives Woodall, Collins, Meadows.

Also Present: Mr. Kingston and Mr. Gingrey.

Staff Present: Caitlin Carroll, Deputy Press Secretary; John Cuaderes, Deputy Staff Director; Linda Good, Chief Clerk; Meinan Goto, Professional Staff Member; and Emily Martin, Counsel.

Mr. WOODALL. The Committee will come to order.

This is a Congressional Oversight Committee hearing. We exist to secure two fundamental principles. First, Americans have a right to know that the money Washington takes from them is well spent. And second, Americans deserve an effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold government accountable to the taxpayers because taxpayers have a right to know what they get from their government.

We will work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the federal bureaucracy. This is the mission of the Oversight and Government Reform Committee.

At this time, I would like to ask unanimous consent that the gentleman from Georgia, Mr. Kingston, and the gentleman from Georgia, Dr. Gingrey, be allowed to participate in today's hearing. Without objection, so ordered.

I want to welcome you all here today for this very important field hearing on the status of the Affordable Care Act's implementation, known to many of us as Obamacare.

I want to thank our Committee's Chairman, Darrell Issa, who unfortunately could not be here with us today, for allowing the committee to hold this hearing. I also want to thank my good friend and colleague whose district we are in right now, Doug Collins, for being the driving force behind this hearing. Without his incredible leadership, we would not be here today, this hearing would not be happening. I am grateful to him for that.

Mr. COLLINS. Thank you.

Mr. WOODALL. We know about the sticker shock that so many Americans are facing today, those self-employed individuals and small business owners who have been getting their insurance on the individual market canceled, and are experiencing rude awakening when they find out, because of the Obamacare mandates, their policies can no longer be continued. But the new Obamacare policy costs more and covers less of the many products that are so important to them. Many more individuals are learning that their doctor is not available to them through their new and, quote, "better" plan.

The numbers do not lie. According to an Associated Press report earlier this month, 900,000 Californians, 130,000 Kentuckians, 140,000 Minnesotans, and nearly 400,000 Georgians have received cancellation notices. In just those four states, that is nearly two million Americans who have already been affected by Obamacare's unnecessary mandates.

At this time, I would like to ask unanimous consent to insert that AP article into the record. Seeing no objection, so ordered.

Mr. WOODALL. According to a recent Heritage Foundation report, Obamacare is succeeding in at least one area. It is destroying individual market competition. There are currently 360 insurers in America that serve at least 1000 individuals—360 insurers that serve at least 1000 individuals. Under Obamacare, that number will drop by 29 percent to only 254 insurers.

In Georgia, there are currently 11 insurers in the individual marketplace, but under Obamacare, there will only be five. That is a 55 percent decrease in insurance competition.

North Carolina will go from 12 insurers to two, an 83 percent drop.

And in two states, New Hampshire and West Virginia, there will only be one individual market insurer left under Obamacare.

I would like to ask unanimous consent to enter that Heritage Foundation report into the record. Seeing no objection, so ordered.

Mr. WOODALL. We know that choice and competition drive prices down and increase consumer service. By driving insurers out of the market, Obamacare is doomed to result in higher prices and in a lower quality of care. And that is before we even begin to experience the certain turmoil that will result from the implementation of the employer mandate next year when large businesses will have to consider whether to increase their costs in order to provide health insurance to their employees, or simply dump those folks onto the exchange.

The lead editorial in today's Chicago Tribune, the President's home state, noted exactly that, that large employers have no incentive to continue their insurance plans, and all of the financial incentives are to dump their employees into the exchange.

Our witnesses today have been experiencing the turmoil in the individual market, experiencing that difficult transition first hand. They can tell us the real world implications of the law and hopefully we can find ways of reforming healthcare that will control costs and will increase quality without creating these negative experiences for so many Americans.

With that, I would now like to recognize my colleague, Mr. Collins, for his opening statement.

Mr. COLLINS. Thank you.

Mr. Chairman, I appreciate being here and I appreciate looking out into this room here, welcoming those who, not only my colleagues that are here from different parts of the state of Georgia, but also my dear friend from North Carolina, Congressman Meadows, who we share a boundary together. Congressman Woodall chairing this and being a part of this today, I appreciate it and with Congressman Kingston and Gingrey providing a lot of experience, I think we are going to have that opportunity today to talk about some really very real issues that are affecting not only northeast Georgia, but America as a whole.

And I am pleased to be here in Gainesville and Hall County for the first Congressional hearing in a little over 10 years. It is good, I can think of no better place in my humble to be here and to hear from the nation and to hear the good and hardworking folks on how our federal government can serve the people better.

I am pleased to be here and as thankful as I am to Chairman Issa and the Oversight Committee staff for the opportunity to hold this hearing today, I wish it could be under different circumstances.

It absolutely pains me to see firsthand the devastating impact that Obamacare is having on our nation, especially our rural communities. The issues my constituents have with Obamacare are not just political. The concerns I continue hearing demonstrate a fundamental philosophical difference between the people of northeast Georgia and the folks who support Obamacare.

First, folks in northeast Georgia and throughout rural America know what it is to live in community. They are generous people who come alongside those who are in need. Doctors and patients in rural America have traditionally been more free to come up with payment arrangements that work for them, so not everyone depends on health insurance. When a major medical expense comes up for someone who cannot afford it, it is people who come together many times in these rural communities.

A community knows itself far more than the Washington bureaucrats and they have far greater interest in meeting the needs of their friends and neighbors than a government agency. The one size fits all nature of Obamacare is an affront to those who know no two communities are the same and not just a one-size approach.

Northeast Georgians are also used to living within our means. Whether we are talking about a dream vacation or sending our child to college, we make financial plans to save enough money to pay for what we want. We are used to making sacrifices to meet our goals. That is why we cannot understand a government that already has catastrophic debt passing a $2.6 trillion healthcare bill into law. Even if all that money was well spent, that is a lot of money to spend today to have our kids and grandkids pay for tomorrow. What rubs salt into the wound is the way the taxpayer money that has been poured into Washington bureaucrats and websites that do not work has literally been wasted.

For a President who has talked so much about economic stimulus, I wonder if he has considered what our economy would look like today if he had taken a more realistic approach to healthcare reform, an approach that did not create so much uncertainty and

take so much out of Americans' wallets. But the biggest fundamental difference between the philosophy of folks in northeast Georgia and the philosophy behind Obamacare can be summed up in two words—individual liberty. Around here, we believe as the founders did, that the function of government should be limited to those that allow each American to pursue their own life, liberty and happiness. Remember, the founders said that we are to have the pursuit of happiness. They did not say the guarantee of happiness, because we have to be a part of that process as well. It is fine for someone else's pursuit of happiness to look different from ours, but frankly, we get offended when someone imposes their version of American dream on us, because each individual story and success is unique.

We do not believe the federal government has the right to compel individuals and families to purchase a product or a service. Even if this Administration had managed a flawless rollout of Obamacare, rural Americans would still have issues with this law. But implementation of this bill has been far from perfect. As I look at our panel of witnesses, one point is abundantly clear. Each of you are here because the President's promises have failed you in some way or they failed someone you know. The barriers to accessible quality healthcare in rural communities are great, but as a result of Obamacare, they are now devastating. In Georgia, three rural hospitals have shutdown already this year and some estimates indicate that 15 more may be closing their doors in the coming months.

Many of you here today probably have growing concerns about Obamacare's impact on you. You may have questions like, ”Will I still be abe to go to my primary care provider?“ ”How far will I have to drive to get the medical services I need?“ ”Will I get to choose among several different providers or just one?“ Or maybe it is even more basic than that. Maybe you are just wondering if you have the ability to keep your job or if your employer will lay you off because he frankly cannot afford Obamacare. Last month, the New York Times reported on the lack of competition in many rural communities resulting in higher premiums. The Times wrote, ”In rural Baker County, Georgia, where there is only one insurer, a 50 year old shopping for a silver plan would pay at least $644.05 before federal subsidies. A 50 year old in Atlanta where there are four carriers could pay $320 for a compatible plan.

Despite the spin that the President and his people try to put on Obamacare, the facts speak for themselves. Families in rural communities will pay more for healthcare under Obamacare. Of the approximately 2500 rural counties served by the federal exchanges, 58 percent have plans offered by only one or two providers. In fact, 530 counties are only served by one provider.

Today, we are going to highlight what the title of this hearing suggests, the high cost and scarce choices facing rural Americans under Obamacare. But I also want to talk about solutions. I would love to hear what our witnesses think Congress can do to promote affordable, accessible medical care in their communities.

Once again, I would like to thank Chairman Issa and his staff, all of our witnesses for being here. I look forward to a constructive

conversation and hope we get some ideas about how to best move forward from here.

And with that, I yield back.

Mr. WOODALL. Thank you, Mr. Collins.

I would now like to recognize the gentleman from North Carolina, Mr. Meadows, for his opening statement.

Mr. MEADOWS. Thank you, Mr. Chairman.

And I want to open up by saying thank you to each one of you who showed up today to hear this hearing. I actually represent western North Carolina, 17 counties from Lenoir, Hickory all the way to Murphy, and we share a common border with Congressman Collins. Not only is he a good friend, but he is someone who really puts the care and concern for the people he represents first. I can tell you first hand, in talking with him on a weekly basis, there is not a week that goes by that he is not saying well, how does this affect the people that I represent. So not only do you have a great representative, but I want to thank you because on a Monday before Thanksgiving, I know there are many other things that you could be doing and yet you are here to express your concern about how this Affordable Care Act that is turning out not to be affordable, is affecting you. And so I want to just say thank you for coming.

I want to thank the witnesses for coming and being willing to share your testimony today. We look forward to hearing from you, hearing that expert testimony and how we can indeed fix it and make sure that it does not affect the people in a more adverse way than it already has.

Many of the facts and figures have been shared today. I can tell you over 473,000 people in North Carolina have lost their coverage. When it comes to being affordable, we are finding out that indeed it is not affordable. You know, even though there were promises made that we could somehow have some insurance policies that were $2500 less, I can give you example after example of people that are having to pay between two and eight thousand dollars more a year to get the same healthcare coverage under this new law. That is troubling to me. I know it is troubling to most of my colleagues, in fact all my colleagues here on the dias. But I also want to say there are a number of other areas that we need to address.

We had a hearing recently in Washington, D.C. where we talked about security and the fact that there has not been a comprehensive security test of this website that continues to malfunction. That is very troubling to me in a time and day and age of identity theft where we would put forth something that should have confidence where people could put in their information and yet we have not done a comprehensive security test. In fact, in that testimony, they were saying that it may not be done for another 60 to 90 days. That is troubling. We had one expert testimony given that said that the best practice would be to take down the site until we can do that security testing. And the question before many of us today is why are we not doing that. We are continuing to rush on to try to meet a November 30th deadline for this website so that we can do that. And even with that, even if it does get up and run-

ning, we know that there are a number of other areas that have been promised that will not be addressed.

I also was to just say that for rural communities—I represent 17 counties, most of them are very rural. When it talks about healthcare and keeping your doctor, that is a critical component, because quite frankly we do not have the choices that you might have in Atlanta, Georgia or the choices that we might have in Washington, D.C., because as you know, healthcare providers, there is a long distance. Dr. Reinhardt is going to be testifying today, I can tell you when we had our two children, we had to travel over an hour and 15 minutes for delivery for my son and daughter. It is not like you just go and check into the hospital right around the corner. It is different.

So I just want to say thank you. We look forward to hearing the testimony and I know the Chairman will be addressing how many of you can provide your testimony for the record, and I just again thank the Chairman, thank the committee staff. This is an unbelievable staff on Oversight and Government Reform. They are diligent, not only on this issue but a number of issues. And to have these hearings where we come out from Washington, D.C. takes a tremendous amount of work. So my thanks to the committee staff, to the folks here at Hall County for being so gracious and hospitable.

And I yield back.

Mr. WOODALL. I thank the gentleman.

I would like to yield to the gentleman from Georgia, Mr. Kingston, for his opening statement.

Mr. KINGSTON. Mr. Chairman, thank you very much for letting me join you. And Mr. Collins, it is always great to be in your area and thank you for letting me come. And same to you Mr. Meadows and Dr. Gingrey, I am proud to be on the dias with you.

As you know, I chair the Appropriations Subcommittee of Health and Human Services, which does the financing for the Affordable Care Act, but also Medicaid and Medicare and Social Security and CMA and so many other vital programs that so many Americans use. So we are very concerned about this from a price tag point of view.

And I just wanted to touch base on a couple of quick things that I want to submit for the record. One, in terms of the objective of Obamacare to reduce the cost of premiums, one need not go outside his own household to hear stories. My daughter who is a 30 year old healthy young woman had her premium go from 160 to 270 a month. And I talked to so many businesses who have experienced the same thing. I talked to a parking lot company in Atlanta, Georgia, 1000 employees. They put 900 on a part time basis. I talked to another business in Cobb County, Georgia, a business that was growing. They stopped at 42 employees, because they knew once they got over 50, they would have a whole new set of rules and regulations under the Affordable Care Act. And so you just think about stopping the growth that you could be having.

I talked to a hospital in south Georgia, and this is a real interesting story of unintended consequences. The hospital identified 65 people which are frequent visitors to the emergency room, 65 people who go basically to the emergency room on a regular basis for

their healthcare needs. What this hospital is doing is actually taking out insurance policies on these 65 frequent visitors. And under Obamacare, they will be able to pay the premium, subsidize for these people, and then be reimbursed for the cost of their medicine and actually come out ahead thousands of dollars by legally gaming the system.

I got a letter from Leonard Blount in Statesboro, Georgia, who is the President of Capstone Benefits. It is a company that deals with healthcare. He said that he had a high deductible plan in which he paid for just about everything until the deductible is met. His premium went from $8020 a year to $14,608. But he was not complaining about the large premium increase. What he was complaining about is that his healthcare high deductible plan has been canceled and is not offered any more and the government sent him a letter saying but do not worry—and this is the exact quote—"Be assured that your new plan meets the requirements of healthcare reform law and provides the major medical benefits and strong financial protection that you need." And he said, please, the government in Washington has no idea what I need. My wife is 58 years old, why would she need prenatal care. And that was what his point was, is that I do not mind the premium increase as much as I am outraged that the federal government is now dictating to me what my family in Statesboro, Georgia needs. I want to submit that for the record.

So, Mr. Chairman, there are so many cases of this, I will submit these. I have another one from Signature Aviation in Savannah where they said our healthcare premium went up, therefore, writing a tenant saying we are just passing the cost on to you. And I would like to submit that.

But thank you for letting me be with you and I look forward to the testimony.

Mr. WOODALL. Thank the gentleman. Without objection, those documents will be submitted into the record.

Mr. WOODALL. Now I would recognize the gentleman from Georgia, Dr. Gingrey.

Mr. GINGREY. Chairman Woodall, thank you very much for giving me the opportunity of being here in Hall County, Gainesville, in northeast Georgia for this very important field hearing, and to join my colleagues, of course Congressman Doug Collins of the Ninth and Congressman Kingston from the First and Mark Meadows from North Carolina, a great member.

I want to just kind of tell the group that is here—and it is a large group obviously—that this is just exactly what we do in Washington. This is a hearing. If there are any C–Span junkies in the room—and I am sure there are—and you watch these hearings sometimes late at night, this is exactly the way it is. You have the committee. The committee of course is usually the full committee, and then four or five witnesses, sometimes you will have more than one panel. In this case, we have one very important panel. And then the audience. Now this audience this morning is just about as big as any audience that I have seen in my 11 years as a member of the House of Representatives.

Oversight is one of the most important things we do. Congressman Kingston mentioned appropriations, of course, paying the

bills, spending the money. But then once those things are committed to, to follow up and to have oversight and Oversight and Government Reform is a separate committee and it is the main committee. And I commend Doug Collins and Rob Woodall and Chairman Issa. But each committee in the House of Representatives actually has an oversight subcommittee and we all do this. I sit on the Energy and Commerce Committee and we have jurisdiction over all of Medicare Part B and C. We have jurisdiction over all of Medicaid and also Peachcare, the SCHIP program. And we have an oversight subcommittee. I sit on both the health and the oversight committees of that committee. So that is the reason why we are doing what we are doing here today. This is just like what we would be doing in Washington, but this obviously is called a field hearing because we are in these districts. And we want to know, we want the audience to be the people that are the most affected by Obamacare, and of course the witnesses, to be the experts on how it has affected them.

So I just wanted to kind of lay that out there and tell you and right from the very start, from my perspective, how I feel about it. The federal government would literally torch a village to kill a gnat. And that is their whole attitude toward things.

What has happened to federalism, which this document talks about, and I am sure all of you believe in, local control and the ability to maintain your own liberty and to buy your own health insurance and the sanctity of the doctor-patient relationship. Sure, the media and the Democrats and this Administration high-fived each other March 23rd of 2010, when this Obamacare became law because they said we have been wanting to do this for 100 years. Well, did you ever think of why maybe they have been wanting to do it for 100 years? Because people 100 years ago did not want to government to take over healthcare, in the days of Woodrow Wilson and Franklin D. Roosevelt, and whoever was trying to push it on their side of aisle. And today, even as we speak, 61 percent of the American people are totally opposed to this abomination.

So I think from that little bit of preface, other than going off my prepared remarks, you get a general idea of how Congressman Gingrey feels about this law. And I definitely look forward and thank the witnesses for being here and look forward to their testimony.

I have been hearing from my constituents for the past seven weeks about these high premiums like my colleagues are talking about. They are in anxiety over finding coverage and even the law's impact on their ability to keep their doctor, to keep their hospital, and to keep their insurance. It is clear that this law was misrepresented from the start. It neither protects patients nor affordable, both to individuals and to the government.

The President's law gives control of one-sixth of our economy to Washington bureaucrats and it imposes a tax increase on middle class Americans and small business owners, many of our witnesses. As the government becomes more involved in healthcare, doctors and patients become further removed from their own care decisions. Dr. Reinhardt will tell us about that. And this results in a more expensive and a more dysfunctional system.

A constituent recently told me that the law has become a financial disaster for his family. The fact is the President's words, "If you already have insurance you like, you can keep it" period, seem to be directly refuted by the millions of cancellation notices already sent to Americans in the past few weeks, many more cancellation notices than sign-ups; right? It does strike me that millions of individuals voted believing one thing and now they find themselves without coverage and they are now scrambling to find coverage in a marketplace that offers only more expensive plans with fewer options for care.

My colleagues have commented in regard to someone 55 years old let us say a single male, does he really need maternity care? And it is just ridiculous what they are trying to do.

We can solve this problem. And I will conclude with this. A lot of times the media, the talking heads on the Sunday morning shows will say well, those Republicans, they just do not have any plan, they want to repeal. But they do not—what are they going to do about the fact that the health insurance in this country, even though healthcare is great and it allows the average man to live to age 78 and the average women to live to age 80, that is far different than back in the 1930s when we first did Social Security and in the 1960s when we did Medicare. So we do have the greatest healthcare system in the world. We just need to address the issues that are making it too costly.

And here is a bill—here is a bill, a comprehensive bill, called the American Healthcare Reform Act. There are seven bullet points on here, not 2700 pages. I am not going to take any more time to go over this, but of course we have a plan. Some of it involves insurance, health insurance reform but of course we have a plan. But we never get the media attention, we never get the press. Let me tell you, that is why I say repeal or go home.

I yield back, Mr. Chairman, and thank you so much for giving me the opportunity.

Mr. WOODALL. Thank you, Dr. Gingrey.

It is now my great pleasure to welcome our first panel of witnesses. Beginning left to right, we have Mr. Raymer Sale. Mr. Sale is the founder and President of E2E Benefits Services and E2E Resources in Duluth, Georgia, which provide employee benefits and HR administration. Mr. Sale founded E2E Benefits and E2E Resources back in 1993 and over the past 20 years, he and his staff have provided services to literally thousands of small business employers and employees. He is the immediate past chairman of the Gwinnett Chamber of Commerce, which is one of the largest chamber organizations in the state, with over 2100 members. And is a member of the Gwinnett Chamber Executive Board. His business has twice been honored as a Pinnacle Small Business Award winner, which distinguishes E2E Resources as one of the top 25 small businesses in Gwinnett County.

I would also like to welcome this morning Dr. Jeff Reinhardt, who is an OB–GYN right here in Gainesville, and the President of The Longstreet Clinic which is one of the largest multi-specialty practices in northeast Georgia with over 550 employees, including more than 150 physicians and mid-level health providers representing over 16 specialties. Dr. Reinhardt's leadership of The

Longstreet Clinic gives him an invaluable window into how Obamacare is already affecting hospitals and private practices.

To his right we have Mr. Michael Boyette who is a small business owner in Ellijay, Georgia. His family's automobile sales business and his own health insurance premiums have been negatively affected by Obamacare and he is here to give us that first-hand story, both of his family and of his business here this morning.

And finally, we have Mrs. Emma Collins from Ellijay, Georgia, who is self-employed. Because of a preexisting condition, she was uninsured. But her condition was manageable and her monthly health bills were very low. Her family has experienced tremendous insurance premium increases thanks to Obamacare. And her family is currently trying to navigate the complicated Obamacare website system. I think there are many Americans who find themselves in that very same situation as Mrs. Collins and her family, and we are so happy to have her here to tell that story today.

As is the custom with the Oversight Committee, pursuant to committee rules, I would ask all witnesses to rise and allow us to to administer the oath. Please raise your right hands.

[Witnesses sworn.]

Mr. WOODALL. Let the record reflect that the witnesses have answered in the affirmative. Thank you. Please be seated.

In order to allow time for discussion, I would ask you all to please limit your opening testimony to five minutes. We have your written testimony, which will be submitted for the record.

You have a timing light there on the table in front of you. Green means go, yellow means we are coming to the end and red means we are there at the end.

It is now my great pleasure to recognize Mr. Raymer Sale.

STATEMENT OF RAYMER M. SALE, JR.

Mr. SALE. Thank you very much, Chairman Woodall and members of the Committee. Thank you for inviting me to participate in this hearing today and I appreciate your interest in the consumers who are living through the implementation of the Patient Protection and Affordable Care Act. This law is complex and does not protect everyone, nor is it affordable in many cases.

Consumers are frustrated with the failure of Healthcare.gov and the high cost of many new policies. We are being led to believe policies in effect prior to 2014 are inferior. Inferior to whose standards? Most of the policies in effect now were purchased to fit the specific needs of the consumer.

We are also being told that cancellation notices are really renewal notices, and this is not true either. The insurance companies are canceling an existing policy, you cannot have that one any more. If you do not select a new policy, your coverage will terminate. By the way, state law controls this and we have not seen the backlash yet that will come when consumers find out their doctors may not be in the network.

Once we get through the individual market, the small and large group plans will be front and center. They will be faced with many of the same issues that are affecting the individual market. Many will see higher premiums requiring new plan designs. You cannot keep your coverage unless it is a grandfathered plan. And just for

the record, the insurance industry has known since 2010 that most plans would lose their grandfather status. Of the roughly 100 employer clients we serve at E2E approximately four have retained their grandfather status and E2E is not one of those.

The law is loaded with opportunities for small and large employers to face severe penalties for not complying with one portion of the law or another. This begins with the age 26 notice that employers were supposed to have distributed back in 2010, to the summary of benefits and coverage that must be distributed at renewal, when an employee is hired, upon a qualifying event, or when requested. Failure to comply with this requirement could result in a fine of $1000. And that is just one requirement. Documentation is imperative because you will have to prove compliance.

As the law matures, this gets worse, as the employer is required to make sure their plans comply with PPACA plan design, track the hours worked by the employees, report the hours to the government, manage hours worked to keep an employee at part time status to control cost, track seasonal employees to be sure they are added to the plan once they pass a certain number of hours, pay higher costs due to new taxes added to the premium. This is going to increase premiums—and it already has—three to four percent. I have got one client that pays $10,000 per month in taxes alone, got about 235 employees covered. Prove to the IRS an affordable plan is offered to the employee, if an employee buys coverage from the exchange. Either upgrade payroll systems or purchase systems that track many of these items mentioned above. All of this is expensive and is a distraction from the main function of the employer, that is to provide services or products and jobs.

E2E has spent thousands of dollars on software upgrades, purchasing new software and educational training so we will be able to advise our clients. And many employers do not understand this law, what it means to their business, because they cannot absorb everything they will be required to do in order to comply.

Currently, most of the E2E clients who qualified have been moved to December 1, 2013 renewals, called early renewals. This action is designed to defer many of the effects of PPACA until 2014. This early renewal action protects plan design, avoids community rates, controls costs and gives government time to observe the effects of the employer and correct or repeal this law. This is confusing to the employee and disruptive to the employer.

Finally, a great concern is the legal exposure as a result of this law. Never in my almost 40 years in the insurance industry have I been concerned with legal action. We are very detailed and effective in the guidance we offer. However, as stated in the opening paragraph, this law is complex. Employers hire and expect E2E to provide the guidance that will allow them to comply with the law. And it is ripe with opportunities for government penalties and fines.

To complicate matters, once PPACA became law, the regulators made changes to the rules here, delayed a portion of the law there, requiring businesses and consumers to change directions and spend additional time and money to comply and adjust. Constant last minute alterations to the rules and the refusal to make permanent modifications that will improve the product build uncertainty,

which is counter-productive, not to mention the lack of respect for the individual or business community.

Again, thank you for the opportunity to be here today and I look forward to answering your questions.

Mr. WOODALL. Mr. Sale, thank you for taking time to be with us today.

It is now my great privilege to recognize Dr. Reinhardt for his opening testimony.

[The prepared statement of Mr. Sale follows:]

Statement of
Mr. Raymer M. Sale, Jr.
President
E2E Benefits Services, Inc

before the
Committee on Oversight and Government Reform
U.S. House of Representatives

November 25, 2013

Good Morning.

My name is Raymer Sale and I am a small-business owner from a suburb of Atlanta called Duluth. I own an insurance agency called E2E Benefits Services, Inc. with a staff of 9. I am here to share with you the issues my clients are facing as they strive to comply with healthcare reform.

I would like to thank the House Committee on Government Oversight and Reform and Chairman Issa for inviting me here today and for electing to hold this public hearing. The impact of the Patient Protection and Affordable Care Act (PPACA) and the new costs it will impose on small-business owners and individuals will be profound.

Only now is the public beginning to see the intended and unintended consequences of the Patient Protection and Affordable Care Act. It wasn't until October 1 that consumers began to receive cancellation notices and were exposed to the higher cost of purchasing health insurance. The problems with Healthcare.gov only added fuel to the fire.

The insurance community has known from the very beginning that prices were expected to increase because of the required additional benefits; however, talking about the prospective increase in the cost of health insurance pales in comparison to showing someone the real numbers. These numbers weren't available until recently.

When an insurance company is required to add a benefit there is a cost associated with that new benefit. The mandated wellness benefits were responsible for a 1% to 2% increase in the cost. The contraceptive benefits were added, followed by the Minimum Essential Benefits. These are followed by the PCORI, Reinsurance and Health Insurance Taxes, which are being passed through to the consumer adding an additional 3% to 4% to the premiums. Our largest client saw their premium increase by over $10,000 per month due to the added tax burden alone. The costs directly tied to mandated benefits have

resulted in an overall increase of approximately 10%. Employers, both large and small, and individuals are seeing these increases in their premiums.

Since 2014 rates became available last month, we have quoted both 2013 and 2014 rates to our individual clients. In almost every case, the 2014 rates have been 50-100% higher. Although the ability to obtain coverage for previously uninsurable conditions is a good thing, it comes at a sometimes steep price. The bottom line is there is no free lunch.

In addition to the points above, since 2010, my agency has spent thousands of dollars to purchase the tools and modify software to help our clients weave through the compliance requirements of PPACA. Additionally, we have spent countless dollars and hours on education, so we could better understand a very complicated law.

This law is heavy with penalties and opportunities for the employer to be fined for failure to comply. The first such opportunity came in 2010 with the Age 26 notice to employees, and many more such requirements continue to appear. Making things even more complicated and costly, requirements have frequently changed, often at the last minute. After many advisors, including my agency, invested significant capital in software to prepare for the "Play or Pay" mandate, that mandate was delayed. Similarly, we spent several days preparing the October 1 notice to employees concerning the existence of the Marketplace. This notice included information about the projected penalties. We didn't send this notice until late September to hopefully incorporate any changes that might be made, but the same day we sent it the information came down that there would be no compliance penalty. When you add to issues such as these the confusion and misunderstanding of the law and its requirements, the costs continue to add up. All of this takes time, and time is money.

For the employer, the associated costs are even greater. The insurance companies began this past summer to offer employer groups the opportunity to renew their existing policies early in order to keep their current benefits and rating structures. These renewals were offered primarily for December 1, 2013 to extend through December of 2014. Maintaining the current policies also gives the government time to see what will and what will not work as the law is implemented and its real world effects become apparent. These early renewals have just served to further confuse employers and have resulted in higher administrative expenses. The end result has been that employers are seeking every possible way to avoid the financial impact of the law and many of them have been successful, but they are really just postponing the inevitable. When they are finally faced with these costs, it is certain that jobs will be affected. Even now, we are seeing a few employers drop coverage altogether, some because of the uncertainly and some because of a prevalent misunderstanding that their employees can now go to the exchange and get "free" coverage.

One of the most costly administrative expenses added to an employer involves the way a group client is now billed. Prior to 2014 companies were usually billed in four tiers - employee only, employee/spouse, employee/child(ren) or employee/family. Unless they had less than 10 covered employees (and sometime even then), the rates would be the same for any employee falling into a given tier. PPACA is now requiring that the community rates mandated for small business be age-billed. Each and every participant in the plan, the employee, the spouse and each child, must have their own line item billing rate. Therefore a group of 45 covered employees may go from 45 billing lines to be reconciled to well over 100. Additionally, much more information including Protected Identity Information, must be gathered, maintained and secured.

Another unintended consequence is that of participation. The reason many employers don't currently offer coverage is that they cannot get enough of their employees to purchase coverage to meet participation requirements. These requirements are not going away and with many employees dropping coverage to try to purchase subsidized coverage or just because the rates have increased so much they will only get that much harder to meet. This will cause more employers to drop coverage altogether, again increasing rather than decreasing the number of people uninsured.

These are some of the issues facing most of our clients. Following are real life scenarios involving actual individual clients:

1. An employer group of 49 FTEs received an offer of early renewal. This client has three separate plans for employees to choose from and the offer called for 11-26% increase in premium to early renew these plans. In comparing this to what the renewal would be if they waited for their scheduled February 1, 2014 renewal, we found that some of the employees would receive a decrease beginning February 1, 2014 but some would receive a much greater increase. There were two employees particularly whose rates would increase from approximately $591 per month to over $1,018 per month, a 72% increase.

2. A rural Georgia client has reluctantly accepted the early renewal offer even though it carried a significant increase in premium. This decision was based partly on the fact that they like their current benefit structure, which was chosen to best serve the needs of their particular employees, and wanted to keep it. This employer has more than 50 FTEs and will be faced with "Play or Pay" in 2015. This employer is in the nursery business and pays approximately 75% of the employee premium. Many of the employees chose not to be covered due to the cost. Beginning in 2015 the employer will be required to offer coverage that is affordable. The law requires employees to either accept this coverage, or to purchase coverage from another source. So, let's look at an example of offering affordable coverage. Let's assume the employee is making $8.00 and

works a minimum of 40 hours per week. This employee will receive a gross income of $1,387 per month. 9.5% is $132 per month the employee can be charged for employer offered group medical insurance. This is more than he would pay for the current coverage and yet he's opting out. I expect he is making a financial decision to house and feed him family instead of purchasing coverage, but in 2014 he will be mandated into coverage. Now let's assume the employee has a spouse and dependent children. The employer's offer of coverage only has to meet the affordability test of offering the employee coverage that doesn't exceed 9.5% of the employee's income without taking into account how costly it may be for the employee to find additional coverage for his spouse and child. The employer is not required to offer "affordable" coverage to spouses or dependent children, and that coverage can lawfully be at a cost well above 9.5% of the employee's income.

3. A roofing contractor has 42 full-time employees and no part-time. This is down from 49 full-time employees 2 months ago. They are not replacing employees who leave because they don't want to run the risk of reaching 50 employees. Rather than become subject to "Play or Pay", they have already decided that they will supplement their labor force with part-time helpers and apprentices whose hours will be strictly monitored not to exceed 30 hours a week. Their first thought was to pay $200 month for each employee to purchase coverage through the exchange, where many would qualify for a subsidy. However, IRS Ruling 2013-54 removed that option for assistance when it clarified that an employer can only help an employee with individual health insurance premium if that contribution is treated as salary in every way, including paying FICA and other taxes, being figure into COLA increases, etc. So their hands are tied when it comes to helping their employees obtain health insurance.

4. A client in the entertainment retail industry has converted a significant portion of their staff to part-time to avoid having to offer them coverage.

Some of the situations our individual clients find themselves in are even more alarming, as evidenced here:

1. We have had numerous clients come to us seeking individual health insurance because they were covered as retirees by a former employer who is now dropping retirees from coverage.

2. A large national company who has multiple franchise-model offices throughout the country announced that effective January 1, 2014 they will no longer allow the franchise-employed personnel access to their health insurance plan, which in turn caused the franchise owners to cease to offer coverage since most are fewer than 50 FTEs. This left thousands

of previously-insured individuals without coverage.

3. A client is seeking individual coverage because the husband's employer, in another state, has about 100 FTEs, and is choosing to drop coverage. They are going from paying the full cost of family coverage to paying $400 per month in salary increase on the mistaken belief the employee can go the exchange and purchase coverage easily for that. We do not believe they are aware of the fine for each employee who accesses exchange coverage, nor are they aware of what the true costs are for an employee such as this one who earns slightly over 400% of FPL.

4. Many more individuals are losing coverage and would qualify for a subsidy to ease the cost burden, but they are terrified they will be uninsured January 1, 2014 because they can't afford the high 2014 premiums and cannot access the subsidy due to the numerous glitches in the healthcare.gov site. These are responsible individuals who want coverage and are willing to pay as much as they can for it but they are being left without viable options.

The examples cited here are not unique. These are the kinds of issues we are facing every day as Americans struggle to understand and comply with the changed world of purchasing health insurance. I truly appreciate the opportunity to appear before this committee and provide testimony. I consider it an honor to be here and a privilege to be able to help our elected representatives become more informed about how healthcare reform is impacting business owners and individuals in our state. If you have any questions, or I can be of additional assistance to you please do not hesitate to contact me.

Thank you.

STATEMENT OF JEFF REINHARDT

Dr. REINHARDT. Good morning, Mr. Chairman, committee members, fellow witnesses and attendees. Thank you for the opportunity to come before you this morning to discuss the impact of the Patient Protection and Affordable Care Act.

As stated, I am Jeff Reinhardt, I am a full time practicing OB–GYN and President of The Longstreet Clinic. I wear several hats as it relates to healthcare. I am a consumer, a provider, and an employer. And I was asked to speak today in my role as a physician and a provider of care.

It is not new news, as Dr. Gingrey mentioned, that healthcare in this country is in crisis. Dating all the way back to 1926, out of concern for the costs and utilization of care, Congress formed a committee on the cost of medical care. This committee was abolished in 1932 after their recommendations were felt to be too radical. This illustrates that cost, access, and quality of care and the government's role in these issues, has been ongoing for some 90 years.

According to data reported by the WHO, the cost of healthcare in the United States changed from about 13.5 percent of GDP during the 1990s to almost 18 percent this year. Last month, Aon Hewitt, a leader in employee insurance benefits, reported that the average healthcare premium for workers has seen increases ranging from 3.3 to 8.5 percent for each of the last seven years, with an estimated increase of 6.7 percent for next year. Also, noting a trend that has seen the employee's share of total healthcare costs jump 150 percent since 2004, clearly increasing cost is a problem.

Access to medical care is influenced by geographic location, a person's literacy and disabilities, and the ability to pay for services. From 2004 to 2008 in Georgia, there has been a reduction in the number of OB–GYN providers from 13.5 to 10.9 per 100,000. This will lead directly to an increase in pre-term birth. That is bad. This reduction in providers is due to the lack of an increase in Medicaid reimbursement since 2002, increased cost of compliance with government mandates such as electronic health records, lack of meaningful protections against frivolous lawsuits, and increasing student loan debt.

In general, the universal access for health care is the emergency room. It is providing the appropriate location of care for people that is our challenge. The nearly 50 million uninsured non-elderly Americans receive much of their healthcare in the ER with about 25 percent of all ER visits being non-emergent. CMS estimates the cost of this to the taxpayer as about $176 billion per year. Additionally, about 55 percent of care provided in the ER is uncompensated, meaning no payment at all is received for services rendered, either by hospital or doctor. Historically, this charity care has been paid for with cost shifting. However, with the stagnant or declining reimbursements, this is becoming increasingly difficult and in some cases impossible.

The imperative about quality is a tough nut to crack. Doctors and other experts cannot seem to agree on the definitions of quality and our ability to gather clinical data is poor.

Well, here is what I know. When I finished medical school, I thought an exchange was what I did the day after Christmas with the sweater that did not fit.

[Laughter.]

Dr. REINHARDT. Right now, I am struggling to educate myself about private exchanges, Medicaid expansion, and doughnut holes. I know that many of the problems discussed here this morning preceded the Affordable Care Act and the old system was broken. I know that when the coordinator called me to testify this morning, I was in one of my rural offices and the patient I had just seen remarked at checkout about how happy she was that she did not have a co-pay for her visit. I know that her co-pay will eventually be rolled into the premium for her insurance and that ultimately she will pay for it. I know that one of my dear employees and friends has been stricken with metastatic pancreatic cancer and that her treatments would have bankrupted her if not for the elimination of annual and lifetime insurance maximums. For her, thank God for the Affordable Care Act. I know that particularly the parts of the Affordable Care Act slated for implementation in 2014 will bring great change, with real people tragically affected and others receiving great benefit. I know that it is too premature to know the full impact of the Affordable Care Act. I know that change is hard. I know that there is a lot of work yet to be done. And I know that I appreciate the opportunity to be here today and to present to you my impressions and thoughts and views and to answer your questions.

Mr. WOODALL. Thank you, Dr. Reinhardt.

It is now my privilege to recognize Mr. Boyette for his opening testimony.

[The prepared statement of Dr. Reinhardt follows:]

Good Morning Mr. Chairman, Committee members, fellow witnesses, and attendees. Thank you for the opportunity to come before you this morning to discuss the impact of the Patient Protection and Affordable Care Act (ACA) specifically, insights I may be able to share with you from the perspective of a practicing physician.

My name is Jeff Reinhardt. I am a full time practicing OB/GYN and am President of The Longstreet Clinic, P.C. We are a physician owned multi-specialty group, formed in 1995. Currently there are about 160 medical providers including about 100 physicians in the group. Geographically we have offices in locations in more heavily populated areas in Duluth, Buford, Braselton, Oakwood and Gainesville working out of large medical centers in Gwinnett Co, population about 842,000; and Hall County, population about 185,000. We also have offices in more rural areas including Dahlonega and Baldwin, caring for patients in smaller hospitals including Chestatee Regional Hospital in Lumpkin Co, population about 30,000; Habersham County Medical Center in Habersham Co, population about 43,500; and Ty Cobb Regional Medical Center in Franklin Co, population about 22,000. Also, we are in partnership with the Department of Community Health, providing obstetric services for patients in our local health department, many of which are currently uninsured and economically disadvantaged. As you can see, we have an extremely diverse patient base – ethnically, socioeconomically and geographically.

Presently, I wear several hats as it relates to healthcare – I am a consumer, provider and employer. Each of these roles has a different set of needs, challenges and motivators. I was asked to speak today about my perspectives as a physician and provider of care.

It is not new news that healthcare in this country is in crisis. Dating all of the way back to 1926, out of concern for the costs and utilization of medical care, our congress formed the Committee on the Cost of Medical Care. The committee was abolished in 1932 after their recommendations were felt to be too radical. This illustrates that issues of cost, access, quality of care – and the government's role in these issues has been ongoing for 90 years.

It is widely accepted that the cost of medical care in this country is a problem. Over the last 20+ years, according to data reported by the World Health Organization, the cost of healthcare in the US changed from being flat and predictable at around 13.5% of our GDP during the 1990's, to increasing annually to almost 18% this year. Just last month, Aon Hewitt, a worldwide leader in employee benefit and insurance consulting reported average health-care premium per worker increases ranging from 3.3% to 8.5% per year for each of the last 7 years, with an estimated increase of 6.7% for next year. Also, noting average cost to employees for out-of-pocket expenses, increasing by nearly 13 percent last year, continuing a trend that has seen employees' share of total health-care costs jump 150 percent since 2004. Clearly increasing cost is a problem. A budget item of nearly 2.5 trillion dollars, with no obvious end in sight to increases is a strong motivator for change.

Access to medical care is an extremely complex issue. It is influenced by geographic location; a person's literacy; disabilities; and the ability to pay for services including both out of pocket costs and costs covered by a payor – be it government program or private insurance. In general, there is a perceived lack of access to care, but few good comprehensive studies about the issue of access exist. Certainly, when there is a decrease in the number of providers per capita, or when providers and hospitals move from more rural areas, geographic access to care is negatively influenced. Here in Georgia, there has been a reduction in the number of OB/GYN providers from 13.5/100,000 to 10.9/100,000 between 2004 and 2008, this from data reported by the Georgia Health News. This will directly impact our ability to prevent preterm births. The reasons for this reduction in provider ratio include stagnant Medicaid reimbursements for over 10 years; the increased cost of compliance with government mandates - such as electronic medical records; lack of meaningful protections against frivolous law suits; and increasing student loan debt.

In general, the safety net for care is the emergency department. This is where the nearly 50 million uninsured, nonelderly Americans receive much of their healthcare, this estimate being from the U.S. Census Bureau data from 2010. These patients have typically delayed seeking care for chronic issues until their

medical needs are much more complicated than they might be had they received ongoing care in a traditional office setting. In a study by the National Institutes of Health (NIH) from 2010, about 25% of all emergency room visits are for non-emergent problems. The Center for Medicare and Medicaid Services (CMS) estimates that cost to the taxpayer for this care is roughly $176 billion. About 55% of care provided in the ER is uncompensated – meaning no payment at all is received for services rendered by either the hospital or physicians. Historically, doctors and hospitals have been able to "cost shift," paying for this "charity" care with "profits" available from the care provided to those with private insurance. However, with stagnant or declining reimbursements, this is becoming increasingly difficult and in some cases, impossible. This has led to consolidation of providers, where small physician practices and small hospitals, are merging with larger physician groups or hospital systems. This has resulted in increased numbers of physicians as employees rather than owners of practices; a reduction in services offered at rural hospitals; and increased costs of care due to increased reimbursement allowances for services performed by hospitals and hospital providers. There are headlines about hospital closings in every state – which implies reduced access, but a presentation 2 weeks ago using Medicare Payment Advisory Commission (MedPAC) data concluded that "access is expected to be strong despite declines in margins." Therefore, it is difficult to make solid conclusions about the availability of access to care, but certainly there is concern about providing the appropriate location for this access.

The imperative about quality is a tough nut to crack. Agreement in the definition of quality is not generally universal and our ability to gather clinical data is poor. Many of our current indicators of quality are based on billing codes and medical claims submitted for charges, and not based on clinical information. For instance, I can submit a charge for Tobacco Abuse, but may not submit a charge for my care which may have included counselling a person about the benefits of stopping smoking.

So, how does the ACA play a role as cause and solution? Clearly, from the data I have reported – almost all of which preceded 2010, these are not new issues, and

have not been the result of the ACA which was signed into law in 2010. This law includes multiple provisions that take effect between 2010 and 2020.

Just looking at 2010, there was a requirement for insurance plans to allow dependents to remain on their parents plans until age 26 – insuring many young adults in school and in transition to the working world; phase outs on both annual and lifetime coverages; eliminating insurance denials for children with "pre-existing conditions;" additional funding for Community Health Centers; as well as Small business tax credits for insurance premiums paid for.

In 2011 there was implementation of "free" preventive care and contraception – with no co-pay for the patient; allowable medical loss ratios for insurance companies; additional taxes for manufacturers and importers of brand-name drugs – subsequently passed on to patients; elimination of over-the-counter medications as allowable purchases from Health Savings Accounts and Flexible Spending Accounts.

Calendar year 2012 brought payment reforms incentivizing quality and penalizing avoidable complications; incentives and imperatives for using electronic health records and standardized billing practices – ultimately with penalties for those noncompliant; and incentives for provider groups to better coordinate patient care and improve quality, help prevent disease, illness and reduce unnecessary hospital admissions.

This year, 2013 brought new funding to state Medicaid programs that choose to cover preventive services for patients; excise taxes for medical devices; limitations on Flexible Spending Account contributions; more payment reforms incentivizing providers to work even more closely to provide care; and it also, brought with it enrollment in Small Business Health Options Plan and individual exchanges.

2014 and 2015 are slated to bring more Consumer Protections, Improvements to Quality and Cost and Increased Access.

Well, here is what I know and what I don't know. When I finished medical school I thought an exchange was what I did the day after Christmas with the sweater that

didn't fit, and right now, I am struggling to educate myself about Private Exchanges, Medicaid Expansion and "doughnut holes." I know that many of the problems discussed here this morning preceded the ACA. I know that when the coordinator called me to testify this morning, I was in one of my rural offices, and the patient I had just seen remarked at checkout, about how happy she was that she didn't have a copay for her visit. I know that her copay was going to be rolled into the premium for her insurance and that ultimately she would pay for it – just not at the time of her visit. I know that the pre-ACA system is broken. I know one of my dear employees and friends has been stricken with metastatic pancreatic cancer and that her treatments would have bankrupted her if not for the elimination of annual and lifetime insurance maximums – for her, thank god for the ACA. I know that particularly the parts of the ACA slated for implementation in 2014 will bring great change, with real people tragically affected, and others benefitted. I know that it is too premature to know the full impact of the Affordable Care Act, judicious data collection and interpretation is needed before objective conclusions can be drawn. I know that change is hard. And, I know that I appreciate the opportunity to have been here today to present to you my limited view and answer any questions that you may have.

STATEMENT OF MICHAEL BOYETTE

Mr. BOYETTE. Thank you, sir.

I am here today to explain how the Affordable Care Act has affected me and my family. My name is Mike Boyette, age 28. My wife is 30 and my daughter is two years old. We have been residents of Georgia for 10 years. My wife is employed by the state as an educator and I am a small business owner.

We have had health insurance through the State Health Benefit Plan for the past six years. Our monthly premium with our current carrier, United Healthcare, is $350 a month. Due to the new healthcare law, our new carrier, Blue Cross Blue Shield, has raised our premium to $540 a month. This results in an increase of $190 a month, a $2280 increase for the year.

You may think we went with a more expensive plan or got more coverage. In fact, we have not. We have less coverage than before, a higher out-of-pocket expense, and a premium that has risen 65 percent. This is not affordable to me.

I do not believe in my government telling me I have to buy something and on top of that, if I do not, I will be fined. I believe the American people have been lied to and misled. I myself liked the President's promises that we could keep our same healthcare and that we would actually be saving money. This was promised and believed by me and many other Americans.

For the year 2013, we had two companies we could choose from, along with four options each company provided. When we went to sign up for our new 2014 healthcare plan, one company was available with three options. One company, three choices—that was it. I thought I was wrong and it was not possible that I would pay more and have less coverage and fewer options. This was not what the President assured me and many other Americans.

When you hear the leader of the free world tell you something, you would like to believe his words have truth, meaning and honesty. I do not believe this to be the case.

More money, less coverage. Obamacare seems to hurt the majority of Americans while only having a positive effect on a very small percentage. I do not understand why this Administration wants so badly to have the Americans rely on their government for food, housing and now healthcare. It concerns me to look into the future. Should the government run the automotive business next, telling us that if we do not buy their cars, we will be fined? When does this stop?

Please fix the issues at hand. Do not create more problems, do not lie about it for political advancement. And I believe we all have been lied to.

If I lie to my customers and tell them something that is not true, I would not have any business. They are wondering where their customers are. Well, they have lied; therefore, they do not have any business. It is time that we as Americans stand up for what is right. This is very cut and dry. This is an Obama tax, not Obamacare.

I would like to thank our elected officials and other Americans who have stood up and fought for this from the very beginning. I urge them to keep fighting for us and hope that they know those fighting for the American people are appreciated. I also hope that

one day justice and real freedom and choice will be back in our healthcare system.

While the future of my healthcare seems uncertain and far from affordable, I hope that those Americans who have been negatively affected, like myself, by Obamacare, can reverse the wrongs that have been done to the millions of us.

Thank you.

Mr. WOODALL. Thank you, Mr. Boyette.

It is now my privilege to recommend Mrs. Collins for her opening statement.

[The prepared statement of Mr. Boyette follows:]

Letter of Testimony

before the
Committee on Oversight and Government Reform
U.S. House of Representatives

by
Michael C. Boyette
Owner
Owl Town Auto
Ellijay, Georgia

November 18, 2013

Good morning,

I am here today to explain how the Affordable Care Law has affected me and my family. My name is Michael Boyette age 28. My wife is 30 and my daughter is two years old. We have been residents of Georgia for 10 years. My wife is employed by the state as an educator and I am small business owner. We have had health insurance through the State Health Benefit Plan for the past six years.

Our monthly premium with our current carrier United Health Care is $350 a month. Due to the new health care law, our new carrier Blue Cross Blue Shield has raised our premium to $540 a month. This results in an increase of $190 a month – a 2,280 dollar increase for the year.

You may think that we went with a more expensive plan or have gotten more coverage. We have not. In fact we have less coverage than before, also a higher out of pocket expense and a premium that has risen 65%. *This is not affordable to me*. I do not believe that ObamaCare has my best interests at heart.

I do not believe in my government telling me that I have to buy something and, on top of that, if I do not, then I will be fined. I believe the American people have been lied to and misled. I myself liked the President's promise that our health care premiums would not increase and that my family could keep the same coverage that we currently have. This was promised and believed by me and many other Americans.

For the year 2013 we had two companies that we could choose from along with four options that each company had. When we went to sign up for our health care plan in 2014 our health provider had only one company. Three options were available – one company, three choices. That was it. I thought this must be wrong. That it was not possible that I would pay more, and have less coverage and fewer options. This is not what I was guaranteed told and led to believe by our leader. This is what I see as being deceitful, wrong, and illegal.

When you hear the leader of the free world tell you something you would like to believe that his words have truth, meaning, and honesty. This is not the case.

More money less coverage – this is not what the American people should settle for. ObamaCare seems to hurt the majority of Americans while only having a positive effect on a very small percentage. There are over 300 million people in this great country. Why hurt the vast majority of Americans to pay for such a small percentage? Why does this administration want so badly to have Americans rely on the government for food, housing, and now health care? It concerns me to think of what could happen in the future. Should the government run the automotive business next? Telling us that if we do not buy their vehicle then we will have to pay a fine. When does this stop?

Fix the issues at hand. Do not create more problems. Do not lie about it for political advancements. I believe we have all been lied to and bait and switch has taken place.

If I lie to my customer and tell them something and it not true then I would not have any business. Why is the administration wondering where there customers are? They have lied and not told the truth about their product therefore there will not be any customers. Millions, if not billions, of our tax dollars have been spent creating and developing this tax. It is time that we as Americans stand up for what is right. This is very cut and dry. This is an ObamaTax – not ObamaCare.

I would like to thank our elected officials and other Americans who have stood up and fought against this law – the ObamaTax – from the beginning. I urge them to keep fighting for us. I hope that they know that those fighting for the American people are appreciated and I also hope that one day justice and real freedom and choice will be back in our health care system.

While the future of my health care seems uncertain and far from affordable, I hope that those Americans who have been negatively affected by ObamaCare – like myself and my family – can reserve the wrongs that have been to the millions of us.

Thank you.

STATEMENT OF EMMA COLLINS

Mrs. COLLINS. Thank you very much and good morning. Thank you for inviting me, I am happy to be here and I am honored to have been chosen to participate in this hearing on the Affordable Care Act, hereafter referred to as the ACA.

My husband and I are both self-employed and as such, we do not have access to group healthcare insurance. He is a certified quality auditor and an independent contractor. I am a licensed massage therapist and I have my own business. We had group insurance when I was employed by a local school system. However, when budget cuts caused my position to be eliminated, we lost that option.

So we researched private companies and applied with several. I was rejected by all these companies because I have a preexisting health condition. So then, we applied for just my husband and our college age daughter, so they could at least have insurance. We found a policy from Humana for them at $265 a month. It was basically catastrophic coverage but that was fine. It was affordable and it gave us financial protection in case of major medical issues. Early October this year, we got a letter from Humana, the policy was being changed. For them to have a plan that was compliant with the requirements of the ACA, our cost went from an affordable $265 a month to an outrageous $898 a month. That is a 240 percent increase. In addition to this much higher premium, the deductible on this exorbitantly priced plan is $6000 for one person and $12,000 for both. So in the event of medical issues with them, this ACA-compliant plan exposes us to the risk of up to $2000 per month. That is in no way, shape or form acceptable or affordable. With the low premium payment that we had, we were willing to accept the risk of a high deductible, but it is just not feasible to combine a high premium with a high deductible.

It is not like my husband and daughter are even at high risk for illness for the plan to be so expensive. They are both athletic, long distance runners and are extremely healthy. So for their rates to increase at this ridiculous amount is just simply unreal.

I still do not know what I am going to do about health insurance for myself. I am very concerned about how much it is going to cost. If it is anything like my husband and daughter's case, it will be anything but affordable.

I have not signed onto Healthcare.gov yet to find out the true cost for me. I am very concerned about the security of my data, the potential for hacking, and the potential misuse of private information entered into that database at this time.

My husband, my daughter, and myself are not the only ones in our family negatively impacted by the new healthcare law. Our married college student son, his wife and their four year old daughter apparently make too little to qualify for a subsidy. However, they make too much to qualify for Medicaid. It makes no sense to set up a program where some of the very poorest financially among us are left out in the cold while those who make only slightly more are given free largess.

While I was looking for information on the public pages of Healthcare.gov, I noticed something curious. On all the pages I looked, the subsidies were promoted. It was implied that most peo-

ple would quality for a subsidy and that their premiums would probably be lower than the ones quoted on the estimation page. But even with the wide variety of financial situations in our family, no one qualifies.

I think it is great to help those who are poor and desperately need help, but that is not what is happening. There is a great gap in the assistance to the poor, through which our son and his family fall. And there is great inequality in how the subsidies are given to those with higher incomes. Why should Congress and staffers who are as well—in most cases financially better—equipped than my family receive subsidies when what we receive instead is outrageously priced health insurance, or being required to pay a fine beginning next year at one percent of our income. The misleading advertising on Healthcare.gov and unfair application of the subsidies all make this costly financial pill even more bitter to swallow.

The ACA will also have a negative impact on our local economy. We currently employ people to clean our home, do yard work and odd jobs around the house. That will have to stop because of the necessary tightening of our budget. This will reduce their income, thus reducing what they are able to add to the economy. We may not make such a dramatic impact just by ourselves, but we are not alone. Imagine this combined with all those others like my family and myself. Once happily contributing to multiple levels of the economy, now required to funnel most of that financial stream into the behemoth that is the ACA.

So because of the ACA, our family will go from having some healthcare coverage we can afford to no healthcare coverage and a fine beginning next year at one percent of our income.

Please repeal the ACA in its entirety. There has to be a better way that would not cripple families like us financially, yet would still help those who simply cannot help themselves.

Thank you again for your time and consideration of this extremely important matter. May God bless you with wisdom.

[The prepared statement of Mrs. Collins follows:]

Testimony of Emma Collins
To the House Oversight and Government Reform Committee
Field Hearing
Gainesville, GA

November 25, 2013

Thank you for giving your time and effort to research the wide-ranging effects of "Obamacare" – The Affordable Health Care Act (ACA.) Thank you also, for allowing me to represent my family and the many self-employed people who are now in similar negatively impacted situations. The effect of the ACA on my family and myself has been, already, considerable. As self-employed persons, my husband and myself are not covered under any group insurance plan, thus we are participators in the private insurance market.

My husband is a Certified Quality Auditor (CQA) who performs independent food quality/safety audits at food manufacturing facilities. He is an independent contractor in his work and owns his own auditing business and has done so for approximately the last thirteen years. I am also an independent contractor as a Licensed Massage Therapist (LMT.) I own my own massage therapy business and operate out of a local medical day spa. I have been self-employed for over two years. We used to be covered by group health insurance when I was employed by our local school system. However, when my part-time position there was eliminated several years ago, that all changed.

As self-employed persons, we carefully researched private health insurance for our family to cover my husband, our college-age daughter and myself. I searched in vain for a company that would insure me at all, since I have the pre-existing condition of having had heart-valve replacement surgery 15 years

ago. Even though I am, in reality, quite healthy, I was refused coverage by all the insurance companies to which I applied. So, we decided to focus on finding insurance coverage for my husband and daughter at least.

We purchased a policy for my husband and our daughter through Humana with a monthly payment of $265 that would cover both of them. It was basically catastrophic coverage, but that was fine and exactly what we needed. We paid out of pocket for their rare medical expenses and for any that I incurred.
In early October 2013, we received a letter from Humana stating that our policy would no longer available as we had purchased. We could purchase the "substandard" plan for only a small increase per month. However, we were told in the letter, if we chose that option we would be reported to the IRS as noncompliant and charged a fine. **To make their policy compliant with the ACA it was now going go up from $265 per month to $898.00 per month. That is a 240% increase!** In addition to a much higher premium, the new policy would have a $6000 deductible for one person and $12,000 for both of them. That adds up to potentially $500 to $1000 **more** a month in cost, just to reach the deductible and then, finally, begin to receive a percentage of reimbursement. While a high deductible was an acceptable risk when we were paying a low premium, it is not workable at all when the premium is already so high.

My husband and daughter are both athletic and healthy. They are both runners and in the last 3 years he has ran a marathon and several half-marathons and shorter races and he and she have both completed 2 half-marathons together as well as she has ran several other races. They are among the healthiest people I know, and for their health insurance coverage to increase at that ridiculous amount is absolutely ludicrous.

I still don't know what I am going to do about health insurance for myself. I understand that one of the provisions of the ACA is that those with pre-existing conditions can't be denied coverage. I had originally hoped that would provide benefits for someone like myself who had been unable to purchase private health insurance previously. At this point, however, I have no idea how much any coverage for me would cost. Sure, they are required to cover me, but there is nothing I know about that requires it to be at an affordable amount for me. We are blessed to make too much money to qualify for a "subsidy", but certainly cannot afford the amounts that this law would try to make us spend on just the two healthiest members of our family, much less me with the pre-existing condition.

I have not signed on to healthcare.gov yet because I am very concerned about my private information being insecure on that site. It seems the website has many issues, and one of the ones that makes me most uncomfortable is the questionable security of the information that one enters into it. Identity theft or other misuse of the private information entered therein is an issue I do not feel has been adequately addressed and/or worked through. Because of my concerns with the safety of my personal information on the website, I have not even attempted to see if I could become one of the few people to get through to sign up and see what my rates will be. Based on the exorbitant cost of coverage for my healthy husband and daughter, I do not have high hopes that coverage for me will be any less expensive, and most likely much more.

My husband, our daughter and myself are not the only ones in our family to be negatively impacted by the new healthcare plan. Our married son, his wife and daughter also have been adversely affected. Our son is a full-time college student, his wife works part-time and they share in the full-time care of their 4-year-old daughter. They make less than the poverty level, but more than the amount that would qualify them for Medicaid. So, they do not make

enough to qualify for a subsidy, but too much for Medicaid since Georgia chose not to place the state under the heavy financial burden of expanding Medicaid. I was recently told that there is supposed to be a waiver form to be developed to eliminate the fine for having no insurance for those in this "gap." They are still left with no insurance and no ability to afford it at this time.

As I was looking on the public pages of the healthcare.gov website, I noticed an odd thing. On those pages of the website, the the subsidies are touted constantly and one is over and over encouraged to see what subsidies for which one qualifies and told that one's premiums will probably be lower than the cost cited because of the subsidies. However, even with the variety of financial situations in our family, NO ONE in our family qualifies for the subsidies at all. It seems from the website presents it, that most everyone qualifies, but when one starts looking at the nitty-gritty of it, that list narrows down a lot. I am not a great fan of the subsidies, though, anyway, because of the way they are applied. I gladly would help the poor and those who desperately need help, but it seems the subsidies have reached out far beyond that. When our family, who is by no means rich, does not qualify for subsidy, but is required to pay for exorbitantly priced insurance in full or pay a fine, but yet, politicians and staffers in the Congress and Executive Branch have subsidies – something is wrong. Why should our family be required to carry the burden of those who are as well, and most instances better, financially equipped as we? Misleading advertising on healthcare.gov and unfair application of the subsidies all make this painful financial pill even more bitter to try to swallow.

Now, with the skyrocketing cost of health care coverage thanks to the "ACA" my family will be bearing an incredibly heavy financial burden, simply to obtain health care coverage. This will have a very negative impact on our contribution to the local economy. We currently employ someone to clean

our home on a regular basis. That will have to stop because of the tightening of our financial purse strings thanks to healthcare coverage. So, it flows on down to her, reducing her income and reducing the income she has to add to the local economy. We also employ other persons to perform yard work and odd jobs. That will also have to stop, thus reducing the income of those people too. Our discretionary spending will have to be decreased drastically with the vast bulk of it going directly toward maintaining health care coverage we do not want. This is spending we would normally do at local shops, restaurants, gas stations, hair salons, and so on. We may not make so much of a dramatic impact just by ourselves on this, but we are not alone. All those of us who are self-employed and blessed financially enough to not receive a subsidy will be forced to do the same thing. This certainly does not sound like a harbinger of an upswing of the economy to me. If it has the negative impact on our economy that I, with just my local effect, can foresee – imagine this combined with all those others like my family and myself. Once, we were happily contributing to multiple levels of the economy, now we will be required to funnel most of that financial stream into only one thing – the health care behemoth of the ACA.

Originally, my family and I thought that this health care reform might actually work out to be a good thing in our lives. However, as self-employed small business owners, we are being penalized and placed under a potentially very heavy financial burden. We would much prefer it would simply go back to how it was. We had affordable coverage for my husband and daughter. We realized the financial risk we took to pay for their healthcare coverage out of pocket because of their high deductible and to cover out-of-pocket any health care expenses I might incur. However, with the outrageous cost increases that the ACA is bringing to bear; it will not take long for coverage under the ACA to cost us much, much, more than we were paying before with little benefit to us. I would much rather save the money and apply it as needed to healthcare, than to pay it up front for dubious coverage that may

not be needed, or what we even want, if and when it is needed. Now, because of the ACA and its mandates, our family will go from having some health care coverage that we can afford, to no health care coverage and a fine of 1% of our income.

I do understand there is some value in health care reform. However, the lack of choices of types of policies (no catastrophic care over the age of 30, for example) and lack of choice over what is covered (maternity coverage being a requirement, for example, regardless of whether it is needed or wanted) create a mandatory high cost. What about an *a la carte* system? This would help our family considerably, since we could then choose to pay for the items we needed and only those items. If we choose not to elect a certain type of coverage, then so be it. We would have to pay out of pocket if it became necessary. Thus, we could have truly *Affordable Health Care*, not this unaffordable quagmire that is the *ACA*.

In summary, I am a 47 year old, self-employed healthy woman with a pre-existing condition. I currently have no health insurance. My 51 year-old, self-employed healthy husband and 22 year-old healthy college student daughter have private health coverage. Their current coverage rate of $265 has been tripled in price to $898.00 per month due to requirements to make their policy ACA compliant. This, combined with the unknown cost of "required" health insurance for me, is an excessive financial burden on our family. Please do all you can to repeal the ACA in its entirety. There has to be a better way that will not place such an onerous burden on our family and those like us yet will help those who truly cannot help themselves.

Thank you again for your time and consideration of this extremely important matter. May God bless you all with wisdom.

Mr. WOODALL. Thank you, Mrs. Collins. Thank you all. I will begin the first round of questions.

And Mrs. Collins, I think you hit it on the head with your ask for a blessing of wisdom. I was with a member of Congress a week and a half ago when he noted how many state legislators had been elected to the Congress and he wondered if a wand of wisdom was suddenly passed over you when you went to Washington, D.C., that you believed that Washington had all the answers, answers that you could not find while you were a state legislator.

Mr. Sale mentioned that this was a marketplace that our state legislatures and regulators have been working in for a long, long time. In fact, I saw Senator Renee Unterman with us this morning.

I really do believe that the level of conversation has increased dramatically. The focus—I remember back in 1996 when the feds eliminated preexisting conditions for federally regulated plans, but they did not try to interfere in state regulated plans. But as Dr. Reinhardt pointed out, lifetime caps, the elimination of those lifetime caps, has been something that both consumers and the industry itself has come together to say, you know, this is something that we could do. I sincerely believe if we had voted on the Affordable Care Act, six pages at the time, instead of 2400 pages at the time, there would have been some benefits in there for some folks. But we would have rejected so many of these things that we continue to talk about rejecting today. It is you and your family, Mrs. Collins, that were the poster child of why we need the Affordable Care Act. And here you are, the very family that we intended to help—not saying we have not done so at all. At the same time, Mr. Boyette believed those promises and is finding them unfulfilled.

You talked about subsidies on the web page. When I heard that every family's policy was going to be $2500 cheaper under the Affordable Care Act, I thought it actually meant that premiums were going to go from a level that we all thought insurance costs were too high, and insurance costs were going to come down. But it sounds like from your reading of the web page what it means is premiums are just going to go up even higher but we are going to create enough of a federal subsidy to try to bring those down below what we were paying before.

Is that an accurate reflection?

Mrs. COLLINS. That is how I perceived it. It was that basically if you—they will take from those that make too much to get the subsidy, to give to those who will receive a subsidy. But even at 75 percent, if it covers 75 percent of these plans, I have been at incomes of those people that have the eligibility to receive the subsidy. It is still going to be a very painful financial burden, even paying that 25 percent.

Mr. WOODALL. Dr. Reinhardt, you talked about the folks who are receiving non-emergency emergency room care and the literally hundreds of billions of dollars that go out the door in that way. I do not believe there is a man or a woman in this room who does not believe that folks, who have no healthcare choices in their life, deserve and require access to healthcare. That seems like a solution—a problem that we could come together on a solution for. We do not want those folks in the emergency room.

Is it your expectation that what we are seeing under the Affordable Care Act is going to eliminate that emergency room traffic?

Dr. REINHARDT. I think the degree to which it will reduce that is going to be measurable. The degree to which that gets changed is going to be unclear, because part of what we will do in this process of trying to provide a more appropriate location for access, is we will have to retrain people. So historic patterns of seeking care, habits if you will, are hard to break. And so those individuals that will get coverage or be provided coverage through, you know, federally qualified care centers, subsidized care centers, if you will, I think retraining them that that is where they go for their care, I think that is going to be a great challenge for us. So the degree to which you will reduce that 25 percent of non-emergent visits to the ER, I think that is going to take time to be able to calculate.

Mr. WOODALL. I do think there is a common commitment to improving access. My uncle is a primary care doc down in south Georgia. He said, ”Rob, you can hand out all the new Medicaid cards you want to, but I am the only doc in five counties who will see Medicaid patients, and I cannot fit anybody else in my waiting room.“ So that handing out cards does not improve access.

You talked about the number of OB–GYNs per thousand Georgians going down. I cannot imagine when we are creating an incentive for doctors not to get in the business, or even worse for docs with experience and talent to leave the business. If we continue to see the ratio of docs to patients declining, we are going to end up with access issues. There is just no way around it.

Mr. Sale, what I understood you to say was that of 100 clients that you looked at whose plans were supposed to be grandfathered under the ”if you like your healthcare, you can keep it,“ something that was designed to mitigate problems that folks knew would occur, that only four of those companies still maintain their grandfathered status today?

Mr. SALE. That is correct. Most of the plans lost their grandfather status because the insurance carriers made dramatic change in the benefit structure. Early on when the law was passed, they said if you even change carriers, you lose your grandfather status. And one of my larger accounts lost grandfather status by June of 2010. So most everyone is gone, and the ones that we have found that still have it were caught in the early renewal changes, moving their renewal dates to December. And we found four of them that actually still had grandfather status. We had done all the rules—we had done all the compliance that the employer needed, but we just did not keep up with them until we came to this renewal status.

Mr. WOODALL. And finally, thinking about Mrs. Collins' request to repeal and start over from scratch, that is the same request the Chicago Tribune is making. But all the turmoil that we are seeing that is creating that desire to repeal and start over again, did I understand you to say that what we are seeing is just the tip of the iceberg, that folks are going through a process called early renewal to try to mitigate the damage that is happening and when those early renewals expire, there is going to be a whole other round of insurance complications?

Mr. SALE. This is true. What we have done in our practice, and what many agents have done, at the encouragement of the insurance companies, is to change the renewal date from whenever it was going to occur in 2014, to 2013, because they avoid the plan designs that are going to be required, the metal plan designs if you will, they avoid the community ratings which are going to be a big item when they hit the board too.

The problem we have here is it is going to be real difficult for me to renew another group of 100 employees, 100 employer clients in December of next year. So there are going to have to be some changes. But the foundation behind this is to give—just like when the Healthcare.gov hit the streets and all the politicians—not all of them, but the Administration is a better word—was touting "it is going to work," "it will work, do not worry about it," "everything is protected," "it is going to be flip the switch on October 1st and your life is going to be a new life." Well, that is going to happen again when all these other renewals start in 2014. People have to actually live it so they can believe it. I can tell you all day long your premium is going up 20 percent and you are going to say okay, well, you may be biased or you are an insurance agent. I understand, but is that really true. And then somebody else is out there saying those things really are not true, they are just pulling your leg. It is true and I can assure you, come 2014 it is going to be another firestorm out there.

Mr. WOODALL. Well, there are a lot of folks this holiday week who are thankful that they have not yet been adversely affected by the Affordable Care Act but it sounds like this is just the beginning and there is more, sadly, pain and frustration for American families to come.

With that, I would like to recognize the gentleman, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman. I appreciate it.

What is interesting to me, you talk about this, we look at it from a different perspective, is a fundamental difference—I spoke about that a little bit in my opening statement—a fundamental difference in government's role and also a fundamental difference in what is actually happening in healthcare and what should be happening in healthcare. This concerns me, and it came out in Dr. Reinhardt's testimony and Mr. Sale, you just brought it out just a moment ago. I heard a quote early on after they started getting the renewals and started looking at everything, I heard this quote and it was from I believe it was California, I am not exactly sure, but the quote was, "I liked this Affordable Care Act but I did not realize I was going to have to pay for it."

[Laughter.]

Mr. COLLINS. And I think that is a fundamental problem when you look at this. And really what it is—and Dr. Reinhardt, I am going to get my first question in to you here. You brought up something that goes back to an old literature, it's a tale of two worlds—or a tale of two cities—however you want to put it. You have got those that are benefitting, and I am not going to deny in this room that there are some who see a lower premium, better coverage, there is some benefits, which could have been addressed without changing the way we deliver healthcare in this system, without a government basically takeover.

But at the same point, you are also having people lose their healthcare in the way that Mr. Boyette described. You are changing.

Are you see this in rural healthcare maybe exasperating this problem, that some might actually get a little help but in actuality we are taking on the rural healthcare problem and making it a lot worse?

Dr. REINHARDT. Well, I think none of this happens in a vacuum, so this—a lot of the statistics I mentioned this morning were data that was collected before 2010. So it is pre-Affordable Care Act. These issues have been going on for a long time, that reduction in workforce of OB–GYNs was between 2004 and 2008, pre-Affordable Care Act. So these are issues that I think we have to address.

You know, if you think about it from the perspective of—let us look at it just from my perspective as a physician who finishes his residency and comes out here into the outside world. And let us say I had finished in 2009 and I came out here and I am slapped in the face with a 906 page Affordable Care Act and I am in a partnership with four other doctors. What do we do? Do we each take 150 pages and go home and read it overnight and come back together the following morning and say okay, this is how we are going to implement this? Heck no, we are confused, we need advice, we need help. And so we have to, through the economies of scale, you know, hire somebody or merge with another organization who has the faculties to help me as a provider adhere to laws. The HIPAA law, you know, and TOLA. These are laws that preceded the Affordable Care Act. This is not a new problem created by this. And so what has happened is you have had a lot of consolidation of providers, a lot. You have small practices that can no longer function in that capacity. Many of these people are seeking job security just like you and I, just like the members of this panel. Job security seems to be with the people with the deepest pockets and that is our hospital systems.

So you are seeing physicians begin—well, it is a decade old trend, but they are being hired by larger medical groups like myself or by hospital systems. The law in this country allows hospital systems to charge more for the care that they provide, a significant amount. So if you have providers in rural areas, okay, that are now employees of hospitals, you have reduced the number of providers. In many cases, you probably reduced the insurance companies that are participating with those providers, and you have elevated the cost of care because now you are paying more for the very same thing you got last year at the very same place. That was not the fault of the Affordable Care Act, but the Affordable Care Act is another one of those 900-page laws that has just put another stone in our pocket of burden. This consolidation has forced a lot of scrutiny around where I go as a provider to provide care.

And this is the answer to your question. Many of these providers are beginning to be consolidated into more urban areas. So care that we may have been providing in more rural areas, it is no longer there because your doctors and your providers are being consolidated into more urban areas.

The full extent of that, again, I think it is too early to know. We had three hospital closings this year, but if you look at Med Pak

data, they will tell you that there are plenty of hospital beds available in this country.

The Affordable Care Act was meant to provide care in the proper place and for many of these hospitalized patients, the proper place is not in the hospital, so it actually motivates care out of the hospital. So that has freed up some hospital beds. So is it because the Affordable Care Act is working and it is forcing people into a more appropriate location of care, which is out of the hospital, or do we have a stable number of hospital beds? I do not know the answer to that question.

Mr. COLLINS. One of the things you hit on and just in a round about question is I think what we have here is a healthcare set up that had an ideological bent, this is what we want to do, without the look at the cost. And also I believe it was set up by folks who basically have not owned businesses, have not run businesses, they basically signed the backs of checks instead of fronts of checks, as I have said before. And I think when you look at that, that is a whole different process.

Real quickly, I know my time is out, but I do want to ask Mr. Boyette. You made an interesting comment that I think Mrs. Collins sort of jumped on as well. It is the issue that is not talked about. We talk about the shifting cost of exchange cost, we talk about, you know, how much it is going to be and who lost, who did not. But what you brought up was an interesting process. And those, the vast majority of people—remember, most people had healthcare before this. This was not an issue where we are taking a group, but what you said is really interesting and I think it is going to be really interesting here in the state of Georgia for all state employees is this issue of now you went to one provider with three choices.

Mr. BOYETTE. Absolutely.

Mr. COLLINS. And I think—that affects you. How does that affect—I want you to elaborate on it, you touched on it briefly in your testimony. Did you find that shocking? Like I think I have that kind of issue in my own household.

Mr. BOYETTE. Well, absolutely. I mean, you know, variety is the spice of life. You know, we like to pick and choose, you know, and when you go from eight options to four options and, you know, the whole time believing that it is going to get better, our healthcare system is going to improve and when you see it first hand, it is not. You know, it is very disappointing.

Mr. COLLINS. Well, I think that is something for everyone to understand here, is the insurance industry, just like every other industry, is going to find ways to adapt to what they have to do. And if they have to give a cheaper premium over here, they are going to find other ways to cut their costs and make premiums go up on the other side. And I think you brought up something that is often missed in this process.

Mr. BOYETTE. That is what hurts the most. It hurts the most when it hits your pocket. I mean just like Mrs. Collins here, and myself, and many other Americans, you know, it hurts the most when it hits your pockets.

Mr. COLLINS. Your comment right there, "it hurts the most when it hits your pockets" is sort of why we are sitting here today. And something that was promised——

Mr. BOYETTE. I watched the YouTube clips the other day. You know, it is heartbreaking.

Mr. COLLINS. It promises a cotton candy world and the reality is cotton candy goes away, life comes on, and you get a premium and you get a process that is not just right now but it is going to fail in the future.

And with that, my time is out, Mr. Chairman, I yield back.

Mr. WOODALL. Thank you, Mr. Collins.

I would like to yield now to Mr. Meadows of North Carolina.

Mr. MEADOWS. Thank you, Mr. Chairman, and thank each of you for your testimony.

I know, Mr. Chairman, this is not a town hall, but in going around, there were a few individuals that I know had some testimony and so forth. One particular gentleman had talked about how he had lost his coverage as part of a pension plan, and so I would ask unanimous consent for anybody who has written testimony that they have seven legislative days to be able to submit that testimony as part of this hearing.

Mr. WOODALL. Without objection, if anyone has testimony, they can submit it to the Oversight Committee within the next seven days and we will make that part of the official record.

Mr. COLLINS. Will the gentleman yield?

Mr. WOODALL. Sure.

Mr. COLLINS. And for those—and especially being here, you can call my office and we will facilitate getting your stories in. You just contact us. Many of you here, you know my office, you just get that in and I appreciate the Chairman.

Mr. MEADOWS. I thank the Chairman.

Dr. Reinhardt, let me follow up a little bit with you and then I am going to come to you, Mr. Sale, with some questions. You identified some issues.

Is there anything in the Affordable Care Act that you believe will help that trend of doctor shortages? You know, you were talking about that was a trend I think that was happening up until 2008 and continues on now. Is there anything in there that you believe that will allow us to have greater physician accessibility in rural areas?

Dr. REINHARDT. You asked two questions there. You may not realize it, but you asked about the doctor shortage. I have been asked this question before by my state legislators, about whether or not there is anything in there that will stimulate more physicians to go and get trained. And the answer to that question is if there is, I have not seen it, heard it, or read about it.

The second question though, that you really kind of asked in there as well was access. Like are we going to be able to deliver providers into areas where it is underserved. And there is some money in the Affordable Care Act that is supposed to go to provision of community health. I have looked at data from 2007, 2010, 2011, 2012, at number of providers in those facilities. Again, these are the federally qualified health centers. I have looked at the numbers in terms of the number of patient visits and it is all going

up. Again, I think it is hard to know whether or not this is an increase in the number of providers to these areas. There are some inducements about paybacks for student loans in there. So if I was toting around $200,000 of student loan, which is roughly the average nowadays, which is a house and a half for a lot of Americans. You know, I might be induced to go into a rural area and work in one of these centers. So there is some language in there and some mechanisms in there to begin to bring care providers into some of these underserved areas.

Mr. MEADOWS. Let me go on, because maybe it is just in western rural North Carolina that we have this issue. But in rural areas, high speed internet is not always available and in fact in a number of my counties, it is very difficult—access to Healthcare.gov or even computers to get on because of the low income level. Are you finding the same thing in Georgia here?

Dr. REINHARDT. I think there is no question that the access—there is some presumption in this process that access to the computer is available to everybody. And, you know, I do not think that is—I have developed Tourette's syndrome personally since we—where I curse a lot since implementation of our electronic health record about two years ago.

[Laughter.]

Mr. MEADOWS. That will be quoted on the news, I can tell you.

[Laughter.]

Dr. REINHARDT. Sometimes the truth is funnier than fiction. But I think that—and we have good access. So in more rural areas where your access is less continuous and less certain, I think that we have got to come up with more creative ways to provide, you know, registration for these individuals in these areas that either do not have computers or where that access is intermittent.

Mr. MEADOWS. Thank you, Dr. Reinhardt.

Mr. Sale, in your opening testimony, you mentioned something that was very concerning to me because Mr. Boyette was saying that if you could keep your healthcare plan—if you liked it, you could keep it. And that he banked on that. And yet you said—and correct me if I am wrong—in 2010, insurance companies knew that there would be a number of cancellations. Did I hear you wrong or is that correct?

Mr. SALE. No, you heard me correct. What happened and the way the grandfather law was designed, if you made certain changes to your plan, you would lose the status at the beginning. If you changed carriers, you would lose the status. And employers were faced with 20–25 percent rate increases if they had had an unhealthy year. And if they went to another carrier, they may get a 10 percent decrease in their rates and so it was smart to change carriers to do that. And so you would lose grandfather status. And then you had to publish that your plan met—you had to publish to the employees that you thought your plan was a grandfathered plan based on what you knew about it. And that letter had to go out to the employees telling them that their plan did not contain or would not contain some of the benefits that a non-grandfathered plan would contain.

And so early on, we began to see this happening. I was—I guess we were at an insurance company meeting when it was discussed

that people would lose their grandfather status. I did not really believe it because I thought that these plan designs would be sufficient to retain it. But in reality, it did—it is true. And most all of ours have lost it.

Now one of the carriers that we use went through their portfolio and changed everything that they could and that alone killed the grandfather status. There was no way you were going to keep it and it just happened to be the largest block of business that I had was with this carrier.

Mr. MEADOWS. So what you are saying is that the 400,000 Georgia residents that the Chairman talked about in his opening statement, that has lost coverage here in Georgia, that is not a surprise to you based on what you knew in 2010?

Mr. SALE. No, sir.

Mr. MEADOWS. Okay. Mr. Boyette, I am going to finish with this because I am running out of time and Mrs. Collins, I will follow up with you with a few questions if we have a second round. But Mr. Boyette, much of what has been talked about out there with the Affordable Care Act is saying that the type of policy that you had before was really substandard, you know, they were just preying on your stupidity, they were just trying to—you did not really know what you had and what you are going to get with these new three options, one carrier option, is really better and that you really do not know the facts.

How would you respond to that?

Mr. BOYETTE. You do not know my policy.

Mr. MEADOWS. Let me ask you, has anybody from the federal government called you to ask you about your healthcare or even——

[Laughter.]

Mr. MEADOWS. —do they know what your children's names are?

Mr. BOYETTE. No, sir.

Mr. MEADOWS. So they probably do not know your individual needs as well as you do.

Mr. BOYETTE. No, not at all.

Mr. MEADOWS. I yield back, Mr. Chairman.

Mr. WOODALL. I thank the gentleman.

I would like to recognize the gentleman, Dr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. Boyette, the government probably does know the names of your children.

[Laughter.]

Mr. GINGREY. That is part of the problem here.

You know, I am so glad that the gentleman from North Carolina, Representative Meadows, mentioned about, you know, this is not a town hall meeting, but to give everybody here—and it is such a crowd—and I sure hope everybody in the back can hear because our hearing rooms in Washington are not this deep, and as I previously said, not always this well attended. But we definitely want to hear from you and maybe we can even stay around just awhile afterwards and take some individual questions because I know in Washington, the situation is the same, the format is the same, the dialogue is between the members and the witnesses, and the questions are between the members and the witnesses, and not those

in attendance, not the audience. But let me tell you, in Washington, the audience for the most part is a bunch of lobbyists, a bunch of special interest people who are on one side or the other of an issue. The audience today is we, the people, we, the people, who are every one of you being adversely affected by this. And my heart goes out to you.

[Applause.]

Mr. GINGREY. I wish we could have an opportunity to hear from all of you.

The witnesses have all given great testimony and I thank all of you—Mr. Sale, Mrs. Collins. I can relate I guess more directly to Dr. Reinhardt as we are both OB–GYNs, he currently and me previously. And Mr. Boyette, this may surprise you, but my dad and his two brothers were in the automobile business, just as you are, and it was called Gingrey Motors in Aiken, South Carolina. And you are Owl Town Auto in Ellijay, Georgia.

Now I am sure you sell pre-owned vehicles, they sold used cars.

[Laughter.]

Mr. GINGREY. But times do change. And honestly, I bet my dad, they made 50 to 75 dollars a car at best. And in those days, there was no Medicare, there was no Medicaid, there was no Peachcare. There was hardly any welfare. But mom and dad kept shoes on us and, you know, we went to good public schools and we were clothed and fed and did all right—we did all right.

So that is what we need, in a way, to get back to, that self responsibility of pulling yourselves up by your bootstraps. And the federal government being there to help those who, through no fault of their own, absolutely cannot help themselves. And of course I am for that. But we have gotten to the point where, as I say, federalism is all the federal government, and it should be mostly the states and we, the people, if you believe, as I do, this sacred document.

So I will direct my first question then, Mr. Boyette, to you and just real simple. Would you also like to comment on how this law will affect your family's financial decisions as you go forward? I know you have a young daughter and I know you and your wife are expecting a new baby soon. Just what is this going to do to you in being able to provide food, clothing and shelter for your family?

Mr. BOYETTE. Well, as I said earlier, you know, it is $200 a month more, my premium, what I am going to have to pay out of pocket. That is a lot of diapers. You know, all our expenses have gone up and anybody will tell you that, going to the grocery store, and this is just one more expense, me, as an American person, I do not need. Just plain and simple.

Mr. GINGREY. Mrs. Collins, you had mentioned in your testimony, and I wanted to just touch on this, I think you mentioned that it did not seem right to you that members of Congress and certain staff of members of Congress were in Obamacare, had to sign up through the Washington, D.C., it is called the Health Link Exchange, but it is one of these federal exchanges that does not work, but that members of Congress had to sign up. And of course, the law says if you are between—your income is between 100 percent and 400 percent of the federal poverty level, I think 400 percent for a family of four is about $88,000 a year, that you were eligible

for a subsidy. Obviously at that high a level, less subsidy than if you made 100 percent of the federal poverty level where your subsidy may be 75 percent of the premium. But President Obama, by executive fiat, or whatever you want to call it, said that members of Congress and their staff would still get this 70 percent supplement. You mentioned that in your testimony.

I would like to ask you how you feel. I would like to know how the members of the audience, if they had a chance to ask a question or throw things, how they feel about a situation like that and the lack of fairness of that.

Mrs. COLLINS. Well, it disturbs me greatly. It is very frustrating. We are not rich by any means, we do not qualify for a subsidy, and that is okay. But I do not understand why people from no virtue of their own other than their employment, get a subsidy to cover virtually all of their insurance cost when my family is going to be financially devastated by this, if we follow through.

On the other hand, we also have our son and his wife and their daughter who do not make enough to qualify for a subsidy, they are not even up to poverty level. He is a full time college student, she works part time, they share in care of their daughter. They do not qualify for a subsidy, yet they make too much for Medicaid. So what is happening to them is they simply have no insurance. Now I understand they will have a form they can sign so they do not even have to pay a fine, but that is ridiculous. They looked at insurance yesterday on Healthcare.gov. I had looked at it before for them on the estimators. And on the cost estimator for their insurance, it was going to be, at the cheapest level plan, almost 40 percent of their total income before taxes. They are going uninsured while members of Congress and staffers are getting 75 percent of their pay. There is something wrong there.

Mr. GINGREY. Amen.

Well, I see my time is expired as well.

[Applause.]

Mr. GINGREY. Mr. Chairman, I wanted to ask Dr. Reinhardt a question but I will yield back and maybe there will be a second round?

Mr. WOODALL. We will begin a second round right now. I will start that out.

Mr. Collins and Mr. Boyette are both on the receiving end of this, the folks to whom the promises were made, the folks that—genuinely I think there is a national commitment to making sure that folks have access to care. We have Mr. Sale and Dr. Reinhardt on the trying-to-make-good-on-those-promises end of things, which is a little harder.

Dr. Reinhardt, you mentioned federally qualified health centers. I do not know if everybody knows what a community health center is. We have been funding those in this country for four decades, and it is a community-based clinic where folks can show up for absolutely any need that they have and based on their income, they will be charged on a sliding fee scale, to try to make those services that they require affordable. That sounds strangely familiar to me. Let us find folks who need access to care, let us take a look at their income and let us make sure they have appropriately priced care.

I think about the hundreds of billions of dollars that have gone into compliance on this issue. I think about the trillion dollars—not figuratively a trillion, but actually a trillion, a million million. They tell me if you started a small business on the day Jesus Christ was born and you lost a million dollars a day seven days a week, every day from the day Jesus was born until today, you would have to lose a million dollars a day seven days a week for another 732 years to lose your first trillion dollars.

We are spending that on the President's commitment to getting access. What would that mean to rural areas if we committed to spend a trillion dollars on expanding those community health centers that you talk about. Because Mr. Boyette has said as plainly as anyone I have ever heard that he does not want the help that folks are trying to give him, that he was happier before. That strangely, he knows more about what he needs than we do. We have Mrs. Collins, who is exactly who this bill was intended to help, she says it is making things worse—not a little worse, not one order of magnitude worse, but did you say 240 percent worse for your premiums?

Mrs. COLLINS. Yes, sir. And that is just for my husband and my daughter. That does not even include the required coverage for me that I have no idea how much it is going to be.

Mr. WOODALL. I ask you, Dr. Reinhardt, because you are in the caretaking business, you took an oath here this morning, but you took another oath a long time ago, to care for people and their healthcare needs. Let us get past whether or not we care about each other. Mr. Collins in his opening statement talked about what it means to be in community with one another, what it means to care about one another.

These dollars are going out the door, they are coming out of everybody's pocket in this room. I understand the President is heavily invested in this, the bill has his name on it. Could we have done any better? Could we have done any better? And do you believe your patients would be better served if we stripped this language out and started over again from scratch, to identify exactly those concerns that you have on your mind?

Dr. REINHARDT. There has got to be more than one way to skin a cat. Mr. Collins, I wrote down one thing and it was what you said, and it is that it is people who come together. And whether or not we have the system we had in the 1990s, 2000s or today, as we morph from kind of the old way of doing things into this new way of doing things, there are going to be people who receive great benefit and people who are left in a difficult situation.

Mr. WOODALL. Help me understand that, because I trust you on that, I trust my doctor. I get to choose my doctor, I hope I still get to choose my doctor in years to come. But I trust you, so when Mr. Boyette says he did not have any complaints to begin with, he liked what he had to begin with, his family was well served to begin with. But here in this legislative process, he has been stripped of what he liked, now he has something that he does not like. I do not understand why we had to hurt him to help the folks that you talked about. I want to help those folks. I just do not want to hurt the Boyette family in the process.

Dr. REINHARDT. I think the notion that one size fits all does not work in most things in life and it does not work here.

Mr. WOODALL. Mr. Sale mentioned that in his opening statement. He said the policies that were being outlawed were inferior policies. That is disappointing to Mr. Boyette and his family, that he had something inferior. How does it feel to be superior now, Mr. Boyette?

Mr. BOYETTE. I do not feel any more superior.

Mr. WOODALL. It is amazing to me, those things in life that I have done and done poorly, the failures that I have had in life. The ones that I caused and brought on myself, I feel a little better about. Those failures in life that someone else forced upon me, I am still a little bitter about. And I see folks who are willing to take responsibility for the decisions that they make and all they ask for is the freedom to make those decisions.

I will close with you, Mr. Sale, following up on Mr. Meadows' question. You said there was discussion in the insurance community as soon as this law was passed—arguably before the law was passed, as the language was being vetted and passed around the country—that the grandfathering language, the language that was supposed to be the if-you-like-your-insurance,-you-can-keep-it language, that folks knew from day one that that had no possibility—that language had no possibility of making good on that promise.

As an administrator to small businesses in a little old state like Georgia, you looked at that language in 2010. Was it obvious to you on day one that if you like your insurance, you can keep it; if you like your doctor, you can keep them, period— was it obvious to you on day one that that was a promise that could never be fulfilled?

Mr. SALE. Well maybe not exactly on day one, but shortly thereafter because the National Association of Health Underwriters either forwarded a document or produced a document that said they felt that 80 percent of the plans would lose their grandfather status within the first couple of years. And I may not be exactly, whether it is one year or two years, which one it was. But as this law began to unfold, it became very clear. Now this 2700 or 2400 pages, whichever it happens to be, document, has been being gone through forever trying to look under every bit of information we could figure. So it may not have happened on day one, but the law was passed on March—signed on March 23rd, implemented on September of 2010, and it was very close after that that we began to get the rumblings that, yeah—because once Congress passed it, then people began to delve into it.

So yeah, it was pretty close up front, because even on the individual plans, you have got four plans to choose from, the metal plans—the bronze, silver, gold and platinum—but nobody's plan out there was gold, silver, bronze or platinum, they were all something other than that. And of course, then these new plans have so many more added benefits that are going to make life a lot easier for you, it includes free doctor visits for wellness and birth control pills and all of that sort of stuff that just inflate the cost of the plan and take the design basically away.

Mr. WOODALL. I believe that if you like your doctor, you should be able to keep your doctor. I believe if you like your plan, you should be able to keep your plan. I believe we should be able to

take steps that reduce the cost of insurance in this country, and I believe we should take steps to take care of families that are dealing with lifetime caps and are dealing with preexisting conditions. But I also believe that at the end of the day the patients in the Boyette family should be able to decide for the Boyette family what policy is best for them and the members of the Collins family should be able to describe what is best for them.

I cannot believe that any proposal that comes out of Washington, D.C. that tells you that you do not know best for you can ever be the right plan for America.

And with that, I would like to recognize Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

I think going back to this—and Mr. Sale, you made an interesting comment and it is something for all of us here to realize. You could read—and I could hand it out today, lock the door and say okay, everybody read 2700 pages of the Affordable Care Act. And I would ask you then, at the end of the thing, we would have a test, I would hand it out. And I would say okay, here is questions about this bill. And the problem is that you would not be able to answer what the bill actually does because the 2700 pages basically stated at the end of every paragraph, "to be determined by," "to be determined by," "to be determined by." And if we want to take that in perspective, we have an eight foot high, literally, stack of documents that are the regulations that have been proposed on the 2700. So in other words, you have the 2700 is the inside of the trunk of the tree, and then you have eight foot at this point, and still growing, regulations that are in effect. There is no way that you can honestly understand this.

I think this is the part that has become the problem. From the state perspective, from the local perspective, from the national perspective, this is the issue that we have got to come to grips with. The State of Georgia chose not to expand Medicaid. I applaud them for that. I sat on the Appropriations Committee in Georgia, we could not afford it.

We have got to get back to some basic common sense on this issue. And part of the problem we have got here is that Congress has passed bills such as the Affordable Care Act that had 2700 pages but also said "By the way, we are going to let you figure out how to deal with it."

So I have got a flip question here. One, we are going to start with compliance costs, but then Mrs. Collins and Mr. Boyette, I want to give you an opportunity. On sort of the professional, the doctor, caring side, I am going to prepare you now so you can just think about it. What could we do better? Given your circumstances, what could help you, and I just want you to think about that.

But I want to come back over here for just a second. Compliance cost, from Mr. Sale and also from The Longstreet as well. We sort of danced around it. Give me sort of an idea of how much compliance costs are affecting business and doctors' practices and others, that you are seeing right now.

Mr. SALE. I cannot give you a dollar figure because I do not have one. But I can assure you that the employers are very serious on trying to comply and they are having staff do things that we recommend. And what we are doing is we are sending out bulletins

to our clients to say you need to be prepared to do this and you need to be prepared to do that. And then when we get to specific issues, then we involve the attorneys at 300 and 400 dollars an hour to get specific.

I cannot tell you the dollar value, Dr. Reinhardt may be able to tell you exactly what has gone on with his compliance, but we have in my office, I know we spent almost $800 on one piece of software that would allow the employer to see if their plan qualified under the play-or-pay rules.

We have spent about—the program is right now in the middle of about a $2500 modification to our HR software that will allow the employer to track hours worked each week inside a calendar month so that they can determine whether employees are full time or full time equivalents. And by the way, according to information we have, beginning in 2016, employers actually have to report that to the IRS, that yes, we have X number of employees and each one of them worked so many hours a week.

And then on top of that, I know that I have got personally over $1100 tied up in two training programs that I went to at the American College early on to try to figure out, you know, what our responsibilities were going to be in this. And then we have people in the office that have spent more money than that.

So I can speak only for my company, but maybe Dr. Reinhardt can help you.

Dr. REINHARDT. From the perspective of corporate cost, I cannot even begin to give you an estimate. We have a very robust compliance process within our corporation, always have. It is funny, I was going to suggest they ask you about that because much of the advice regarding compliance we have gotten from the vendor through which we purchase our insurance.

Mr. COLLINS. Before I go to the other two, would it be a fair statement—because I am often criticized in my position, because I am not a fan of this bill. I believe there are things we can do—and before anybody says well you do not know anything about preexisting conditions, I have a daughter with spina bifida—I get it. And there are a lot of other cost issues that we have out there.

The money that you are having to spend, and other businesses are having to spend, just for the record, could be spent on—if a business was doing better—on job creation, you know, working on better benefits. Would that be a fair statement? Instead of having to spend it on compliance costs for something they are still not sure about.

Dr. REINHARDT. Let us make a list.

[Laughter.]

Mr. COLLINS. Exactly.

Mr. SALE. What he said.

Mr. COLLINS. Exactly.

Mr. SALE. One insurance company sat in my office the other day—now I cannot verify this as being an accurate statement, I do not think the gentleman made this up. But he said his insurance company has spent one billion dollars since 2010 in compliance. And off the record, I will be glad to give you that name and you all can verify it.

Mr. COLLINS. Amazing.

Back to my question now, for both of you, and whichever one of you wants to answer—and if you do not, I completely understand.

But one of things I want to be able to do here—there is no doubt about where I stand on this law or any part of it. But there is a part here, there is an issue of how do we help people, how do we make sure—and not everybody is going to be helped and especially the false dream that was proposed with this. Because there is a balance here, and it never was intended to cover everybody.

But in your specific case, just from your thoughts as a citizen, what do you think?

Mrs. COLLINS. I have thought about this a lot actually. As someone with a preexisting condition, it would be great to be able to get insurance. However, I do not think it is fair for my husband and daughter to have to pay an exorbitant amount just to cover the risk for insurance for me. We would prefer as a family—and my husband and I have discussed this at length—an a la carte system. Why he as a man having to have maternity insurance, that is ludicrous. Why can we not get catastrophic care insurance? Oh, great, because we are too old, we are over 30 and in the new system, you cannot get it if you are over 30.

What we would prefer to have would be an a la carte system where we could choose what types of coverage we needed and take personal responsibility; if we choose the wrong ones, then okay, we pay. And be able to have a catastrophic care plan.

We are, overall, quite healthy and to pay for our care as we need it. But then for those that cannot, I love the community health centers, expand those. That would help people like my son and daughter-in-law and their daughter—expand those community healthcare centers for those that cannot afford. And offer the opportunity for catastrophic care for those of us that simply do not want to have to pay exorbitant premiums to cover every single little thing. And that would be what we would like to see happen.

Mr. COLLINS. Mr. Boyette, any thoughts on that?

Mr. BOYETTE. Yes, sir. What I would like to see done the first time was do it right the first time.

Mr. COLLINS. Okay.

Mr. BOYETTE. How long, you know, did these guys have to, you know, prepare for this October 1st Obamacare rollout? Three years roughly?

Mr. COLLINS. Give or take.

Mr. BOYETTE. Give or take. You know, that is a long time to get their stuff together, keep their promises on stuff.

Mr. COLLINS. I think what you bring out, I think the bottom line, it was—when you take the base bill, it was never able to work, it was never a thought-out plan, it was never a vetted bill, it was never something—it was something we have got to pass because we have a set number of political deadlines and numbers. And politics is numbers. Bottom line. If you have enough numbers, you can pass what you want. And that is what they needed. But they passed a bill that was not workable, that is why you have the eight foot stack of regulations as we go forward.

And I think that is why we are here today and I appreciate, you know, from the different perspectives here. Yes, we have got to find solutions, we are a country that needs to be a part of the solution,

but a lot of that is just government getting out of the way and helping where it needs to help instead of trying to blanket plan, and in other words, hurt a lot of other people and compliance costs and everything else.

And with that, Mr. Chairman, I yield back.

Mr. WOODALL. Thank the gentleman.

The gentleman from North Carolina, Mr. Meadows.

Mr. MEADOWS. Thank you, Mr. Chairman.

Dr. Reinhardt, let me pick up a little bit on what you were sharing, because you were talking about the compliance costs and just that you have done a great job with that, but that it is just very costly.

Are there any federal regulations that have come down the pike that have not ultimately cost you to comply with?

Dr. REINHARDT. Here is a political answer—without a little time to think about it, I cannot come up with one off the top of my head.

Mr. MEADOWS. All right. So let me ask you, for each dollar that we spend on complying to federal regulations, is that a dollar that is not spent on really providing healthcare to your patients?

Dr. REINHARDT. I am not sure that is a totally fair answer. If you are looking for compliance specifically with government regulation, some of that actually has resulted in——

Mr. MEADOWS. Better care?

Dr. REINHARDT. Well, I think absolutely some of it is better care, some of is increased and improved reimbursement to our practice in terms of——

Mr. MEADOWS. Let me hit on that reimbursement, because I have visited a number of hospitals and a number of healthcare providers, and what they have said is they have gotten caught up in this having to make sure that they put down the correct coding. It can get kicked out as Medicare or Medicaid fraud just because the coding is incorrect when actually the procedure was justified, but it was—instead of putting H2R, it was H2RA. Do you see that in your—you have a big practice, do you see that as something that you have to spend just making sure your coding is correct to get your reimbursement?

Dr. REINHARDT. I do, and I think that may actually be one of the advantages of the ICD–10 transformation we are going to go through.

Mr. MEADOWS. Sure.

Dr. REINHARDT. I will tell you that one of the great frustrations that we are struggling with right now around measuring quality of care is how do you develop data banks that help us evaluate quality of care. Most of the data that is available is based around billing data and billing codes. As an example, if a patient comes to me who is a smoker, I can sort of submit a charge code for tobacco abuse. But if I counsel that patient, there is not much of a way for me to communicate with the insurance company that I did that counseling. That would be considered to be good care.

So we actually are struggling to try to figure out how to communicate that we have done something that would be deemed to be quality, to a system that largely just accumulates charges. And that is a great challenge for us.

Mr. MEADOWS. So what you are saying is there is an incentive to do another procedure or do something that would qualify for reimbursement instead of providing the healthcare counseling that would be considered a lot more advantageous to your patient.

Dr. REINHARDT. I think you have hit in large part on the reason for payment reform. Right now, we are in sort of a pay for procedure environment, where if you do something you get reimbursed, rather than a pay for outcome, where if you do something well, you get reimbursed at a higher rate for accomplishing it better. And that is why we are trying to figure out how to report this quality information in a way that we can transfer or transform that incentive to actually do things into an incentive to do the right things.

Mr. MEADOWS. All right. Mr. Sale, let me go to you because you get to deal with a number of companies. Are you seeing any companies that you deal with that are not hiring people to try to stay below that 50 employee threshold, or if they are hiring people, that they are hiring them on a more part-time basis. Are you experiencing that at all? Are you seeing that with your clients?

Mr. SALE. We are hearing conversation about it. I cannot tell you that I have seen any of my clients that have actually done it. I do know that we have one client that I talked with the other day, actually not a client, it is a friend that works for this company. We were talking about their group size and this person said our company is at 40 lives and we will never be more than 49, because we do not want to cross that 50 threshold.

We have another person whose corporate headquarter is out in the midwest, has over 100 employees, and they just said we are out of the insurance business. And they have been paying for the full cost of the employee, and they are giving the employees $400 a month. This particular person has come to our office; to cover he and his family was going to be over $1200 a month, if I recall their bottom line. So, while I cannot tell you that I have had actually an employer say this is what we are doing, they are talking about it.

Mr. MEADOWS. So Mr. Sale, are you saying that that one particular instance that you gave at the end there, that you have people that are losing their healthcare coverage because he is getting out of the healthcare business altogether and he is just going to purchase it for he and his family?

Mr. SALE. That is correct.

Mr. MEADOWS. Mrs. Collins, let me come back and finish up with you. You have got a preexisting condition.

Mrs. COLLINS. Yes.

Mr. MEADOWS. For many of us, we saw the covering of a preexisting condition to be a good thing with this law.

Mrs. COLLINS. Uh-huh.

Mr. MEADOWS. We said, you know, that really as a compassionate, fair country, we believe in taking care of our friends, our neighbors and our community. And so I saw that. It came home to me recently though, because I have got a sister with stage four cancer, who is losing her coverage because of this Affordable Care Act and losing the ability to see her doctor because of that.

Is that something that you are seeing personally? How are you going to grasp this with you preexisting condition?

Mrs. COLLINS. Well, right now being uninsured—the preexisting condition that I have is I actually have an artificial heart valve and I take blood thinners every day. I am always at risk for stroke or for some kind of incident like that. We are just aware that right this minute we—if I had something major happen, then it would very potentially be catastrophic for our family. So as someone with a preexisting condition, I would love to have a catastrophic care plan that would cover me.

Mr. MEADOWS. So you are saying under the ACA, that you, because of your age—and I know that you may be 29, but because of your age, you do not qualify for a catastrophic plan.

Mrs. COLLINS. Correct, I am 47 and otherwise I am in great health, and I do not qualify for that, no. And before the ACA was passed, I did not qualify for any plan. We were rejected by multiple companies because of my issues. So I was very happy for it to be—that only aspect, I thought this is great. But it has unfortunately not been the case.

Mr. MEADOWS. So basically, what you are telling me is that this is the American people being forced to buy a particular product at a particular price, to not be able to make those choices on your own.

Mrs. COLLINS. Right.

Mr. MEADOWS. Which means that ultimately you are having to not make other purchases that perhaps you and your family would make, because you are having to focus on a narrow set of what the ACA is forcing you to look at.

Mrs. COLLINS. Absolutely. Given the financial burden that we will be bearing should we comply with the ACA and all three of our family members have insurance coverage through it, our discretionary spending would plummet dramatically. And like I mentioned in my statement, you know, we have people that we hire around the house to do different things. That in and of itself would probably not make that big of an account in the economy. The fact that we go out to eat or that we go to the local shops or that we buy from our local car dealerships, or whatever we do. Us alone are not going to make that big of a difference, but all the people in our situation, they are going to have no choice but to do the same thing. And that is frustrating.

Mr. MEADOWS. Thank you, Mrs. Collins.

Mr. Chairman, I yield back.

Mr. WOODALL. Thank you, Mr. Meadows.

Dr. Gingrey.

Mr. GINGREY. Mr. Chairman, thank you.

A couple of my colleagues asked the question could we have done any better. I think maybe a more appropriate question would have been could we have done any worse.

[Laughter.]

Mr. GINGREY. Because I absolutely do not think we could have done any worse. I do think we could have done better.

Let me just offer a suggestion and then ask the witnesses, to see how they feel about this. I have not worked out all the fine details and maybe it is a little bit half-baked at this point.

But you understand, the witnesses and I am sure everybody in the audience, something called COBRA, Consolidated Omnibus

Budget Reconciliation Act of 20 years ago, or whatever. But what COBRA allows is that you are working for a company and you get laid off, the company downsizes or you quit for some reason, you decide to go to take another job. You can continue to be in that group plan that that company has offered and maybe you have been there 15–20 years and everybody pays the same premium. And you have been in great health. You started it right out of college, you are 10 feet tall and bullet proof, you do not smoke, you do not drink, you do not sky dive, you do not do any dangerous things. And you have had very few claims.

So the insurance company that has that policy for that company and those employees has really done pretty well on you. I hope you—the hypothetical you—is getting an annual physical or maybe a physical every two years. But bottom line is the health insurance company, as far as that group is concerned, has really made a nice profit off of you over 10 or 15 years.

But during that time, you could have developed high blood pressure, you could have developed Type 2 diabetes, you could have had a malignant melanoma, you could have had a heart attack. You may well have had a stint put in. And then all of a sudden though, you are fine, you are recovered, you are working, you are still working. But you find the ideal job that you want to transition to or you get laid off and you lose your job.

So federal law allows you to continue in that plan for 18 months, right, 18 months. You have to pay the entire premium, do you not, the employer part if it is 60 percent, if it is 50 percent, whatever they paid, you have to pay it all plus a two percent administrative fee. And you have that for 18 months.

And let us say that at the end of 18 months, you are 52 years old. What in God's name are you going to do until you turn 65? You are not disabled, you just now have a preexisting condition. Well, why not—and this will be my question to the panel—why not say that a person in that situation should have the option to own that policy and continue to keep it until they turn 65, if they want to, and pay that premium, and not put them in that God-awful position of not being able to get coverage, be denied, or if they could get coverage, some new insurance company say well, yeah, but five times standard rate or eight times standard rate.

Now that is called health insurance reform. That is really what we needed, I thought, from the very get-go. That is why I say we could not have done worse, we darn sure could have done better.

But let me just ask—and Mr. Sale should be the expert on this, and do not be afraid to shoot holes in this because as I say, I have not fully thought it out, but believe me, we do have other ideas. Mr. Sale.

Mr. SALE. It is a good idea, Congressman. And the idea of being able to keep insurance is certainly important, because the one thing that the law could have done prior to the PPACA law is to have a pool for the uninsurable individuals, those who, through no fault of their own, end up being placed in that category. And it does not need to be—it just could be molded in with all the other costs of coverage that we have, that idea of keeping your COBRA coverage or going on and extending it is certainly not a bad idea.

Mr. GINGREY. Well, I appreciate your response and we will move over to Dr. Reinhardt. But I mean you even could say pay a little bit more for your premium for that option, for that ability, if you are willing to do that, if that is necessary actuarially to make it work.

Dr. Reinhardt.

Dr. REINHARDT. I think the word actuarial is a good word, because the implication there, if you were to allow a person to do that is to calculate what the expected cost of care for someone with that diagnosis, say Type 2 diabetes, what is the expected cost of care for that individual for medications, co-morbidities including their increased risk of heart attack, high cholesterol and things of that nature—what are the expected costs for that individual and should not that individual be expected to pay for those things.

And so we go to the actuarial tables and you can all boil this down to math, statistics and what-not, what is going to be the cost of that person during the course of their lifetime. Better yet, what is going to be the cost of the care for that person in this particular calendar year, age 52, et cetera. And essentially that number is amortized over the course of a year. These are companies which, according to the law, are allowed to make 15 percent profit or whatever it is, their loss ratio could be 85 percent.

So I think that yeah, that sounds like a good idea, but I also believe that the patient should be required to pay for the expected cost of their care during that period of time.

Mr. GINGREY. Well, Dr. Reinhardt, thank you very much for bringing that up because I may not have made myself completely clear on that. That option, to continue that COBRA until you reach Medicare age, because you now have these preexisting conditions, that option of course would be only from that insurance company that had that group policy where you were a member paying a premium for a set number of years. I would say that if you worked there one year, no. But if you worked there 20 years or 15 years, some break point where you say surely this particular health insurance company, whether it is a Blue, Cigna, Aetna, United, you name it, has made enough money off of you already, and surely they would have the compassion and the good marketing sense to be willing to cover you until you turned age 65.

Mr. Boyette.

Mr. BOYETTE. I am going to let Mrs. Collins speak on that. I am not too——

Mrs. COLLINS. Okay, as far as the COBRA, I could see there could be some benefit in that. It would concern me the cost that that would end up going on into.

I would love to see a health savings account, I think the HSAs were great, and see those be rewarded. And see as many people as can take responsibility for their own healthcare costs without bankrupting themselves. But also cover the people in the middle like the woman that Representative Meadows referenced with pancreatic cancer. There needs to be some sort of—something to cover that where you cannot be just cut off. When you are in the middle of treatment, that is basically going to be a death sentence.

So I like the idea of COBRA, I think there are some other things that I would love to see happen. Like I said, some more individual-

ized choices and more individual responsibility and that sort of thing.

Mr. GINGREY. Yeah. And they are all in here as part of the American Healthcare Reform Act, Republican proposal coming out of the Republican conservative study committee of the House of Representatives.

So, Mr. Chairman, my time has expired. I thank all of you, I thank all of the witnesses, you all have been fabulous.

Thank you, Mr. Chairman, I yield back.

Mr. WOODALL. Thank you, Dr. Gingrey.

Mrs. Collins, I will say to you there is a bill out there called H.R. 25, the Fair Tax, that is the subject of a different hearing——

[Laughter.]

Mr. WOODALL. —for a different day.

[Applause.]

Mr. WOODALL. But that changes all of those tax incentives so that you and I can buy that policy when we turn 18 and take responsibility for those decisions.

Everyone on this panel up here is a co-sponsor of that fair tax and it is amazing how many of these decisions come back to the federal government and how we have pushed behavior in this direction instead of allowing it to take that natural course.

For a final word, I would like to yield to Doug Collins.

Mr. COLLINS. I appreciate that, Mr. Chairman.

One, something was said early on about the attendance and I have the great privilege of representing Georgia's Ninth Congressional District and I tell them all the time it is not only one of the most conservative districts in the country, I believe it is, in my humble opinion, the best district to be able to represent. And it is shown in this room today.

[Applause.]

Mr. COLLINS. Dr. Gingrey, this is normal in Georgia Nine. This is normal in Georgia Nine. We have been a round a great deal, because they are passionate, because they believe in individual freedoms, they believe in a government of a constitutional role. And I think these are the things we have talked about today and a problem with a bill that, frankly, may at some point have had good intentions but bad ideology. It had bad ideology to say we are going to fix it for everybody, but maybe not you, and maybe not you, but yet sell it as if it would. Cost to the person may go down for some, it may go up for others. But for everybody, as taxpayers, you will pay for this plan, like it or not.

And so when we look at this, I just want to thank the staff, my staff that is here today, they worked very hard on getting this done, our district staff, our Washington staff, and I just want to thank them. And they are in the room today. They are very special to me and I appreciate them. They will be here if you have those statements that you would like to submit for the record, you can get those to us and be a part.

The OGR staff, again, we talked about are great to work with and to get this put up, and Chairman Issa and the rest of the staff.

To my colleagues that I shared the dais with today, it is special to have you here with us today—Congressman Woodall, Meadows, Gingrey and Mr. Kingston had to leave. We are just trying to do

what we promised and that was to listen and to be a part and, you know, find solutions as we go forward.

The witnesses who have taken their time. But I do want to take one moment here to remember a witness who is not here. Josh Kinsey was intended to be here today. I got to know Josh when I would go to White County and I got to represent White County while I was in the State House. Josh run a little pharmacy on the square, had a little soda shop next to it, his pharmacy was there and Josh is just one of those guys in the Chamber, he is just one of those vivacious kind of guys that you just like to be around.

He has closed his practice because of compliance costs, because of the uncertainty of this law and the uncertainty of healthcare. He made a choice that he had to make for him and his family, which I find no fault in, you have to do that.

But here was another example of an independent pharmacy, and others in healthcare, having to make choices that limit choices, do not expand them, they limit choices. He went to work for a bigger firm and that is great, that is what needs to happen in his life. But I am saddened today that he could not be here because he just started his new job and could not be here to tell you about the folks that he took care of and how this has affected him.

I make this statement all the time—what we do is a lot about paper, but in the end, it is all about people. And that is something we can never forget. So we look at that, the people in this audience, you make it up, these witnesses, my colleagues, it is just good to be here today, but also to still be in a country where we can still debate these and find solutions.

And with that, I yield back.

Mr. WOODALL. I thank the gentlemen.

As all of you know, America is not run by 51 percent of Americans, it is run by the 51 percent who care enough about America to show up. I thank each and every one of you who took time out of your day to be here, both the folks who came to give us their testimony on the panel and those who came to be with us in the hearing room today.

And with that the Committee stands adjourned.

[Whereupon, at 12:01 p.m., the Committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

Obamacare fallout: Millions face sticker shock following insurance cancellations
By Associated Press

MIAMI — Dean Griffin liked the health insurance he purchased for himself and his wife three years ago and thought he'd be able to keep the plan even after the federal Affordable Care Act took effect.

But the 64-year-old recently received a letter notifying him the plan was being canceled because it didn't cover certain benefits required under the law.

The Griffins, who live near Philadelphia, pay $770 monthly for their soon-to-be-terminated health care plan with a $2,500 deductible. The cheapest plan they found on their state insurance exchange was a so-called bronze plan charging a $1,275 monthly premium with deductibles totaling $12,700. It covers only providers in Pennsylvania, so the couple, who live near Delaware, won't be able to see doctors they've used for more than a decade.

"We're buying insurance that we will never use and can't possibly ever benefit from. We're basically passing on a benefit to other people who are not otherwise able to buy basic insurance," said Griffin, who is retired from running an information technology company.

The Griffins are among millions of people nationwide who buy individual insurance policies and are receiving notices that those policies are being discontinued because they don't meet the higher benefit requirements of the new law.

They can buy different policies directly from insurers for 2014 or sign up for plans on state insurance exchanges. While lower-income people could see lower costs because of government subsidies, many in the middle class may get rude awakenings when they access the websites and realize they'll have to pay significantly more.

Those not eligible for subsidies generally receive more comprehensive coverage than they had under their soon-to-be-canceled policies, but they'll have to pay a lot more.

Because of the higher cost, the Griffins are considering paying the federal penalty — about $100 or 1 percent of income next year — rather than buying health insurance. They say they are healthy and don't typically run up large health care costs. Dean Griffin said that will be cheaper because it's unlikely they will get past the nearly $13,000 deductible for the coverage to kick in.

Individual health insurance policies are being canceled because the Affordable Care Act requires plans to cover certain benefits, such as maternity care, hospital visits and mental illness. The law also caps annual out-of-pocket costs consumers will pay each year.

In the past, consumers could get relatively inexpensive, bare-bones coverage, but those plans will no longer be available. Many consumers are frustrated by what they call forced upgrades as they're pushed into plans with coverage options they don't necessarily want.

Ken Davis, who manages a fast food restaurant in Austin, Texas, is recovering from sticker shock after the small-business policy offered by his employer was canceled for the same reasons individual policies are being discontinued.

His company pays about $100 monthly for his basic health plan. He said he'll now have to pay $600 monthly for a mid-tier silver plan on the state exchange. The family policy also covers his 8-year-old son. Even though the federal government is contributing a $500 subsidy, he said the $600 he's left to pay is too high. He's considering the penalty.

"I feel like they're forcing me to do something that I don't want to do or need to do," Davis, 40, said.

Owners of canceled policies have a few options. They can stay in the same plan for the same price for one more year if they have one of the few plans that were grandfathered in. They can buy a similar plan with upgraded benefits that meets the new standards — likely at a significant cost

increase. Or, if they make less than $45,960 for a single adult or $94,200 for a family of four, they may qualify for subsidies.

Just because a policy doesn't comply with the law doesn't mean consumers will get cancellation letters. They may get notices saying existing policies are being amended with new benefits and will come with higher premiums. Some states, including Virginia and Kentucky, required insurers to cancel old policies and start from scratch instead of beefing up existing ones.

It's unclear how many individual plans are being canceled — no one agency keeps track. But it's likely in the millions. Insurance industry experts estimate that about 14 million people, or 5 percent of the total market for health care coverage, buy individual policies. Most people get coverage through jobs and aren't affected.

Many states require insurers to give consumers 90 days' notice before canceling plans. That means another round of cancellation letters will go out in March and again in May.

Experts haven't been able to predict how many will pay more or less under the new, upgraded plans. An older policyholder with a pre-existing condition may find that premiums go down, and some will qualify for subsidies.

In California, about 900,000 people are expected to lose existing plans, but about a third will be eligible for subsidies through the state exchange, said Anne Gonzalez, a spokeswoman for the exchange, called Covered California. Most canceled plans provided bare-bones coverage, she said.

"They basically had plans that had gaping holes in the coverage. They would be surprised when they get to the emergency room or the doctor's office, some of them didn't have drug coverage or preventive care," Gonzalez said.

About 330,000 Floridians received cancellation notices from the state's largest insurer, Florida Blue. About 30,000 have plans that were grandfathered in. Florida insurance officials said they're not tracking the number of canceled policies related to the new law.

National numbers are similar: 130,000 cancellations in Kentucky, 140,000 in Minnesota and as many as 400,000 in Georgia, according to officials in those states.

Cigna has sent thousands of cancellation letters to U.S. policyholders but stressed that 99 percent have the option of renewing their 2013 policy for one more year, company spokesman Joe Mondy said.

Cancellation letters are being sent only to individuals and families who purchase their own insurance. However, most policyholders in the individual market will receive some notice that their coverage will change, said Dan Mendelson, president of the market analysis firm Avalere Health.

The cancellations run counter to one of President Barack Obama's promises about his health care overhaul: "If you like your health care plan, you'll be able to keep your health care plan."

Philip Johnson, 47, of Boise, Idaho, was shocked when his cancellation notice arrived last month. The gift-shop owner said he'd spent years arranging doctors covered by his insurer for him, his wife and their two college-age students.

After browsing the state exchange, he said he thinks he'll end up paying lower premiums but higher deductibles. He said the website didn't answer many of his questions, such as which doctors take which plans.

"I was furious because I spent a lot of time and picked a plan that all my doctors accepted," Johnson said. "Now I don't know what doctors are going to take what. No one mentioned that for the last three years when they talked about how this was going to work."

• *Associated Press writers Christina A. Cassidy in Atlanta; Rachel La Corte in Olympia, Wash.; Marc Levy in Harrisburg, Pa.; Tom Murphy in Indianapolis; Juliet Williams in Sacramento, Calif.; and Kristen Wyatt in Denver contributed to this report.*

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BACKGROUNDER

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Health Insurers' Decisions on Exchange Participation: Obamacare's Leading Indicators

Edmund F. Haislmaier

Abstract
How have health insurance companies responded to Obamacare? Insights into how Obamacare is likely to alter the health care system can be gleaned from analyzing insurer decisions to participate, or not participate, in the new exchanges. An analysis of the decisions shows that in the vast majority of states the Obamacare exchanges will offer less, not more, insurer competition than the state's current individual market. Obamacare's complicated, income-based design of premium and cost-sharing subsidies will result in the exchange market essentially offering something akin to Medicaid managed care for the middle class. The resulting picture is one that millions of Americans are likely to find unappealing.

In the run-up to the launch of the Obamacare[1] health insurance exchanges, attention increasingly focused on the premiums for the new coverage—specifically the degree to which they might be higher or lower than current premiums.[2]

Yet, changes in premiums tell only part of the story. Additional insights into how Obamacare is likely to alter the health care system can be gleaned from analyzing insurer decisions to participate, or not participate, in the new exchanges. Analyzing insurer exchange participation decisions in light of current insurance market data and other public information can yield important insights into how insurers expect the implementation of Obamacare to change America's health system.

Health insurers are the market actors with the strongest motivation to understand how Obamacare is likely to alter the decision

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KEY POINTS

- Compared to the current individual health insurance market, insurer participation in the Obamacare exchanges represents a 29 percent net decrease in insurer competition nationwide.
- Obamacare's cost-sharing subsidies pay insurers to offer coverage to lower-income exchange enrollees with no deductibles and only nominal patient co-pays. As a result, Medicaid managed-care insurers are participating in the exchanges and many insurers are offering exchange plans with "narrow networks" that limit coverage to providers willing to accept low reimbursement.
- The insurers that decided to participate in the Obamacare exchanges are mainly a mix of Blue Cross carriers seeking to extend their market dominance, group-market carriers looking to retain enrollees when employers drop coverage, and Medicaid managed-care insurers expanding into a market they view as similar to their current business.
- The exchange market will essentially offer Medicaid managed care for the middle class.

making of the other players in the system—employers, individual consumers, and health care providers. Numerous provisions of Obamacare that will take effect in January 2014 will interact to reshape the health care market in significant ways. Because health insurers are either directly or indirectly affected by most of those changes, they have been forced to rethink their business plans.

Health insurers also have access to more comprehensive and granular data (from their own businesses) to feed into their assessments. Furthermore, they have had three years to analyze the data, map the interactions, and adjust their business plans in response to their expectations for the effects of Obamacare. Those factors all make insurer behavior a leading indicator for the likely path of future health system change under Obamacare.

It is possible to intuit some of the reasoning behind insurer decisions to participate, or not, in exchanges by examining state-level current market data and comparing it to state-level insurer exchange participation. Current market data offers a picture of each insurer's existing business focus, while exchange participation decisions can be presumed to reflect insurer expectations for Obamacare. Any patterns that emerge from such an analysis offer evidence of the extent to which insurer behavior is consistent, or inconsistent, with theoretical expectations.[3]

Divergent Expectations

In the three years since the enactment of Obamacare, there has been substantial disagreement between its supporters and opponents about the law's likely effects on health care markets. Until now, the two sides have supported their respective arguments with largely theoretical analyses. Now, with insurer-participation decisions finalized, and the exchanges open, it is possible to begin comparing the theories to reality. There are three broad areas in which the expectations of Obamacare's proponents and opponents differ:

1. **Increased vs. reduced insurer competition.** Proponents have argued that Obamacare's standardization of private health insurance and its creation of insurance exchanges offering easier consumer comparison shopping, along with substantial new premium subsidies, will stimulate greater competition among health insurers.

   In contrast, opponents have argued that Obamacare's product standardization and new insurer regulations, such as the "minimum loss ratio" regulation, are more likely to discourage insurer participation in the exchanges, induce smaller carriers to exit the market, raise barriers to market entry for new players, and limit the ability of existing carriers to expand beyond their current markets.[4]

2. **Coverage expansion vs. coverage substitution.** Proponents have argued that Obamacare will produce its intended effect of extending health insurance coverage to most of the currently uninsured population. They point to Obamacare's Medicaid expansion, new exchange coverage subsidies, and the individual mandate as factors that they believe will, collectively, produce a significant coverage expansion.

   In contrast, opponents have argued that any increase in coverage is likely to be much less than proponents forecast. They point to past experiences with expansions of Medicaid and the Children's Health Program (CHIP), in which a significant portion of the new enrollment was the product of the so-called crowd-out effect of individuals switching from private coverage to newly

1. Patient Protection and Affordable Care Act (PPACA) of 2010, Public Law 111-148.
2. For the most thorough analysis to date of premium changes, see Drew Gonshorowski, "How Will You Fare in the Obamacare Exchanges?" Heritage Foundation *Issue Brief* No. 4068, October 16, 2013, http://www.heritage.org/research/reports/2013/10/enrollment-in-obamacare-exchanges-how-will-your-health-insurance-fare.
3. All results reported in this *Backgrounder* that reference, or are otherwise based on, current market data, were derived by the author from insurance market data by state, carrier, and business segment, as reported in state insurance department regulatory filings, aggregated by the National Association of Insurance Commissioners (NAIC), and formatted into a comprehensive subscription data set by Mark Farrah Associates.
4. Edmund F. Haislmaier, "Health Care Consolidation and Competition After PPACA," testimony before the Subcommittee on Intellectual Property, Competition and the Internet, Committee on the Judiciary, U.S. House of Representatives, May 18, 2012, http://thf_media.s3.amazonaws.com/2013/pdf/Testimony-Insurance%20Consolidation.pdf.

available, and more generously subsidized, public coverage.[5] They argue that Obamacare's Medicaid expansion, new exchange coverage subsidies, and employer mandate are likely to produce similar shifts from private to public coverage. They also expect that Obamacare's new benefits and rating rules will make exchange plans more expensive (and thus, less attractive) to many of the uninsured (particularly younger and healthier) even after applying the new premium subsidies. Consequently, they expect the result to be a much lower net increase in coverage than supporters envision.

3. **Increased vs. reduced access to care.** Proponents have argued that Obamacare's coverage-expansion provisions will increase access to care. Opponents argue that, while access to care may improve for some of the newly insured, the increased costs and regulations imposed on private insurance are likely to result in less access to care for many others, particularly those who already have coverage. Opponents anticipate that insurers will respond to Obamacare's imposition of higher costs by excluding more providers from their networks and reducing provider reimbursement rates—resulting in more doctors who refuse to participate in their plans.

Of course, any definitive assessment of the accuracy of these contending expectations must await more complete data from real-world experience. For now, however, analyzing health-insurer-exchange-participation decisions at least indicates what those central players in the system expect, and thus, how the market is initially responding to Obamacare.

Determining Insurer Exchange Participation

The first measure for determining the extent of insurer exchange participation is the number of insurers offering coverage in each state's exchange. Since each participating insurer will be offering multiple plans, most of which are variations on the same basic design, the number of plans offered in each exchange has little significance. Indeed, the differences among the plans offered by each insurer will mostly consist of variations in the level of enrollee cost sharing, as Obamacare requires all exchange plans to offer standardized minimum benefits at prescribed levels of enrollee cost sharing. In fact, offering additional benefits above the required minimum risks making a plan more expensive and less competitive.

Also, the reported number of insurers participating in a state's exchange is sometimes misleading. That is because in some states an insurer may offer coverage through two or three of its subsidiaries—in which case, it is really one, not two or three, insurers participating in the exchange. For example, Illinois lists eight insurers as participating in its state exchange. However, the real number is five, because in Illinois Humana offers coverage through two subsidiaries, and Aetna offers coverage through three subsidiaries.[6] Conversely, a carrier operating in multiple states may elect to participate in the exchanges in some or all of those states. However, each state-level exchange participation by a multi-state carrier is a separate business decision. That is because insurance market competition occurs at the state level, states differ in the structure of their insurance markets and insurance regulations, and under Obamacare the approval criteria for exchange participation can vary from state to state.

Consequently, counting the number of insurers that participate in each state at the parent-company level is the most appropriate methodology. Thus, in this analysis, participation in a state by two or more subsidiaries of the same carrier is counted as participation by the one (parent) company, while participation by the same parent company in more than one state exchange (whether through the same or different subsidiaries) is counted separately for each state. This methodology also omits carriers that will

5. For a discussion of the economic literature on the crowd-out effects of Medicaid and CHIP expansions, see Paul L. Winfree and Greg D'Angelo, "The New SCHIP Bill: The Senate Must Protect Private Coverage," Heritage Foundation *WebMemo* No. 2246, January 26, 2009, http://www.heritage.org/research/reports/2009/01/the-new-schip-bill-the-senate-must-protect-private-coverage.
6. In Illinois, Aetna is offering coverage through its subsidiaries Aetna Life Insurance Company, Coventry Health and Life Insurance Company, and Coventry Health Care of Illinois, Inc., while Humana is offering coverage through its subsidiaries Humana Health Plan, Inc., and Humana Insurance Company. The three other carriers are: Blue Cross Blue Shield of Illinois (a subsidiary of Health Care Service Corporation), Health Alliance (the trade name of the Carle Foundation), and the new Land of Lincoln Health Insurance CO-OP. News release, "Governor Quinn Announces Health Plan Rates Are 25 Percent Below HHS Estimates," Office of the Governor Pat Quinn, September 24, 2013, http://insurance.illinois.gov/newsrls/2013/09/QHPRates.pdf (accessed October 21, 2013).

be offering only dental insurance in the exchanges, as supplemental dental plans will only qualify for subsidies if purchased in conjunction with a major medical plan. Furthermore, simply purchasing a dental plan does not constitute compliance with Obamacare's individual mandate. Similarly, carriers that will only offer plans to small businesses in the separate Small Business Health Options Program (SHOP) exchanges are also excluded from this analysis, as those plans do not qualify for exchange subsidies.[7]

This methodology finds that the 51 exchanges in the states and the District of Columbia will have a total of 254 participating carriers, for an average of five carriers each.[8] New York will have the most, with 16 participating carriers, while New Hampshire and West Virginia will have the fewest, with only one carrier offering plans in each state's exchange. Table 1 summarizes the extent of insurer competition in the exchanges. As Table 1 also shows, there does not appear to be any correlation between the level of insurer participation and whether the state or the federal government operates the exchange. Rather, state-specific exchange participation seems to generally reflect current insurance-market-participation patterns in the various states.

TABLE 1

Insurer Exchange Participation

States listed in **bold** indicates state-run exchange.

Number of Participating Insurers	Number of States	States
16	1	**New York**
13	1	Wisconsin
12	1	**California**
11	3	Ohio, **Oregon**, Texas
10	1	**Colorado**
9	2	**Massachusetts**, Michigan
8	2	Arizona, Florida
7	2	Pennsylvania, **Washington**
6	1	Utah
5	5	Georgia, Illinois, **Minnesota, New Mexico**, Virginia
4	9	**Idaho**, Indiana, Iowa, Louisiana, **Maryland**, Nebraska, **Nevada**, Oklahoma, Tennessee
3	11	Arkansas, **Connecticut**, Kansas, **Kentucky**, Missouri, Montana. North Dakota, New Jersey, South Carolina, South Dakota, **District of Columbia**
2	10	Alabama, Alaska, Delaware, **Hawaii**, Maine, Mississippi, North Carolina, **Rhode Island, Vermont**, Wyoming
1	2	New Hampshire, West Virginia

Notes: All figures are at the parent company level (i.e., an insurer offering exchange coverage in a state through two or more subsidiaries is counted as one company).
Source: Author's calculations based on federal and state information on exchange participation.

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Assessing Obamacare's Effects on Insurer Competition

One measure for assessing the effect of the Obamacare exchanges on insurer competition is the number of new entrants in the market. Of the 254 insurers participating in the various exchanges, only 25 are new ones—and 23 of those are so-called CO-OP insurers funded by federal grants and loans under a program created by Obamacare.[9] It is highly uncertain how many of those CO-OPs will be successful over the long term, given that they were created more in response to government policy than to any unmet market demand and that, even if successfully launched, they will likely generate little surplus capital (due to Obamacare's restrictive minimum loss ratio regulations) needed to fund future expansion.[10]

7. There are six instances where a carrier will be offering coverage in a state's SHOP exchange, but not in its individual exchange—one each in: Connecticut, Iowa, Maryland, Michigan, Rhode Island, and the District of Columbia.

8. The list of exchange-participating insurers was compiled by the author. The source for the federally facilitated exchanges is data from HealthCare.gov, "Health Plan Information for Individuals and Families," https://www.healthcare.gov/health-plan-information (accessed October 16, 2013). Information for the state-run exchanges comes from either the state's exchange or its insurance department.

9. One more CO-OP, in Ohio, failed to become licensed in time to participate in the exchanges next year. See Carrie Ghose, "Obamacare-Backed Insurer Left Off Online Marketplace After Missing License Deadline," *Columbus Business First*, August 27, 2013, http://www.bizjournals.com/columbus/blog/2013/08/obamacare-backed-insurer-left-off.html?page=all (accessed October 22, 2013).

10. Edmund F. Haislmaier, "Effects of the PPACA's Minimum Loss Ratio Regulations," testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, September 15, 2011, http://www.heritage.org/research/testimony/2011/12/effects-of-the-ppacas-minimum-loss-ratio-regulations.

The other two unsubsidized start-up insurers are both in New York. One is a regional plan sponsored by a local hospital system, the North Shore-Long Island Jewish Health System. This last insurer is the only one of the 25 new carriers with reasonable prospects for long-term success, as it is backed by an established local health system. As such, it seems to be following the same business strategy that a number of other local health systems throughout the country have successfully employed in the past.

Another measure for assessing the effects of the Obamacare exchanges on insurer competition is the number of existing carriers that are expanding into new markets. Nationally, there is only one instance of an established insurer expanding into a new market in response to Obamacare. That insurer is another carrier sponsored by a local health system, the Carle Foundation, which currently offers coverage (its Health Alliance plans) in Illinois and Iowa. In addition to offering coverage on the Illinois exchange, it will also offer coverage in Nebraska through that state's exchange.

It is, then, reasonable to conclude that Obamacare's provisions for expanding coverage by organizing state-based exchanges, subsidizing exchange coverage, and imposing an individual mandate to buy coverage, have so far had virtually no effect on inducing either the creation of new health insurers or the expansion of existing health insurers into new markets where they previously did not offer plans. Rather, the only significant increase in insurer competition will be as a result of direct government funding to create 23 new CO-OP insurers, for which there is high uncertainty about whether there will be sufficient market demand in the coming years.[11]

Yet another way to measure the effect of Obamacare on insurer competition is to compare, in each state, the number of carriers currently offering individual insurance to the number that will be offering coverage through the exchanges. That comparison is relevant because the plans offered in the exchanges will be for individual coverage. Also, the vast majority of exchange enrollees will likely qualify for new premium subsidies—theoretically making the exchanges an attractive source of coverage for consumers and a potential business opportunity for insurers.

In addition to the 25 new insurers, there are 36 instances in which an existing insurer not currently offering individual coverage in a state will offer such coverage through the state's exchange. However, that increase is offset by the fact that, in most cases, insurers whose principal line of business in a state is individual coverage have elected to not participate in the exchanges.

Table 2 compares, by state, the number of insurers participating in the exchange with the number of carriers that currently offer individual coverage. The data show that, despite 61 instances of new or existing carriers offering individual coverage for the first time through the exchanges, nationally there will still be 29 percent *less* insurer competition in the exchanges relative to the current market. Seven states will have the same level of competition in both markets, and five states will have more carriers offering exchange coverage than now offer individual coverage. In the remaining 38 states and the District of Columbia, fewer insurers will offer coverage in their exchanges relative to the number that currently offer individual-market coverage.[12]

Thus, in the vast majority of states, the Obamacare exchanges will offer less, not more, insurer competition than the state's current individual market.

Assessing Insurer Competition Within States

While state-level insurer participation is an important measure, it still overstates the actual level of competition that will occur in many states. That is because in most states, plans will be offered and priced on a local basis, and in many states few of the insurers participating in the state's exchange will offer plans in every county or region of the state.

For instance, the California exchange divided that state into 19 rating regions. In three of those regions (encompassing Los Angeles and San Diego)

11. Jay Hancock, "Rocky Opening Leaves Health Law's New Co-Ops Jittery," *Kaiser Health News*, October 15, 2013, http://capsules.kaiserhealthnews.org/index.php/2013/10/rocky-opening-leaves-health-laws-new-co-ops-jittery/ (accessed October 22, 2013).
12. The current individual market is much smaller than the other market segments. In this analysis, only carriers with 1,000 or more individual market enrollees in a state (as of the first quarter of 2013) are counted as currently offering such coverage. The assumption is that those carriers were likely still writing new individual policies as of 2012, while any carrier with fewer individual market enrollees was likely no longer writing new individual policies.

TABLE 2

Insurer Competition: Number of Insurers Offering Individual Coverage

State	In the Current Market	In the Exchange	Obamacare Effect on Competition
Alabama	4	2	-50%
Alaska	4	2	-50%
Arizona	11	8	-27%
Arkansas	7	3	-57%
California	12	12	0%
Colorado	14	10	-29%
Connecticut	7	3	-57%
Delaware	4	2	-50%
Florida	18	8	-56%
Georgia	11	5	-55%
Hawaii	2	2	0%
Idaho	5	4	-20%
Illinois	12	5	-58%
Indiana	11	4	-64%
Iowa	5	4	-20%
Kansas	9	3	-67%
Kentucky	6	3	-50%
Louisiana	8	4	-50%
Maine	4	2	-50%
Maryland	8	4	-50%
Massachusetts	8	9	13%
Michigan	14	9	-36%
Minnesota	6	5	-17%
Mississippi	5	2	-60%
Missouri	12	3	-75%
Montana	2	3	50%
Nebraska	4	4	0%
Nevada	5	4	-20%
New Hampshire	2	1	-50%
New Jersey	3	3	0%
New Mexico	3	5	67%
New York	10	16	60%
North Carolina	12	2	-83%
North Dakota	3	3	0%
Ohio	12	11	-8%
Oklahoma	8	4	-50%
Oregon	10	11	10%
Pennsylvania	14	7	-50%
Rhode Island	2	2	0%
South Carolina	9	3	-67%
South Dakota	4	3	-25%
Tennessee	10	4	-60%
Texas	18	11	-39%
Utah	9	6	-33%
Vermont	3	2	-33%
Virginia	10	5	-50%
Washington	7	7	0%
West Virginia	4	1	-75%
Wisconsin	15	13	-13%
Wyoming	5	2	-60%
District of Columbia	4	3	-25%
Total	**360**	**254**	-29%

Notes: All figures are at the parent company level (i.e., data for all subsidiaries of a company are aggregated under the one parent company). Since the current individual market is much smaller than the other market segments, current market figures are for carriers with 1,000 or more individual market enrollees in the applicable state, as of the most recent reporting period for which complete data are available (first quarter of 2013).
Sources: Author's calculations based on federal and state information on exchange participation and Mark Farrah Associates market data for current market participants.

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there will be a choice of six carriers, while five other regions will have a choice of only three carriers.[13] Thus, while 12 carriers are participating in California's exchange, in any given region of the state, enrollees will have a choice of plans from only one-quarter to one-half that number. Indeed, only two of the 12 participating carriers are competing statewide in all rating regions.

In the New York exchange, plans will be offered at the county and New York City borough level. While 16 carriers are participating in New York's exchange, the greatest competition will occur in four of the five New York City boroughs and Nassau County on Long Island, with nine carriers offering plans in each of those jurisdictions. In contrast, five New York counties have only two competing carriers, and 11 counties have only three. None of the 16 carriers participating in New York's exchange is offering coverage on a statewide basis.[14]

Furthermore, the largest states are not the only ones that will experience more limited local competition. For instance, Wisconsin is the state with the second-highest number of insurers participating in its exchange (13 carriers), but as in New York, none of them is offering coverage statewide. At the county level, actual competition in Wisconsin will consist of less than half the total number of participating insurers. The most competition will be six insurers—but that will only be the case in four Wisconsin counties. Eleven counties will have five competing insurers, 10 counties will have four competing insurers, 17 counties will have three competing insurers, another 17 will have two competing insurers, and the remaining 13 counties will have only one insurer offering exchange coverage. Thus, in 42 percent of Wisconsin's 72 counties, enrollees will be able to obtain exchange coverage from only one or two insurers.[15]

Similarly, while four insurers are participating in Iowa's exchange, three will offer plans in 14 of the state's 99 counties. The other 85 counties will have only two competing insurers each.[16] Indiana also has four insurers in its exchange, but all four will offer plans in only 6 of that state's 92 counties. Thirty Indiana counties will have only one insurer offering exchange coverage, and another 35 counties will have only two insurers.

In Arkansas, while three insurers are participating in the exchange, in 24 of the state's 75 counties (nearly one-third) only one carrier will offer coverage. In Mississippi, two carriers are offering coverage in the exchange, but they will compete directly in only five counties—the four counties that encompass Jackson and its surrounding area, and a fifth county that is a suburb of Memphis, Tennessee. In the other 77 Mississippi counties, the exchange will offer coverage from only one of the two carriers.[17]

Other states also have similar patterns of less insurer competition at the local level, particularly in more rural areas. In fact, only four states have *both* an above-average level of insurer participation in the exchange (six or more carriers), *and* a choice of plans in every region of the state from at least half the participating carriers, as shown in Table 3. Yet, those are states that already have more competitive markets, as evidenced by that fact that in no case does an insurer in any of the four states currently have even a 50 percent market share in a state's individual or employer-group market.

Assessing Insurer Participation Decisions

Each insurer decision to participate, or not participate, in a given state's exchange is the product of a variety of factors and considerations. While much of the thinking behind those decisions is not public, an examination of current insurance market data and other public information provides some insights into how insurer decisions reflect carrier expectations for Obamacare's market effects.

The private health insurance market can be divided into six basic business segments, or product "lines," each with different business characteristics:

13. Covered California, "Health Insurance Companies for 2014," September 2013, https://www.coveredca.com/PDFs/English/booklets/CC-health-plans-booklet-rev2.pdf (accessed October 22, 2013).
14. NY State of Health, "Health Plans by Counties and Boroughs," http://healthbenefitexchange.ny.gov/sites/default/files/Health%20Plans%20by%20County.pdf (accessed October 22, 2013).
15. Healthcare.gov, "Health Plan Information for Individuals and Families."
16. Ibid.
17. Ibid.

(1) individual coverage; (2) employer group coverage; (3) administrative services only (ASO) for self-insured employers; (4) Medicaid managed care; (5) Medicare Advantage plans; and (6) various "supplemental" coverage products, such as dental plans, vision care plans, Medicare supplemental policies, and prescription drug plans.

Some insurers concentrate on offering products in only one or two market segments, while others have a broader business portfolio, offering products in most or all segments. Thus, an insurer's principal business segment in a state is an important reference point for understanding that insurer's decision to participate, or not, in the state's exchange.

For instance, it is not surprising that carriers whose principal current business consists of offering Medicare Advantage plans will generally not participate in the exchanges, since the exchanges are designed to offer individual major medical coverage to the non-elderly. Nor is it surprising that insurers whose principal business is offering supplemental coverage plans will also generally not participate in the exchanges—other than those offering stand-alone dental plans, which, as previously noted, are not relevant to an analysis of insurer exchange participation.

That leaves four health insurance business segments where it is possible to look for patterns in insurer exchange-participation decisions that might give indications of carrier expectations for the effects of Obamacare.

The Individual Market. Because of the highly favorable tax treatment given to employer-sponsored insurance, individual coverage has long been a small subset (less than 10 percent) of the total private health insurance market. Such coverage is typically purchased by those without access to an employer-sponsored plan, such as the self-employed. However, Obamacare could potentially expand the individual market significantly, as the new exchange coverage will consist of individual plans accompanied by new federal subsidies for enrollees with incomes between 100 percent and 400 percent of the federal poverty level (FPL).

TABLE 3

States with Insurer Exchange Participation Above the National Average and Coverage Offered in Every Region of the State by at Least Half the Participating Insurers

State	Insurers Participating in Exchange	Insurer Competition at Rating Region Level	
		Maximum	*Minimum*
Colorado	10	9	5
Massachusetts	9	9	5
Oregon	11	10	9
Utah	6	6	4

Source: Author's calculations based on federal and state exchange participation information.

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However, in the exchange market there is almost a complete lack of participation by insurers whose principal business in a state is individual coverage. There are only three instances of such carriers deciding to participate in a state's exchange, and in all three cases the carrier's principal business in most other states is not individual-market coverage.[18]

Employer Group Coverage Market. This segment consists of insurers focused mainly on selling traditional employer-group policies. Their customers are typically small to medium-size employers, each with anywhere from a few employees to several hundred. In contrast to individual-market insurers, a large share of the carriers whose principal current business consists of offering employer-group market plans have elected to participate in the exchanges. For this category of insurers there are, nationally, 84 instances of carriers electing to participate in the exchange, versus 46 instances of carriers declining to participate—a participation rate of 65 percent to 35 percent. Thus, carriers whose principal business is employer-group coverage are effectively betting on the Obamacare exchanges by a ratio of two to one.

18. Centene, primarily a Medicaid managed care insurer, is participating in the exchange in Arkansas, where its only current business is through a subsidiary in the individual market. Humana operates in all states, with Medicare Advantage plans accounting for the largest share of its total enrollment. Humana is participating in the exchanges in 14 states and in two of them, Colorado and Utah, its largest business segment in the state happens to be the individual market.

Employer Self-Insured Market. While smaller employers tend to purchase so-called fully insured group coverage from an insurer, larger employers tend to "self-insure" their employee health plans—meaning that the employer, not the insurer, bears most of the risk for the plan's cost. However, self-insured plans almost always contract with an insurer, or another third-party administrator (TPA), to administer the benefits and process the claims. Insurers refer to contracts of this kind as administrative services only (ASO). Among the group of insurers whose principal business consists of ASO contracts with self-insured plans, there are, nationally, 78 instances of carriers participating in the exchange, versus 127 instances of carriers declining to participate—38 percent participation versus 62 percent nonparticipation.

However, there is an important caveat. This group includes 41 Blue Cross and Blue Shield insurers. Relative to their peers, there are other factors likely at play in Blue Cross participation decisions, such as the fact that many of them also have the largest share of the individual market in their state.

Thus, in order to form a more precise picture it is necessary to further divide the category of insurers whose principal business is ASO for self-insured employers into two subgroups. Doing so shows that for the subset consisting of Blue Cross carriers, 39 (95 percent) are participating in the exchanges, while two are not. In contrast, for the subset consisting of non–Blue Cross carriers, in only 39 instances (24 percent) are they participating in the exchanges, while in 125 instances (76 percent) they are not—a *nonparticipation* ratio of three to one.

Medicaid Managed-Care Market. During the past two decades there has been significant growth in states contracting with private insurers to deliver benefits to Medicaid enrollees, particularly non-elderly, non-disabled enrollees. The growth has been in both the number of states adopting this approach and the number of enrollees covered by "Medicaid managed care."[19] Among insurers whose principal business in a state is Medicaid managed care, nationwide there are 50 instances of carriers electing to participate in the exchanges, versus 103 instances of carriers declining to participate—33 percent participation versus 67 percent nonparticipation.

What Insurer Participation Decisions Indicate

There are five distinct patterns that emerge from this analysis. Each of those patterns offers evidence of the extent to which insurer behavior is consistent, or inconsistent, with theoretical expectations.

Pattern #1: Overwhelming participation by Blue Cross and Blue Shield carriers. Of the 62 Blue Cross and Blue Shield licensees in the U.S., all but three will participate in the exchanges.[20] This pattern is likely explained by the fact that Blue Cross carriers tend to occupy a unique competitive position in their local markets. Unlike its competitors that typically focus on one (or sometimes, two) market segments, a Blue Cross carrier is often the dominant insurer in two (or more) market segments in its state.

Consequently, the exchange participation decision of a Blue Cross carrier likely involves other considerations—such as whether it already has a dominant position in the individual market (as many do), or higher "brand awareness" among consumers—that might give it an advantage over other carriers in an exchange. For those Blue Cross carriers that are still nonprofits, there is the added consideration that tax law requires them to justify their nonprofit status by demonstrating a "community benefit." So, participating in the exchanges might help them make the case that they offer a community benefit, even though they largely operate the way their for-profit competitors do.

In sum, this pattern suggests that Blue Cross carriers view the exchanges as another market segment in which they can further leverage their existing local market dominance.

Pattern #2: Virtually no participation by individual market-focused carriers. Despite the fact that the exchanges will offer individual coverage, and that most enrollees will receive a federal premium subsidy, there is virtually no

19. For a concise discussion of the types and distribution of state Medicaid managed care programs, see Kaiser Commission on Medicaid and the Uninsured, "Medicaid Managed Care: Key Data, Trends, and Issues," *Policy Brief*, February 2012, http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8046-02.pdf (accessed October 23, 2013).

20. The only ones not participating in the exchanges are Blue Cross and Blue Shield of Mississippi, and Wellmark, the parent company of the Blue Cross and Blue Shield licensees in Iowa and South Dakota.

participation in the exchanges by insurers whose principal current business in a state consists of offering individual-market coverage. Indeed, there is *no* national carrier with an individual-market focus offering coverage in *any* of the exchanges.[21]

The most likely explanation is that carriers specializing in individual-market coverage tend to be relatively small, and that most individual policies are currently purchased from larger insurers—such as Blue Cross and Blue Shield carriers—that also have a large presence in other segments of the market.

A closely related factor is the considerable uncertainty that all insurers have about the expected risk profile of the exchange market, particularly the greater probability of higher-than-expected claims costs. Small carriers are less able than large ones to absorb substantial unanticipated losses. Obamacare's minimum loss ratio regulations also preclude insurers from increasing premiums in future years by enough to recoup any initial losses.[22] Thus, the only safe way for a small insurer to enter a market as uncertain as the new exchanges would be to "rate defensively"—meaning to start off charging premiums that reflect their actuaries' worst-case scenarios. However, since such higher premiums would make their plans less competitive, they might decide it is not worth the effort.

Whatever their reasons, it is quite clear that this group of carriers overwhelmingly concluded that the Obamacare exchanges are *not* an attractive business opportunity.

Pattern #3: Significant participation by employer group market-focused carriers. As noted, this group of insurers has elected to participate in the exchanges by a ratio of two to one. The most plausible explanation for this pattern is that carriers focused on this market segment anticipate significant erosion in employer-group coverage, as their customers—particularly smaller employers—are induced by Obamacare to drop their group plans and send their workers to the exchanges. Indeed, many workers in smaller firms would actually be financially better off if their employers dropped group coverage, as they would receive more generous subsidies for coverage through the exchanges.

It is also reasonable to infer from this behavior pattern that two-thirds of these carriers likely believe that offering coverage in the exchanges will give them an opportunity to retain at least some of their present enrollees when employers drop their current group plans in response to Obamacare.

This pattern is confirmed by the behavior of the largest carrier in this category, Kaiser Permanente, which operates in eight states and the District of Columbia. Seventy-six percent of Kaiser's total current enrollment comes from employer group plans, and Kaiser has elected to participate in the exchanges everywhere it operates.

Another confirming data point is the fact that of the 36 insurers that will be participating in the exchanges despite not currently offering individual coverage, 11 are carriers whose principal current business is employer-group coverage.

In sum, the behavior of this group of insurers appears to offer market confirmation of the expectation among Obamacare opponents that a significant number of employers (particularly smaller ones) are likely to drop their current group coverage plans in the coming years.

Pattern #4: Relatively little participation by carriers focused on providing administrative services to self-insured employer plans. In nearly two-thirds of cases the carriers in this group have opted not to participate in the exchanges. As noted, when the Blue Cross carriers are excluded, the nonparticipation rate for this group rises to three-quarters.

Most significant is that this group includes three of the four major insurers that operate nationally in all 50 states and the District of Columbia—Aetna, United, and Cigna. The exchange participation decisions of all three carriers strongly confirm this pattern. Nationally, 61 percent of Aetna's total business is ASO for employer self-insured plans, and Aetna will participate in only 16 of the exchanges.[23] For United, 54 percent of its total business is in this market segment, and it will participate in four exchanges.[24] In Cigna's

21. The two largest individual market-focused carriers operating nationwide are Sun Life Assurance Company and Assurant. Neither carrier is offering major medical exchange coverage in any state. All of Sun Life's major medical business is in the individual market, as is 79 percent of Assurant's business (the remaining 21 percent is employer-group coverage). Both carriers also offer free-standing dental plans.

22. Haislmaier, "Effects of the PPACA's Minimum Loss Ratio Regulations."

23. Aetna also participates in SHOP, but not in the individual exchange in Maryland.

24. United also participates in SHOP, but not in the individual exchanges in Connecticut, Michigan, Rhode Island, and the District of Columbia.

case, this coverage category accounts for 84 percent of its total business, and Cigna will offer exchange coverage in only five states.

The most likely explanation for this pattern is that insurers expect enrollment in the employer self-insured market segment to remain relatively stable under Obamacare. That expectation seems reasonable on several grounds. First, self-insured employers tend to be large—or very large—employers and as such would be subject to Obamacare's employer mandate penalties if they dropped coverage. Second, many workers in self-insured firms have family incomes that are too high to qualify for exchange coverage subsidies in the absence of an employer plan. Third, self-insured plans are exempt from Obamacare's requirement to cover a minimum set of "essential benefits," which means that they retain significant leeway to control future cost growth by making adjustments to their benefit designs.

Indeed, with respect to the last point, it is quite plausible that Obamacare will produce an *expansion* of the self-insured market segment—at the expense of the "fully insured" employer group-coverage segment. While Obamacare imposes the minimum essential benefit requirements only on insurance policies sold in the individual and small group markets, it also includes a provision that expands the definition of "small group" from 50 workers to 100 workers, starting in 2017. Thus, it would not be surprising if, faced with the onset of that costly mandate, in future years more medium-sized employers shift the coverage they now offer their workers from fully insured to self-insured plans.

Pattern #5: Notable participation by carriers focused on Medicaid managed care. At first glance, the two-to-one nonparticipation ratio among this group does not seem surprising. Another key component of Obamacare is the expansion of Medicaid to millions of low-income, able-bodied adults. Despite the Supreme Court ruling that Congress could not force states to expand Medicaid, the Congressional Budget Office projects that Obamacare will still add 9 million individuals to Medicaid in 2014.[25] Thus, it would be understandable if insurers whose principal business is Medicaid managed care decided to stick with what they know best, and took a pass on participating in the exchanges.

However, that explanation raises the intriguing question of why one-third of this group *did* elect to participate in the exchanges. One likely explanation is that because the incomes of many individuals fluctuate above and below the threshold for Medicaid eligibility, Medicaid managed-care insurers that participate in the exchanges will be better positioned to retain those enrollees in their plans. In those cases, the principal change would simply be the source of the government subsidies paying for the coverage. The other possibility is that this subgroup of carriers actually views offering exchange coverage as an attractive business opportunity in its own right.

This participation pattern is essentially the same for states that are, and are not, adopting the Medicaid expansion. That, too, is understandable, as insurers had to make their exchange participation decisions last spring, at a time when many states were still debating whether to adopt the Medicaid expansion.

Among insurers whose principal business in a state is Medicaid managed care, one-third are participating in the exchanges. Those carriers account for 50 (20 percent) of the 254 exchange participating carriers nationwide. If other insurers who also have Medicaid managed-care business—but for whom it is not their principal business—are included, the figure rises to 108 carriers, 43 percent of the 254 exchange participating insurers. Furthermore, of the 36 insurers that will participate in exchanges despite not currently offering individual coverage, 22 are carriers whose principal current business is Medicaid managed care.

However, 14 states do not have Medicaid managed care and, hence, have no carriers currently offering such coverage. Table 4 shows that, among the 36 states and the District of Columbia that operate part of their Medicaid programs through managed-care plans, nearly half (49.5 percent) of the carriers participating in their exchanges operate Medicaid managed-care plans in the state. Indeed, in 28 instances Medicaid managed-care accounts for *over 90 percent* of the carrier's current business in the state. Table

25. Congressional Budget Office, "Table 1: May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf (accessed October 23, 2013).

4 also shows that 31 states will have at least one insurer with Medicaid managed-care business in the state offering coverage on the exchange, and that in 18 states half or more of the insurers in the state's exchange currently have Medicaid managed-care business. Indeed, in six states Medicaid managed care is the *principal* current business of half or more of *all* exchange carriers—six of the 11 in Texas, three of the five in New Mexico, two of the four in Indiana, and one of the two each in Delaware, Mississippi, and Rhode Island.

Clearly, a number of carriers offering Medicaid managed care view the exchanges as a business opportunity. However, digging deeper into the data reveals distinctly different responses to Obamacare by the four biggest multi-state carriers in this category—Molina, Wellcare, Centene, and WellPoint:

- **Molina.** Just under 90 percent of Molina's total business consists of Medicaid managed care, and Molina is offering exchange coverage in nine of the 10 states where it currently operates. The exception is Louisiana, which is the only state where Molina's Medicaid business is not "at risk"—meaning that the company contracts with the state to manage the coverage of some Medicaid enrollees, but does not assume the risk for the cost of their coverage.

- **Wellcare.** In contrast to Molina's "all-in" position, Wellcare is "all-out" when it comes to the exchanges. Medicaid managed care accounts for 77 percent of Wellcare's total enrollment nationwide, but it is not participating in the exchanges in any of the six states where it offers that coverage. In fact, Wellcare is not participating in *any* exchange in *any* state—making it the only major multi-state health insurer of any kind to entirely avoid the exchanges.

- **Centene.** The approach taken by Centene is closer to that of Molina. Ninety percent of Centene's total enrollment comes from the Medicaid managed-care plans that it operates in 14 states. In seven of those states, Centene is offering exchange coverage, and those seven states collectively account for 75 percent of Centene's total Medicaid managed-care enrollment. Centene is also offering exchange coverage in two other states where it does not have Medicaid managed-care business. One is Massachusetts, where Centene already offers coverage through that state's existing Health Insurance Connector—which is being transitioned into an Obamacare exchange. The other is Arkansas, which does not currently have Medicaid managed care. In both states, Centene is offering exchange plans through its Celtic Insurance Company subsidiary, a small, individual market-focused insurer that it acquired in 2008.

- **WellPoint.** Perhaps the most interesting response among these four is WellPoint's. It operates Blue Cross plans in 14 states and will participate in the exchanges in all of those states. However, last year WellPoint acquired AmeriGroup—a Medicaid managed-care insurer operating in 12 states. In the states where AmeriGroup operates, but where Wellpoint does *not* have a Blue Cross subsidiary, the company will *not* participate in the exchanges. Thus, WellPoint has essentially responded to the exchanges as a Blue Cross carrier. The company apparently views its acquisition of AmeriGroup as a play on the Medicaid expansion—not as a way to leverage broader participation in the exchanges.

Effects of Obamacare's Cost-Sharing Subsidies on Exchange Coverage

One major feature of Obamacare that has received relatively little attention is the law's cost-sharing subsidies for lower-income exchange enrollees. Yet, understanding how those subsidies operate—and how they interact with the other provisions of Obamacare—goes a long way toward explaining not only why Medicaid managed-care insurers are participating in the exchanges, but also why many insurers are offering exchange plans with "narrow networks" that limit coverage to certain providers.

Obamacare provides both premium subsidies and cost-sharing subsidies for exchange coverage, and both sets of subsidies vary based on enrollee income.

Most of the attention has so far focused on the premium subsidies for exchange enrollees with family incomes between 100 percent and 400 percent of the FPL. Those premium subsidies are calculated at enrollment based on the individual's family income and with reference to the second-lowest-cost Silver plan that is offered in the

enrollee's location.[26] For example, if it is determined—by applying the statutory formula to the enrollee's income—that an enrollee will be responsible for paying $100 a month for coverage, and if the reference plan (second-lowest-cost Silver plan) costs $250 a month, that enrollee's subsidy will then be set at $150 a month.

Once the enrollee's premium subsidy is calculated, he can apply that amount to the purchase of any available exchange plan in the Bronze, Silver, Gold, or Platinum coverage levels, with responsibility for paying the difference (if any) between the subsidy amount and the total premium. So, to continue the foregoing example, if the enrollee picks a more expensive plan, say, one costing $300 a month, he would have to pay $150 a month for coverage ($300 premium minus $150 subsidy). If instead the enrollee picks a less costly plan, say, one with a $200 a month premium, he would only have to pay $50 a month for coverage ($200 premium minus $150 subsidy).

However, the cost-sharing subsidies work very differently. To start with, they only apply to Silver plans—so an enrollee *must* buy a Silver plan to benefit from the cost-sharing subsidies. Second, the cost-sharing subsidies are paid directly to the insurer, without the enrollee knowing the amount. All that the enrollee knows is that the deductibles and co-payments that come with *his* coverage are less than the plan's standard amounts. For example, if the plan's deductible is $2,000 but an enrollee's income qualifies for cost-sharing subsidies that pay the insurer to lower his deductible to $500, the enrollee will be told that, for *him*, the deductible is $500. The plan's premium, and the premium subsidy that the enrollee receives, remain the same. Thus, for the same premium, the enrollee will be getting the plan with lower cost-sharing requirements.

Of course, that makes the actual cost of the plan to the insurer (for that enrollee) more expensive than the stated premium, but the federal government pays the insurer the additional cost-sharing subsidy to cover the difference.

Thus, different individuals can purchase the same plan for the same nominal premium, while, based on their different incomes, ending up with different deductible and co-pay levels for their coverage. Table 5 illustrates how this will work. The third row in the table shows the effect of the premium subsidies. An enrollee with an income of 400 percent of the FPL will be responsible for paying $364 a month for the reference plan (the second-lowest-cost Silver plan), while an enrollee with an income of 100 percent of the FPL has to only pay $19 a month for the same coverage. The federal government pays the difference (if any) between those amounts and the plan's premium to the insurer as a premium subsidy.

The next 14 rows in Table 5 show how the plan's various cost-sharing provisions will also be adjusted based on enrollee income. Thus, an enrollee with an income of 400 percent of the FPL will have a $2,000 deductible and be charged a $45 co-pay for each doctor visit, while an enrollee at 100 percent of the FPL will have no deductible and be charged only $3 for each doctor visit—even though both enrollees bought *the same plan*.

Those adjustments, of course, increase the real cost of the coverage for the second enrollee, but the nominal premium remains the same. Instead, the federal government pays the insurer a *second* set of subsidies (the cost-sharing subsidies) to cover the difference between the real and nominal premium that results from the requirement that the insurer reduce the plan's deductibles and co-pays for lower-income enrollees. The result is that lower-income enrollees will pay very little in either premiums or out-of-pocket expenses for their coverage, while Obamacare's complicated subsidy scheme will reimburse insurers for the extra cost of those features.

However, this design creates a problem for insurers. A substantial share of their exchange enrollees are likely to be on the lower end of the income scale. That is because lower-income individuals are not only more likely to be uninsured and seeking coverage, but will also find exchange coverage more attractive, as they will be able to buy plans with very low co-pays and heavily subsidized premiums.

26. Obamacare standardizes health insurance plans based on the concept of "actuarial value." A plan's actuarial value is the average share of total expenses for the covered benefits that the plan pays. So, an actuarial value of 70 percent means that the plan, on average, pays 70 percent of the total expense for the covered benefits. The enrollee is responsible for paying the remaining costs, according to the plan's schedule of deductibles and co-pays. The four plan categories specified in Obamacare are: Bronze (60 percent actuarial value), Silver (70 percent actuarial value), Gold (80 percent actuarial value), and Platinum (90 percent actuarial value). See Public Law 111-148 §1302(d).

TABLE 4

Insurers with Medicaid Managed-Care Business

The table below lists the 36 states and the District of Columbia that provide some Medicaid coverage through Medicaid managed care (MMC) and the number of MMC insurers that chose to participate in their exchanges. About half of the participating insurers in these states conduct MMC business in their states, and about one-quarter have MMC as their principal business.

	NUMBER OF PARTICIPATING INSURERS IN EXCHANGE			
State	**Total**	*... doing some* business *in MMC*	*... with MMC as* principal business	*... with MMC accounting for* more than 90 percent of business
Arizona	8	2	2	2
California	12	8	5	5
Colorado	10	2	1	
Connecticut	3			
Delaware	2	1	1	
Florida	8	5	3	2
Georgia	5	2	1	1
Hawaii	2	2		
Illinois	5	1		
Indiana	4	3	2	2
Iowa	4			
Kansas	3			
Kentucky	3	1		
Louisiana	4			
Maryland	4	2		
Massachusetts	9	5	2	
Michigan	9	6	4	2
Minnesota	5	4	1	
Mississippi	2	1	1	1
Missouri	3	1		
Nebraska	4	1	1	
Nevada	4	2		
New Mexico	5	4	3	1
New York	16	11	4	4
Ohio	11	5	4	3
Oregon	11	3	1	1
Pennsylvania	7	5	1	
Rhode Island	2	1	1	1
South Carolina	3	1		
Tennessee	4	1		
Texas	11	10	6	1
Utah	6	2	1	
Virginia	5	3	1	
Washington	7	3	3	2
West Virginia	1			
Wisconsin	13	10	1	
District of Columbia	3			
Totals	**218**	**108**	**50**	**28**

Note: Connecticut, Iowa, Kansas, Louisiana, and West Virginia appear on this list because they have insurers that provide MMC, but none of the insurers in those states currently offering MMC will be participating in the state exchanges.
Source: Author's calculations based on federal and state information on exchange participation and Mark Farrah Associates data on current enrollment by carrier, state, and market segment.

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TABLE 5

Sliding Scale Benefits (Single Person)

Percent of FPL Annual Income	100%–150% $11,490–$17,235	150%–200% $17,235–$22,980	200%–250% $22,980–$28,725	250%–400% $28,725–$45,960
Consumer Portion of Premium for Silver Plans (balance paid by federal subsidy)	$228–$684/year ($19–$57/month)	$684–$1,452/year ($57–$121/month)	$1,452–$2,316/year ($121–$193/month)	$2,316–$4,368/year ($193–$364/month)
Deductible	None	$500	$1,500 medical deductible	$2,000 medical deductible
Preventative Care Co-pay	No cost	No cost	No cost	No cost for 1 annual visit
Primary Care Visit Co-pay	$3	$15	$40	$45
Specialty Care Visit Co-pay	$5	$20	$50	$65
Urgent Care Visit Co-pay	$6	$30	$80	$90
Lab Testing Co-pay	$3	$15	$40	$45
X-Ray Co-pay	$5	$20	$50	$65
Generic Medication Co-pay	$3	$5	$20	$25
Emergency Room Co-pay (waived if admitted)	$25	$75	$250	$250
Emergency Medical Transportation Co-pay	$25	$75	$250	$250
Hospital Care and Outpatient Surgery	10%	15%	20% of the plan's negotiated rate	20% of the plan's negotiated rate
Drug Deductible	None	$50, then pay the co-pay amount	$250, then pay the co-pay amount	$250, then pay the co-pay amount
Preferred Brand Co-pay After Drug Deductible	$5	$15	$30	$50
Maximum Out-of-Pocket	$2,250	$2,250	$5,200	$6,350
Actuarial Value	94%	87%	73%	70%

Source: Covered California, "2014 Sliding Scale Benefits: Single Person," http://www.coveredca.com/PDFs/English/CoveredCA_HealthPlanBenefitsSummary.pdf (accessed September 23, 2013).

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The problem is that insurers know that the very low co-pays charged to lower-income enrollees will have virtually no effect on their demand for health care services. Thus, the only way that insurers will be able to control plan costs is by limiting coverage to a smaller number of providers willing to accept low reimbursement in return for a high volume of patients.

This explains why many participating insurers—including ones that do not currently operate Medicaid managed-care plans—are offering narrow network plans on the exchanges. For instance, California Blue Shield has no Medicaid managed-care business, but the plans it offers on the California exchange restrict enrollees to about half the number of providers in its regular network for non-exchange plans.[27] In New Hampshire the only carrier offering coverage on the state's exchange is Anthem (a subsidiary of WellPoint). Because New Hampshire is a state that does not contract with managed-care plans for Medicaid, Anthem has no Medicaid managed-care business in the state. Yet for its New Hampshire exchange plans, Anthem includes only 16 of the state's 26 hospitals in its network.[28] Indeed,

27. Chad Terhune, "Insurers Limiting Doctors, Hospitals in Health Insurance Market," *Los Angeles Times*, September 14, 2013, http://www.latimes.com/business/la-fi-insure-doctor-networks-20130915,0,2814725.story (accessed October 23, 2013).

28. Ben Leubsdorf, "Anthem Takes Heat from N.H. Senators Over Limited Provider Network for Marketplace Plans," *Concord Monitor*, September 19, 2013, http://www.concordmonitor.com/news/work/business/8491779-95/anthem-takes-heat-from-nh-senators-over-limited-provider-network-for-marketplace-plans (accessed October 23, 2013).

insurers throughout the country are responding in much the same way.[29]

Given the parameters set by Obamacare, narrow network plans are less the product of a desire to keep premiums low, or improve quality, but rather of the need to control costs in a market where the insurer cannot rely on standard levels of cost sharing to encourage patients to be judicious consumers of medical services. Put simply, when the government pays insurers to lower cost sharing to the point that some patients are charged less than the price of a sandwich for a visit to the doctor, and calling an ambulance could be cheaper than calling a taxi, insurers know that their only recourse is to limit their plans to covering a smaller group of low-cost providers.

It should, therefore, not be surprising that a number of insurers with Medicaid managed-care business saw in Obamacare's exchange subsidy design an end result that looks a lot like Medicaid managed care—and thus, decided to offer coverage on the exchanges. It is a business model that they already know how to successfully implement. Indeed, Molina's CEO was recently quoted in the *Miami Herald* explaining that "Medicaid is essentially an individual market for low-income patients ... and Medicaid has premiums that are paid for by the state. The reason we went after the exchange is we feel there are a lot of similarities."[30]

Even though insurers can adjust for the inability to use cost sharing to influence patient behavior by offering narrow network plans, that response creates another problem—one for which they do not have a solution. The new problem is that while relying on a limited network of providers accommodates lower-income enrollees who face only nominal cost sharing, it also makes the plan much less attractive to higher-income enrollees.

For instance, in San Diego, the premium for the second-lowest-cost Silver plan for a 40-year-old is $308 a month. Consider two 40-year-old enrollees living in San Diego; one with an income at 150 percent of the poverty level ($17,235 a year), and the other with twice that income at 300 percent of the poverty level ($34,470 a year). The first enrollee pays $57 a month for that plan, with the federal government paying the remaining $251 in a premium subsidy. Table 5 shows that the government also pays the insurer a cost-sharing subsidy to lower the insured's deductible to zero, and his physician co-pays to $3 and $5.

The second enrollee pays $273 a month for the same plan, with the federal government paying only a $35 a month premium subsidy. Furthermore, the second enrollee does not qualify for reduced co-pay amounts. Table 5 shows that his deductible is $2,000 and that his physician co-pays are $45 and $65. If the plan only pays for visits to a limited network of providers, that might be an acceptable trade-off for the first enrollee, but is likely to be an unattractive proposition for the second one—who is paying much more in premiums, has a substantial deductible, and is charged higher co-pays for each visit. Thus, the second enrollee is much less likely to buy the coverage.

Because Obamacare's cost-sharing subsidy design essentially forces insurers to adopt more limited provider networks for at least the Silver-plan level of exchange coverage, those plans will be less attractive to enrollees with incomes between 250 percent and 400 percent of the FPL—as they do not benefit from reduced cost sharing and also get much less in premium subsidies. That could result in enrollees in the bottom half of the exchange income scale (100 percent to 200 percent of the FPL) clustering in Silver plans while those in the upper half of the exchange income scale (200 percent to 400 percent of the FPL) gravitate toward Bronze-level plans that cover more providers and offer lower premiums, but impose higher deductibles and more cost sharing. Indeed, for those with incomes between 300 percent and 400 percent of the FPL, the premium subsidies offered for exchange coverage are so small that many might decide to instead seek coverage elsewhere.

29. Robert Pear, "Lower Health Insurance Premiums to Come at Cost of Fewer Choices," *The New York Times*, September 22, 2013, http://www.nytimes.com/2013/09/23/health/lower-health-insurance-premiums-to-come-at-cost-of-fewer-choices.html?pagewanted=1&_r=3&hp& (accessed October 23, 2013), and Anna Wilde Mathews, "Many Health Insurers to Limit Choices of Doctors, Hospitals," The *Wall Street Journal*, August 14, 2013.

30. Daniel Chang, "Obamacare Plans for South Florida Vary Widely in Prices, Value," *Miami Herald*, October 5, 2013, http://www.miamiherald.com/2013/10/05/3672251/obamacare-plans-for-south-florida.html (accessed October 23, 2013).

Conclusion

The patterns that emerge from this analysis of insurer exchange participation decisions offer the first indications of what the Obamacare exchange market is likely to look like.

When compared with the divergent expectations of Obamacare supporters and opponents, the evidence is more consistent with the expectations of opponents than with those of supporters. Specifically:

- With respect to insurer competition, by any measure Obamacare has produced no more than negligible increases in competition—and in only a handful of states. Furthermore, when compared to the current individual market, the Obamacare exchanges actually represent a significant (29 percent) net *decrease* in insurer competition nationwide. Those results strongly confirm the expectations of Obamacare's opponents.

- On the question of coverage expansion versus coverage substitution, a definitive answer must still await data on actual enrollment during the coming months. That said, the insurer participation patterns revealed by this analysis suggest that, at a minimum, there is an expectation among insurers that Obamacare will produce measurable coverage substitution effects resulting from employers dropping their current plans in response to Obamacare. In particular, the exchange participation decisions of insurers whose principal current business is employer-group coverage are at least consistent with the views of Obamacare opponents on this question.

- When it comes to the question of whether Obamacare will result in increased or decreased access to care, this analysis finds two patterns that confirm Obamacare opponents' expectations for reduced access. The first is the participation in the exchanges by a significant number of carriers with current Medicaid managed-care business—particularly the subset for which Medicaid managed care is their main, or even exclusive, current business. The second is the fact that those insurers, along with others—including ones that do not currently have any Medicaid managed-care business—are offering exchange plans that cover only narrow networks of providers.

For the vast majority of states, the exchanges will offer less insurer competition than the state's current individual market. Most of the insurers whose principal business is employer-group coverage appear to expect significant erosion in that coverage segment due to Obamacare inducing employers to drop their current group plans. Given that the distribution of exchange enrollees will likely be skewed toward the lower end of the 100 percent to 400 percent of FPL income range (and thus, eligible for reduced cost sharing), participating insurers are offering exchange plans with limited provider networks and a significant number of Medicaid managed-care plans opted to join the exchanges.

The insurers who have elected to participate in the exchanges are mainly a mix of Blue Cross carriers seeking to extend their current market dominance, group-market carriers seeking to retain enrollees when employers drop coverage, and Medicaid managed-care insurers expanding into a market that they view as very similar to their current business.

In fact, Obamacare's complicated, income-based design of premium and cost-sharing subsidies will result in the exchange market essentially offering something like Medicaid managed-care for the middle class.

The resulting picture is one that millions of Americans are likely to find unappealing. It is yet another reason why Congress should simply scrap the entire—ill-conceived—law and replace it with simpler and better solutions.

*—**Edmund F. Haislmaier** is Senior Research Fellow in the Center for Health Policy Studies at The Heritage Foundation.*

APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 1 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Alabama	Blue Cross and Blue Shield of Alabama	Blue Cross and Blue Shield of Alabama	Self-Insured Employers (ASO)
	Humana, Inc.	Humana Insurance Company	Medicare Advantage
Alaska	Moda Health	Moda Health	Self-Insured Employers (ASO)
	Premera Blue Cross	Premera Blue Cross Blue Shield of Alaska	Employer Group Insurance
Arizona	Aetna, Inc.	Aetna	Self-Insured Employers (ASO)
	Blue Cross Blue Shield of Arizona, Inc.	Blue Cross Blue Shield of Arizona, Inc.	Self-Insured Employers (ASO)
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Compass Cooperative Health Plan, Inc.	Meritus Health Partners, Meritus Mutual Health Partners	N/A—New Insurer, CO-OP
	Health Net, Inc.	Health Net Life Insurance Company, Health Net of Arizona	Employer Group Insurance
	Humana, Inc.	Humana Health Plan, Inc.	Medicare Advantage
	IASIS Healthcare	Health Choice Insurance Co.	Medicaid Managed Care
	University of Arizona Health Network	University of Arizona Health Plans	Medicaid Managed Care
Arkansas	Arkansas Blue Cross Blue Shield	Arkansas Blue Cross Blue Shield	Self-Insured Employers (ASO)
	Centene Corporation	Ambetter of Arkansas	Individual Insurance
	QualChoice of Arkansas, Inc.	QualChoice Health Insurance	Self-Insured Employers (ASO)
California	Alameda Alliance for Health	Alameda Alliance for Health	Medicaid Managed Care
	Blue Shield of California	Blue Shield of California	Employer Group Insurance
	Chinese Community Health Plan	Chinese Community Health Plan	Medicare Advantage
	Contra Costa Health Services	Contra Costa Health Plan	Medicaid Managed Care
	Health Net, Inc.	Health Net	Employer Group Insurance
	Kaiser Permanente	Kaiser Pemanente	Employer Group Insurance
	L.A. Care Health Plan	L.A. Care Health Plan	Medicaid Managed Care
	Molina Healthcare, Inc.	Molina Healthcare	Medicaid Managed Care
	Sharp HealthCare	Sharp Health Plan	Employer Group Insurance
	Valley Health Plan	Valley Health Plan	Medicaid Managed Care
	WellPoint, Inc.	Anthem Blue Cross of CA	Self-Insured Employers (ASO)
	Western Health Advantage	Western Health Advantage	Employer Group Insurance
Colorado	Access Health Colorado	New Health Ventures Access Health	Medicaid Managed Care
	Cigna Health and Life Insurance Company	Cigna	Self-Insured Employers (ASO)
	Colorado Choice Health Plans	Colorado Choice Plans	Self-Insured Employers (ASO)
	Colorado Health Insurance Cooperative, Inc.	Colorado Health Insurance Cooperative	N/A—New Insurer, CO-OP
	Denver Health Medical Plan, Inc.	Denver Health Medical Plan	Employer Group Insurance
	Humana, Inc.	Humana Health Plan, Inc.	Individual Insurance
	Kaiser Permanente	Kaiser Foundation Health Plan of CO	Employer Group Insurance
	Rocky Mountain Health Plans	Rocky Mountain View, Rocky Mountain Mesa County Exclusive	Self-Insured Employers (ASO)
	UnitedHealth Group	All Savers Insurance Co.	Self-Insured Employers (ASO)
	WellPoint, Inc.	HMO Colorado, Inc.	Self-Insured Employers (ASO)
Connecticut	EmblemHealth	ConnectiCare	Employer Group Insurance
	HealthyCT, Inc.	HealthyCT	N/A—New Insurer, CO-OP
	WellPoint, Inc.	Anthem Blue Cross Blue Shield	Self-Insured Employers (ASO)
Delaware	Aetna, Inc.	CoventryOne	Medicaid Managed Care
	Highmark Health Services	Highmark Blue Cross Blue Shield Delaware	Self-Insured Employers (ASO)

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Florida	Aetna, Inc.	Aetna, CoventryOne	Self-Insured Employers (ASO)
	Blue Cross Blue Shield Florida	Florida Blue, Florida Blue HMO, Florida Health Care Plans	Self-Insured Employers (ASO)
	Centene Corporation	Ambetter from Sunshine Health	Medicaid Managed Care
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Health First	Health First Insurance, Inc.	Medicare Advantage
	Humana, Inc.	Humana Medical Plan, Inc.	Medicare Advantage
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Preferred Medical Plan, Inc.	Preferred Medical Plan	Medicaid Managed Care
Georgia	Alliant Health Plans	Alliant Health Plans	Employer Group Insurance
	Centene Corporation	Ambetter from Peach State Health Plan	Medicaid Managed Care
	Humana, Inc.	Humana Insurance Company, Humana Employers Health Plan of Georgia, Inc.	Employer Group Insurance
	Kaiser Permanente	Kaiser Foundation Health Plan of Georgia	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
Hawaii	Hawaii Medical Service Association	Hawaii Medical Service Association	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente Hawaii	Employer Group Insurance
Idaho	Blue Cross of Idaho Health Service, Inc.	Blue Cross of Idaho	Employer Group Insurance
	Cambia Health Solutions, Inc.	BridgeSpan Health Company	Employer Group Insurance
	Intermountain Healthcare	SelectHealth, Inc.	Medicare Advantage
	PacificSource Health Plans	PacificSource Health Plans	Employer Group Insurance
Illinois	Aetna, Inc.	Aetna, Coventry Health Care	Self-Insured Employers (ASO)
	Health Care Service Corporation	Blue Cross Blue Shield of Illinois	Self-Insured Employers (ASO)
	Humana, Inc.	Humana Insurance Company, Humana Health Plan, Inc.	Employer Group Insurance
	Land of Lincoln Mutual Health Insurance Company	Land of Lincoln Mutual Health Insurance Co.	N/A—New Insurer, CO-OP
	The Carle Foundation	Health Alliance Medical Plans	Employer Group Insurance
Indiana	Centene Corporation	Ambetter from MHS	Medicaid Managed Care
	MDwise	MDwise	Medicaid Managed Care
	Physicians Health Plan of Northern Indiana, Inc.	Physicians Health Plan	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
Iowa	Aetna, Inc.	Coventry Health Care of Iowa Inc.	Self-Insured Employers (ASO)
	Avera Health Plans	Avera Health Plans	Employer Group Insurance
	CoOportunity Health	CoOportunity Health	N/A—New Insurer, CO-OP
	Gundersen Health Plan, Inc.	Gundersen Health Plan, Inc.	Employer Group Insurance
Kansas	Aetna, Inc.	Coventry Health and Life, Coventry Health Care of Kansas, Inc.	Employer Group Insurance
	Blue Cross and Blue Shield of Kansas	Blue Cross and Blue Shield of Kansas, Inc	Employer Group Insurance
	Blue Cross and Blue Shield of Kansas City	Blue Cross and Blue Shield of Kansas City	Self-Insured Employers (ASO)
Kentucky	Humana, Inc.	Humana Health Plan, Inc.	Self-Insured Employers (ASO)
	Kentucky Health Cooperative, Inc.	Kentucky Health Cooperative, Inc.	N/A—New Insurer, CO-OP
	WellPoint, Inc.	Anthem Health Plans of Kentucky, Inc.	Self-Insured Employers (ASO)

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Louisiana	Humana, Inc.	Humana Health Benefit Plan of Louisiana, Inc.	Medicare Advantage
	Louisiana Health Cooperative, Inc.	Louisiana Health Cooperative	N/A—New Insurer, CO-OP
	Louisiana Health Service & Indemnity Company	Blue Cross Blue Shield Louisiana, HMO Louisiana, Inc.	Self-Insured Employers (ASO)
	Vantage Health Plan, Inc.	AAA Vantage Health Plan	Employer Group Insurance
Maine	Maine Community Health Options	Maine Community Health Options	N/A—New Insurer, CO-OP
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Employer Group Insurance
Maryland	CareFirst Blue Cross Blue Shield	CareFirst of Maryland, Inc., CareFirst BlueChoice, Inc., GHMSI	Self-Insured Employers (ASO)
	Evergreen Health Cooperative, Inc.	Evergreen Health	N/A—New Insurer, CO-OP
	Kaiser Permanente	Kaiser Foundation	Employer Group Insurance
	UnitedHealth Group	All Savers Insurance	Self-Insured Employers (ASO)
Massachusetts	Baystate Health	Health New England	Employer Group Insurance
	Blue Cross Blue Shield of Massachusetts	Blue Cross Blue Shield of Massachusetts	Self-Insured Employers (ASO)
	Boston Medical Center Health Plan, Inc.	Boston Medical Center HealthNet Plan	Medicaid Managed Care
	Centene Corporation	Ambetter from CeltiCare	Employer Group Insurance
	Fallon Community Health Plan	Fallon Community Health Plan	Employer Group Insurance
	Harvard Pilgrim Health Care, Inc.	Harvard Pilgrim Health Care	Self-Insured Employers (ASO)
	Minuteman Health, Inc.	Minuteman Health	N/A—New Insurer, CO-OP
	Partners HealthCare System, Inc.	Neighborhood Health Plan	Medicaid Managed Care
	Tufts Health Plan	Tufts Health Plan, Network Health	Self-Insured Employers (ASO)
Michigan	Blue Cross Blue Shield of Michigan	Blue Cross Blue Shield of Michigan, Blue Care Network of Michigan	Self-Insured Employers (ASO)
	Caidan Enterprises, Inc.	Meridian Choice	Medicaid Managed Care
	Consumers Mutual Insurance of Michigan	Consumers Mutual Insurance of Michigan	N/A—New Insurer, CO-OP
	Henry Ford Health System	HAP	Employer Group Insurance
	Humana, Inc.	Humana Medical Plan of Michigan Inc.	Medicare Advantage
	McLaren Health Care	McLaren Health Plan, Inc.	Medicaid Managed Care
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Spectrum Health	Priority Health	Employer Group Insurance
	Total Health Care	Total Health Care USA, Inc.	Medicaid Managed Care
Minnesota	Blue Cross and Blue Shield of Minnesota	Blue Cross and Blue Shield of Minnesota	Self-Insured Employers (ASO)
	HealthPartners	HealthPartners	Employer Group Insurance
	Medica Holding Company	Medica	Employer Group Insurance
	PreferredOne Community Health Plan	PreferredOne Insurance Company	Self-Insured Employers (ASO)
	UCare Health, Inc.	UCare Minnesota	Medicaid Managed Care
Mississippi	Centene Corporation	Ambetter from Magnolia Health Plan	Medicaid Managed Care
	Humana, Inc.	Humana Insurance Company	Medicare Advantage
Missouri	Aetna, Inc.	Coventry Health Care, Coventry Health and Life	Self-Insured Employers (ASO)
	Blue Cross and Blue Shield of Kansas City	Blue Cross and Blue Shield of Kansas City	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Employer Group Insurance
Montana	Blue Cross and Blue Shield of Montana	Blue Cross and Blue Shield of Montana	Self-Insured Employers (ASO)
	Montana Health CO-OP	Montana Health CO-OP	N/A—New Insurer, CO-OP
	PacificSource Health Plans	PacificSource Health Plans	Employer Group Insurance

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Nebraska	Aetna, Inc.	Coventry Health Care of Nebraska Inc.	Medicaid Managed Care
	Blue Cross and Blue Shield of Nebraska	Blue Cross and Blue Shield of Nebraska	Self-Insured Employers (ASO)
	CoOportunity Health	CoOportunity Health	N/A—New Insurer, CO-OP
	The Carle Foundation	Health Alliance-Alegent Creighton Health Partner	N/A—New to State
Nevada	Nevada Health CO-OP	Nevada Health CO-OP	N/A—New Insurer, CO-OP
	Saint Mary's Health Plans	St. Mary's	Employer Group Insurance
	UnitedHealth Group	Health Plan of Nevada	Self-Insured Employers (ASO)
	WellPoint, Inc.	Anthem	Self-Insured Employers (ASO)
New Hampshire	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
New Jersey	Freelancers Consumer Operated And Oriented Program Of New Jersey, Inc.	Health Republic Insurance of New Jersey	N/A—New Insurer, CO-OP
	Horizon Blue Cross Blue Shield of New Jersey	Horizon Blue Cross Blue Shield of New Jersey	Self-Insured Employers (ASO)
	Independence Blue Cross	AmeriHealth New Jersey	Employer Group Insurance
New Mexico	Ardent Health Services	Lovelace Health System	Medicaid Managed Care
	Health Care Service Corporation	Blue Cross and Blue Shield of New Mexico	Self-Insured Employers (ASO)
	Molina Healthcare, Inc.	Molina Healthcare of New Mexico	Medicaid Managed Care
	New Mexico Health Connections	New Mexico Health Connections	N/A—New Insurer, CO-OP
	Presbyterian Healthcare Services	Presbyterian Health Plan	Medicaid Managed Care
New York	Affinity Health Plan	Affinity Health Plan	Medicaid Managed Care
	CDPHP	CDPHP	Employer Group Insurance
	EmblemHealth	EmblemHealth	Employer Group Insurance
	Freelancers Health Service Corporation, Inc.	Health Republic	N/A—New Insurer, CO-OP
	Healthfirst	Healthfirst	Medicaid Managed Care
	HealthNow New York, Inc.	Blue Shield of Northeastern NY, Blue Cross Blue Shield of Western NY	Employer Group Insurance
	Independent Health Association, Inc.	Independent Health	Employer Group Insurance
	MetroPlus Health Plan, Inc.	MetroPlus Health Plan	Medicaid Managed Care
	MVP Health Care	MVP	Employer Group Insurance
	North Shore LIJNorth Shore-LIJ CareConnect Insurance Company, Inc.	North Shore LIJ	N/A—New Insurer
	Oscar Insurance Corporation	Oscar	N/A—New Insurer
	The Lifetime Healthcare Companies	Excellus Blue Cross Blue Shield, Univera	Employer Group Insurance
	The New York State Catholic Health Plan, Inc.	Fidelis Care	Medicaid Managed Care
	UnitedHealth Group	United	Self-Insured Employers (ASO)
	Universal American Corp.	Today's Options	Medicare Advantage
	WellPoint, Inc.	Empire Blue Cross	Self-Insured Employers (ASO)
North Carolina	Aetna, Inc.	CoventryOne	Self-Insured Employers (ASO)
	Blue Cross and Blue Shield of North Carolina	Blue Cross and Blue Shield of North Carolina	Self-Insured Employers (ASO)
North Dakota	Medica Holding Company	Medica	Employer Group Insurance
	Noridian Mutual Insurance Company	Blue Cross Blue Shield of North Dakota	Employer Group Insurance
	Sanford Health	Sanford Health Plan	Self-Insured Employers (ASO)

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APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 5 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Ohio	Aetna, Inc.	HealthAmericaOne	Self-Insured Employers (ASO)
	CareSource	CareSource	Medicaid Managed Care
	Catholic Health Partners	HealthSpan, Kaiser Foundation Health Plan of Ohio	Employer Group Insurance
	Centene Corporation	Ambetter from Buckeye Community Health Plan	Medicaid Managed Care
	Humana, Inc.	Humana Health Plan of Ohio, Inc.	Medicare Advantage
	McKinley Life Insurance Company	AultCare	Employer Group Insurance
	Medical Mutual of Ohio	MedMutual	Self-Insured Employers (ASO)
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Summa Health System	SummaCare	Employer Group Insurance
	Vanguard Health Ventures, Inc.	Paramount Insurance Company	Medicaid Managed Care
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
Oklahoma	Aetna, Inc.	Aetna, Coventry Health and Life, Coventry Health Care of Kansas, Inc.	Self-Insured Employers (ASO)
	CommunityCare, Inc.	CommunityCare HMO	Employer Group Insurance
	GlobalHealth, Inc.	GlobalHealth	Employer Group Insurance
	Health Care Service Corporation	Blue Cross Blue Shield of Oklahoma	Employer Group Insurance
Oregon	Atrio Health Plans, Inc.	Atrio Health Plans	Medicare Advantage
	Cambia Health Solutions, Inc.	BridgeSpan	Employer Group Insurance
	Freelancers Consumer Operated And Oriented Program Of Oregon, Inc.	Health Republic Insurance Oregon COOP	N/A—New Insurer, CO-OP
	Health Net, Inc.	Health Net	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance
	Moda Health	Moda Health	Self-Insured Employers (ASO)
	Oregon's Health CO-OP	Oregon's Health CO-OP	N/A—New Insurer, CO-OP
	PacificSource Health Plans	PacificSource Health Plans	Employer Group Insurance
	Premera Blue Cross	LifeWise Health Plan of Oregon	Employer Group Insurance
	Providence Health & Services	Providence Health Plan	Self-Insured Employers (ASO)
	Trillium Community Health Plan, Inc.	Trillium	Medicaid Managed Care
Pennsylvania	University of Pittsburgh Medical Center	UPMC Health Plan	Medicaid Managed Care
	Aetna, Inc.	Aetna, HealthAmericaOne	Self-Insured Employers (ASO)
	Capital BlueCross	Capital Blue Cross, Keystone Health Plan Central	Self-Insured Employers (ASO)
	Geisinger Health Plan	Geisinger Health Plans	Employer Group Insurance
	Highmark Health Services	Highmark Health Insurance Company, Highmark Health Services	Self-Insured Employers (ASO)
	Hospital Service Association Of Northeastern Pennsylvania	Blue Cross of Northeastern Pennsylvania	Self-Insured Employers (ASO)
	Independence Blue Cross	Independence Blue Cross	Self-Insured Employers (ASO)
Rhode Island	Blue Cross & Blue Shield of Rhode Island	Blue Cross Blue Shield of Rhode Island	Self-Insured Employers (ASO)
	Neighborhood Health Plan	Neighborhood Health Plan of RI	Medicaid Managed Care
South Carolina	Aetna, Inc.	CoventryOne	Self-Insured Employers (ASO)
	BlueCross BlueShield of South Carolina	Blue Cross Blue Shield of South Carolina, BlueChoice HealthPlan	Employer Group Insurance
	Consumer's Choice Health Insurance Company	Consumers' Choice Health Plan	N/A—New Insurer, CO-OP
South Dakota	Avera Health Plans	Avera Health Plans	Self-Insured Employers (ASO)
	Sanford Health	Sanford Health Plan	Self-Insured Employers (ASO)
	South Dakota State Medical Holding Company, Inc.	DakotaCare	Employer Group Insurance

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APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 6 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Tennessee	Blue Cross Blue Shield of Tennessee	Blue Cross Blue Shield of Tennessee	Self-Insured Employers (ASO)
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Community Health Alliance Mutual Insurance Company	Community Health Alliance	N/A—New Insurer, CO-OP
	Humana, Inc.	Humana Insurance Company	Medicare Advantage
Texas	Aetna, Inc.	Aetna	Self-Insured Employers (ASO)
	Centene Corporation	Ambetter from Superior Health Plan	Medicaid Managed Care
	Cigna Health and Life Insurance Company	Cigna Health and Life Insurance Company	Self-Insured Employers (ASO)
	Community Health Choice, Inc.	Community Health Choice	Medicaid Managed Care
	Health Care Service Corporation	Blue Cross Blue Shield of Texas	Self-Insured Employers (ASO)
	Humana, Inc.	Humana Health Plan of Texas, Inc.	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Healthcare of Texas	Medicaid Managed Care
	Scott & White Health Plan and Insurance Company	Scott & White Health Plan	Employer Group Insurance
	Sendero Health Plans, Inc.	Sendero Health Plans	Medicaid Managed Care
	SHA, LLC	Firstcare Health Plans	Medicaid Managed Care
	University Health System	CommunityFirst	Medicaid Managed Care
Utah	Aetna, Inc.	Altius Health Plans	Employer Group Insurance
	Arches Mutual Insurance Company	Arches Health Plan	N/A—New Insurer, CO-OP
	Cambia Health Solutions, Inc.	BridgeSpan Health Company	Employer Group Insurance
	Humana, Inc.	Humana Medical Plan of Utah, Inc.	Individual Insurance
	Intermountain Healthcare	SelectHealth	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Healthcare of Utah Marketplace	Medicaid Managed Care
Vermont	Blue Cross Blue Shield of Vermont	Blue Cross Blue Shield of Vermont	Employer Group Insurance
	MVP Health Care	MVP Health Care	Employer Group Insurance
Virginia	Aetna, Inc.	Aetna, CoventryOne, Innovation Health Insurance Company	Self-Insured Employers (ASO)
	CareFirst Blue Cross Blue Shield	CareFirst Blue Cross Blue Shield, CareFirst BlueChoice, Inc.	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance
	Sentara Healthcare, Inc.	Optima Health	Medicaid Managed Care
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield, Anthem Health Plans of Virginia	Self-Insured Employers (ASO)
Washington	Cambia Health Solutions, Inc.	BridgeSpan	Employer Group Insurance
	Centene Corporation	Coordinated Care	Medicaid Managed Care
	Community Health Network of Washington	Community Health Plan of Washington	Medicaid Managed Care
	Group Health Cooperative	Group Health	Employer Group Insurance
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Marketplace	Medicaid Managed Care
	Premera Blue Cross	Premera Blue Cross, Lifewise Health Plan of Washington	Self-Insured Employers (ASO)
West Virginia	Highmark Health Services	Highmark Blue Cross Blue Shield West Virginia	Self-Insured Employers (ASO)

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APPENDIX TABLE 1

Health Insurers Participating in the Exchanges, by State (Page 7 of 7)

State	Parent Company	Name(s) Appearing on Exchange (Including Trade Names and/or Subsidiaries)	Insurer's Current Principal Business in State
Wisconsin	Common Ground Healthcare Cooperative	Common Ground Healthcare Cooperative	N/A—New Insurer, CO-OP
	Dean Health Systems, Inc.	Dean Health Plan	Employer Group Insurance
	Group Health Cooperative of South Central Wisconsin	Group Health Cooperative-SCW	Employer Group Insurance
	Gundersen Health Plan, Inc.	Gundersen Health Plan, Inc.	Self-Insured Employers (ASO)
	Health Tradition Health Plan	Health Tradition Health Plan	Employer Group Insurance
	Medica Holding Company	Medica	Employer Group Insurance
	Mercy Health System Corporation	MercyCare Health Plans	Employer Group Insurance
	Molina Healthcare, Inc.	Molina Healthcare of Wisconsin	Medicaid Managed Care
	Physicians Plus Insurance Corporation	Physicians Plus Insurance Corporation	Employer Group Insurance
	Security Health Plan of Wisconsin, Inc.	Security Health Plan of Wisconsin, Inc.	Employer Group Insurance
	University Health Care, Inc.	Unity Health Insurance	Employer Group Insurance
	WellPoint, Inc.	Anthem Blue Cross and Blue Shield	Self-Insured Employers (ASO)
	Wisconsin Physicians Service Insurance Corporation	Arise Health Plan	Self-Insured Employers (ASO)
Wyoming	Blue Cross Blue Shield of Wyoming	Blue Cross Blue Shield of Wyoming	Self-Insured Employers (ASO)
	WINhealth Partners	WINhealth Partners	Employer Group Insurance
District of Columbia	Aetna, Inc.	Aetna	Self-Insured Employers (ASO)
	CareFirst Blue Cross Blue Shield	CareFirst	Self-Insured Employers (ASO)
	Kaiser Permanente	Kaiser Permanente	Employer Group Insurance

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Source: Data compiled by the author. The source for the federally facilitated exchanges is data from HealthCare.gov, "Health Plan Information for Individuals and Families," https://www.healthcare.gov/health-plan-information (accessed October 16, 2013). Information for the state-run exchanges comes from either the state's exchange or its insurance department. Ownership of subsidiaries and trade names was verified using state insurance department filings.

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For the record

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November 15, 2013

[redacted]
[redacted]
Savannah, GA 31404

Dear Valued Tenant,

We would first like to express our thanks for being a tenant and a customer of Signature Flight Support SAV.

To be able to continue to provide the services which are received at our locations, we must keep pace with the ever-rising costs that are associated with operating airport facilities. As an example, we expect employee healthcare costs and basic facility costs to rise by approximately 10% in 2014 over 2013 levels.

As such, effective January 1, 2014, an increase in tenant hangar and office space rent of 10% will be implemented. If a lease term of one year or longer is signed prior to January 1, 2014, rents will be assessed at the agreed upon rates.

Should you have any questions, please feel free to contact myself or Lon Harden at +1 [redacted] or via email: [redacted]@signatureflight.com or [redacted]@signatureflight.com

Thank you for your understanding and your patronage.

With best regards,

[redacted]
General Manager

WRITTEN REQUEST FOR PANAL PARTICIPATION

Minister Carolyn Reed-Smith   Spartanburg, SC 29316
(864) 621 4311
crstrinty247@gmail.com

Hello, I am Minister Carolyn Reed-Smith.

I have been active in following the fate of the Affordable Health Care Ace (ACA) in South Carolina. I have traveled several times to the SC State House as we lobbied, but the Republicans said NO to the Medicaid ?Expansion flew in a person to teach them how to nullify President Obama's ACA. They did!

I would like to share with you some of the new laws ratified by S.C. State government to nullify the ACA and ask if you could monitor the laws ratified in your state. These laws are designed to derail the ACA!!

In Proverbs 22:22-23, God's Word says "Do not rob the poor because he is poor, nor oppress the afflicted at the gate: for the Lord will plead their cause and plunder the soul of those who plunder them."

We must think about what is best for "All" people.

You can double check @

Legislation > Search Legislation by Bill, Act or Rat Number

http://www.scstatehouse.gov/billsearch.php?billnumbers=3818&session=120&summary=B

- H*3624 (Rat #0035, Act #0024 of 2013)
  Summary: PEBA
  AN ACT TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 9-4-15 SO AS TO PROVIDE THAT THE STATE SHALL DEFEND MEMBERS OF THE BOARD OF DIRECTORS OF THE SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY (PEBA) AGAINST CLAIMS AND SUITS ARISING OUT OF THE PERFORMANCE OF THEIR OFFICIAL DUTIES, AND REQUIRE THAT THE STATE INDEMNIFY THESE DIRECTORS FOR ANY LOSS OR JUDGMENT INCURRED BY THEM UNDERTAKEN BY THEM WHILE SERVING AS A DIRECTOR, OFFICER, OR

MANAGEMENT EMPLOYEE OF PEBA. - ratified title 05/02/13 Ratified R 35 , 05/03/13, Signed By Governor

- (R33, H. 3560 (Word version) AS TO REQUIRE THE JUDICIAL DEPARTMENT AND THE STATE LAW ENFORCEMENT DIVISION TO DEVELOP PROCEDURES FOR THE COLLECTION OF INFORMATION ON INDIVIDUALS WHO HAVE BEEN ADJUDICATED AS A MENTAL DEFECTIVE OR COMMITTED TO A MENTAL INSTITUTION AND FOR THE SUBMISSION OF THIS INFORMATION TO THE NATIONAL INSTANT CRIMINAL BACKGROUND CHECK SYSTEM

- S*0465 (Rat #0056, Act #0048 of 2013 effective 06/2013
Summary: Small Employer Health Insurance Availability Act
AN ACT TO AMEND SECTION 38-71-1330, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO DEFINITIONS IN THE SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT, SO AS TO REVISE THE DEFINITION OF AN "ELIGIBLE EMPLOYEE". - ratified title 06/04/13 Ratified R 56
- H*3620 (Rat #0026, Act #0018 of 2013)
Summary: Captive insurance company
AN ACT TO AMEND SECTION 38-90-160, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE EXEMPTION OF CAPTIVE INSURANCE COMPANIES FROM CERTAIN PROVISIONS OF TITLE 38, SO AS TO PROVIDE AN INDUSTRIAL INSURED CAPTIVE INSURANCE COMPANY IS SUBJECT TO CERTAIN REQUIREMENTS CONCERNING REPORTS FOR RISK- BASED CAPITAL, ACQUISITIONS DISCLOSURE, AND ASSET DISPOSITION, AND CEDED REINSURANCE AGREEMENTS, AND TO PROVIDE THE DIRECTOR OF THE DEPARTMENT OF INSURANCE MAY ELECT NOT TO TAKE REGULATORY ACTION CONCERNING RISK-BASED CAPITAL IN SPECIFIC CIRCUMSTANCES. - ratified title 26

- S*0460 (Rat #0079, Act #0066 of 2013)
Summary: Insurance
AN ACT TO AMEND SECTION 38-45-90, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO DUTIES OF

BROKERS PLACING BUSINESS WITH NONADMITTED INSURERS, SO AS TO REVISE THE PROOF THAT THE DIRECTOR OF THE DEPARTMENT OF INSURANCE MAY REQUIRE FROM A BROKER SEEKING TO PLACE BUSINESS WITH A NONADMITTED INSURER, TO PROVIDE A NECESSARY DEFINITION, AND TO IMPOSE CERTAIN DUE DILIGENCE REQUIREMENTS ON " IMPOSE CERTAIN DUE DILIGENCE REQUIREMENTS ON THE BROKER. - ratified title

- **H. 3621ratified # 27** (Word version)) -- Reps. Sandifer and Gambrell: AN ACT TO AMEND SECTION 38-5-120, AS AMENDED, CODE OF LAWS OF SOUTH CAROLINA, 1976, RELATING TO THE REVOCATION OR SUSPENSION OF A CERTIFICATE OF AUTHORITY TO TRANSACT BUSINESS IN THIS STATE BY AN INSURER, SO AS TO REVISE PROVISIONS CONCERNING HAZARDOUS INSURERS.
- (R38, S. 448 (Word version)) -- Senators Alexander, Peeler, Cleary and S. Martin: AN ACT TO AMEND THE CODE OF LAWS OF SOUTH CAROLINA, 1976, BY ADDING SECTION 40-47-938 SO AS TO PROVIDE CIRCUMSTANCES IN WHICH A PHYSICIAN MAY ENTER A SUPERVISORY RELATIONSHIP WITH A PHYSICIAN ASSISTANT; RELATING TO THE PRESCRIBING OF DRUGS BY A PHYSICIAN ASSISTANT, SO AS TO AS TO DELETE A PROHIBITION AGAINST PRESCRIBING SCHEDULE II CONTROLLED SUBSTANCES; TO AMEND SECTION 40-47-995, RELATING TO THE TERMINATION OF A SUPERVISORY RELATIONSHIP BETWEEN A PHYSICIAN AND PHYSICIAN

Two of the main contentions of the Republican Party to the ACA are the amounts of money that would be spent and the American people need less government control over our lives.

1. Many of the States have that have accepted the ACA and adopted the expanded Medicaid have proven that it works!!
2. The ACA website was broken because of an OVERLOAD of Americans that need CARE!!!! Fix it NOT ditch it!!!

3. President Obama won the election of 2012,,, "Fair and Square"!!! His platform was the ACA. Now the Republicans are going through the BACK DOOR to NULLIFY the ACA. Putting laws in place so the average American will not know the main reason for their support of nullification is for the insurance companies to keep their profits.
4. In SC now, there are laws that tax our tax dollars to fight againsT the ACA!, Fly in , spend money to keep "SOME" without healthcare.

THE REPUBLICAN INTEREST SHOULD BE FOR THE GOOD OF THE PEOPLE

NOT FOR THE SPECIAL INTEREST GROUPS IN A.L.E.C.!!!!!!

THE PEOPLE HAVE SPOKEN!!! AT THE POLLS IN 2012, AND WE CONTINUE TO SAY, ALLOW THE TRUTH TO BE TOLD AND HEARD!! OBAMA CARE COULD WORK,,,, IS WORKING.. AND IS THE AMERICAN WAY !!!!!!!