COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Testimony of J.P. Wieske
Council for Affordable Health Coverage

Committee on Energy and Commerce, Subcommittee on Health
Hearing on "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access"

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Introduction

Chairwoman Eshoo, Ranking Member Burgess and Members of the Subcommittee, I appreciate the opportunity to testify today on the issue of lowering consumer costs and expanding access, and for continuing the dialogue surrounding the status of the individual health insurance market.

I am J.P. Wieske, Vice President of State Affairs at the Council for Affordable Health Coverage, also known as CAHC, which is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. I testified before this committee in my prior role as Deputy Commissioner of Insurance for the State of Wisconsin in February of 2017. In that role, I was involved with a number of health insurance issues including serving on Wisconsin's high-risk pool board, working with the state legislature, and assisting with operationalizing the Affordable Care Act (ACA). I would also note that in my former role, I have had some leadership experience on state issues serving as Chair of the National Association of Insurance Commissioner's Regulatory Framework Task Force, Chair of the Pharmacy Benefit Manager Subgroup, Chair of the Network Adequacy Subgroup, and Chair of the Health Care Regulatory Alternatives Workgroup. It should be made clear that my views do not reflect the views of the state of Wisconsin nor the National Association of Insurance Commissioners.

CAHC's membership reflects a broad range of interests—organizations representing patient groups, consumers, small and large employers, insurers and health plans, biopharmaceutical manufacturers, and physician organizations. CAHC is concerned health costs are too high and rising too fast. In fact, costs continue to rise faster than the economy, while premiums are increasing about four times faster than wages. As a result, by 2030 the typical family will spend more than 40 percent of their income on health care.[1] We support many reforms to promote affordability, including efforts to reform health markets, improve health care transparency, promote value-based care, and strengthen patient adherence to medications.

My testimony will address the following topics:

1. The Individual Market Generally
2. Reinsurance / 1332 Waivers
3. Navigators / Outreach
4. State Based Exchanges

The Individual Health Insurance Market

In essence, the individual market functions as a residual market by providing coverage to anyone not eligible for anything else. This creates a unique set of needs. Some consumers need coverage only

[1] "2015 Milliman Medical Index." Milliman, May 2015. http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf

temporarily between employment-based coverage. Some are temporarily too sick to work. Others are entrepreneurs who are working independently and starting their own business. This is a market that needs to serve this diverse population.

The ACA made massive changes to health markets. It created new consumer protections, corrected market imbalances, and reduced the number of uninsured Americans to historic lows. Yet there are high and growing health insurance premiums, marked by average double-digit price increases on exchange plans both this year and next. 2018 data from eHealth shows the average cost of an individual (Obamacare) health insurance plan has increased 123% since 2013. During that same period of time, average monthly premiums for families increased 174%. The result is an unbalanced and expensive market that is driving away many of the healthy consumers the exchanges need to attract in order to hold coverage costs down over the long term. This fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making health care more affordable and accessible for all Americans.

Based on my experience in Wisconsin, it's clear that the ACA created winners and losers among enrollees in the individual health insurance market. Before, HIPAA provided guaranteed issue coverage and guaranteed renewability for those that maintained coverage, but there were no subsidies and premiums could rise sharply as enrollees aged. People whose applications for coverage were denied used the state's subsidized high-risk pool, which in Wisconsin was good coverage at fairly reasonable prices.

In the pre-ACA market, only employers and their employees were subsidized through tax-favored treatment. Most employees can pay for their benefits pre-tax through Section 125 / Cafeteria plans. Consumers in the individual market did not receive that help. And make no mistake, consumers in the individual market are the most vulnerable.

Now, most individual market consumers in Wisconsin are receiving subsidies for their coverage, which has made it more affordable. Unfortunately, because the overall risk pool in the individual market has worsened – with not enough younger and healthier enrollees to offset the costs of those older and sicker – the cost of coverage for those without subsidies has become even more unaffordable.

I realize Wisconsin may have been a special case. Before the ACA, Wisconsin had a high functioning risk pool that subsidized the premiums of those with health conditions and provided comprehensive insurance coverage for care from any medical provider in the state. Not all state high risk pools functioned so well and neither did some markets. HIPAA may have provided guaranteed issue and guaranteed renewability to individuals maintaining continuous coverage, but in some states, insurers were allowed to significantly raise premiums for individuals whose medical expenses were expected to be high.

Taken as a whole, when we compare the pre-ACA and post-ACA individual market, it is clear that we have solved for some problems while inadvertently creating others, and as a result, there is still

work to do. With the shared aim of lowering costs and increasing access to our health care system, I hope that the details I will offer on Wisconsin's individual market will shed light on the potential impact of proposed legislative changes considered here today.

What Happened in Wisconsin?

Prior to the ACA, in states like Wisconsin, relatively young and low-risk individuals enrolled in the individual market, and the sick were subsidized through broad based subsidies like those offered in a high-risk pool.

Since my experience has primarily been in the state of Wisconsin, I will highlight the issues I observed in my prior role as Deputy Insurance Commissioner for Wisconsin. As a reminder, I do not speak for the state of Wisconsin in any capacity.

When we worked to operationalize the ACA for Wisconsin residents, our main goal was to ensure Wisconsin consumers were protected from any negative consequences. We had planned to create our own version of an exchange that would have been a one-stop portal for folks eligible for Medicaid and subsidized ACA coverage. We worked extensively with stakeholders and the high-risk pool to create a new risk mitigation program under federal law and provide a glide path for high-risk pool members. We had planned to build on the Office of Commissioner of Insurance's regulatory authority to ensure compliance with law in the same way we had done with HIPAA.

Without question, the first open enrollment during the early implementation of the ACA in 2013 ranged from problematic to completely dysfunctional. While there were a number of discreet factors that contributed to that outcome, a common thread was the lack of state control and flexibility at a time when states were trying to interpret the new law and regulations, and develop and implement action plans, all while operating with extremely short timeframes. Learning from that experience, it is imperative that in the context of any fixes to the ACA that states need more flexibility not less. States know what will work in their state. What works in Wisconsin will not necessarily work in

Michigan, Texas, or California. As with the old Medicaid adage, if you have seen one state insurance market, you have seen one state insurance market.

I can only extrapolate from my experience in Wisconsin. I know some of my former colleagues faced similar issues while others did not.

In the reports issued around the reinsurance program in Wisconsin, we highlighted the problems:

- higher rates
- higher cost sharing, and
- fewer insurers in the market.

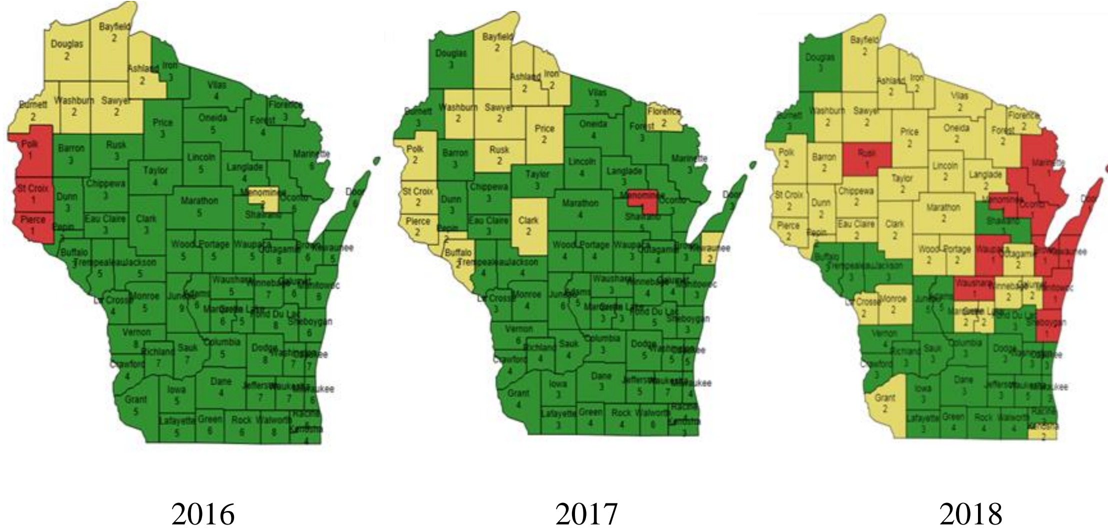
Insurers who offered coverage in the individual market just a few years ago – and indeed are still active in the small group market – have left the individual health insurance market. It is easy to see why: Wisconsin insurers lost more $500 million in the individual market since the start of the ACA. Loss ratios have exceeded 100% after the various temporary risk mitigation programs ended. Premiums had a huge jump with the ACA, and despite lower rates in Wisconsin in 2019, insurance is still mostly unaffordable for those not receiving a subsidy.

In short, the post-ACA market has its own issues. Premiums are too high. Consumers have fewer choices with higher cost-sharing and narrower networks. Insurers operating in the market have lost significant amounts of capital which negatively impacts their other lines of business, and raises costs for all consumers.

Reinsurance

Our primary effort was to pass the reinsurance program known as the Healthcare Stability Plan. At roughly this time in 2017, it was likely that two health plans were functionally dropping out of the ACA market. This would leave the state with just one insurer in a number of areas including my hometown of Green Bay, Wisconsin. For this section of the state, it meant the only insurer providing

coverage was Common Ground, the state's federal co-op. The maps below highlight the issue as we entered the rate and form filing period.



2016 2017 2018

Green: 3 or More Insurers
Yellow: 2 Insurers
Red: 1 Insurer
Source: Wisconsin Office of the Commissioner of Insurance (OCI)

The health insurers remaining in the market raised significant concerns about whether or not they could take on as much risk as required by the new market. Even more considered dropping out because of the risk. While Wisconsin had numerous insurers in the market, most of them covered only a relatively small region and in some counties were facing taking all of the risk. Most businesses seek the kind of monopoly status these insurers had, but in the individual market they were concerned that capturing the market could drive them to insolvency.

The goal at this point was to create a solution to make coverage both more affordable and bring back new entrants. While alternatives to reinsurance were considered, the restrictions surrounding the 1332 waiver process made it untenable to impact the 2019 plan year through more innovative reforms.

Ultimately, a solution was crafted to create a $200 million reinsurance program covering claims between $50,000 and $250,000, with the ability to make adjustments in future years. The shared savings model under the ACA's 1332 process limited the state's liability to about $72 million dollars

while the federal government – through the savings on the ACA subsidies it would otherwise have to pay – would cover the remaining about $128 million. This reflects a 64% pass through rate.

The net result was positive for Wisconsin consumers. Wisconsin received numerous inquiries about market re-entry, and ultimately insurers entered new markets in several areas. This was especially true in the Green Bay area. More importantly, it led to lower premiums across the state. Reinsurance reduced premium rates by a little more than 10 percent from where the rates would have been. Ultimately, rates were lower by roughly 4.2% from the 2018 rates.

While the program met its goal, it is important to note that reinsurance is not a panacea. It is another way to provide a government subsidy. It doesn't change the fundamentals of the risk pool nor make the market healthier. It also doesn't attract the young and healthy back into the market. Long term, the same reinsurance money will have diminishing returns; in other words, it will require more money to continue to provide the same savings. It is also important to note that it will have little effect on those consumers already receiving subsidies – between 100-400% of poverty in Wisconsin's case.

One other important lesson from reinsurance is that the program has to build in appropriate incentives. Insurers must retain some of the risk in reinsurance or there will be no incentive to properly manage the program. While states need access to additional funding, it is important for individual states to consider costs and impact in designing the program. A poorly designed program without a state stake could lead to perverse market impacts including a negative impact on other market segments.

Navigators

There is no question that people continue to need assistance in purchasing coverage, and while Navigators have provided some assistance, the claim that loss of navigator funds is alone responsible for the drop in 2019 enrollment is misguided. A fair analysis may find a number of factors contributed, including a robust economy with very low unemployment which should lead to higher rates of employment-based insurance coverage.

The loss of agents in the individual health insurance market has created many problems and navigators are just not a substitute for driving enrollment. Wisconsin licensed over 100,000 agents, both domestic and from outside the state. Unfortunately, federal policies like overly restrictive medical loss ratio rules, have encouraged insurers to move away from using agents. Access to agents provides consumers with value before and after their purchase of insurance and they have long played a role in assisting consumers in understanding their policies not just at time of sale, but when the consumer has a claim. An agent typically also has a longer-term relationship with their client,

and assisting them in changing plans from year to year is done with an understanding of their personal history.

The federal navigator program is a program that operates largely outside of the current health insurance system. Even before the reduction in funding, we saw fewer and fewer navigators and navigator entities. Anecdotally, many navigators are appropriately referring clients to agents or brokerage firms to actually effectuate coverage. In many cases, the navigator program is centered around large population centers with limited availability to the rural community. It is in these areas where it is particularly important for an insurance advisor to deeply understand issues like network adequacy, carrier reputation, and many other local concerns.

In short, a stronger emphasis on Navigators alone as an enrollment solution may not provide the value some seek or expect.

It is also important to find consumers where they want to shop. Younger consumers who have largely abandoned the individual market shop online for most things. They are generally not interested in face-to-face interactions. Any legislation should provide states and the federal government more flexibility in connecting consumers with insurers and brokerage firms that are using technology to link consumers with products. If we truly want to increase outreach opportunities, we need to allow the industry to innovate.

State Exchange Funding

Health exchanges are a fundamentally sound idea. They reflect the proposition that informed consumers can stimulate system-wide improvements in the cost and quality of health care as they have in other realms. The exchanges are designed to facilitate online comparison shopping for health insurance plans by providing a transparent review of complicated price and coverage details. CAHC has conducted an annual survey to assess the e-commerce competency of the public exchanges created after the enactment of the ACA. The subjects of our study include the 12 exchanges run by individual states and the District of Columbia, as well as the federal health exchange, Healthcare.gov, which provides services in 38 states.

Our independent review offers an unbiased look at all of the exchanges — each a monopoly serving a captive market within their respective state. In some cases, it appears that certain state-run exchanges are subject to chronically weak legislative oversight and the structural flaws inherent in monopolies that are well-documented (including insensitivity to customer needs and lagging innovation). Total reliance on public exchanges and enrollment efforts have proven to be insufficient

to offer consumers consistently functioning sites that both inform and ease the plan selection process.

- More than half the exchanges (7) received a D or F —all of them state-based. There was one A, four Bs and one C. The average exchange website scored 71 out of a possible 100 on our composite index, and had 3 best-in-class shows.

- Healthcare.gov, the federally-facilitated exchange that serves 38 states, ranked fourth in our index, scoring 81 out of a possible 100. The federal exchange had four best-in class showings. Key minuses included a rudimentary cost calculator—one based on a default order that prioritizes premiums alone rather than more important indicators of consumer value, such as expected annual out-of-pocket costs. These deficiencies can present a misleading view if the expected costs and benefits of plans to consumers.

- Variation in exchange composite scores indicate the consumer experience is uneven across the country, with an F (a 48) at the low end and a high of 92. This may reflect the varying levels of commitment (both political and financial) to public exchanges.

Despite the more than $5 billion spent to establish and maintain public exchanges, most have been operating below the state of the art in consumer accessibility and decision-support tools even though these tools are often found in the private sector. As a result, consumers are not receiving the benefits of available technologies to support sound decision-making, and fewer consumers enroll.

The number of unique requirements, constraints, and embedded processes that government entities must navigate is significant, and slows the government's ability to respond and adapt quickly. This structure is intentionally designed to guide federal agencies broadly, but is not made to facilitate quick, dynamic responses that technologically demands and requires. As a result, with respect to exchanges, government-run programs simply cannot keep up with market demand. We believe competition is better for consumers. In no other sector does the government compete with private industry to the disadvantage of the consumer, and we believe that consumers, the government, and industry will all be better served if we work together to improve the consumer experience in the individual market.

As I highlighted in the opening section, Wisconsin was an early grant recipient to create a state-based exchange. The grant funds were used to explore options, but ultimately found that the rules surrounding creation of an exchange were overly prescriptive and burdensome. A regulator in another state described the exchange rulemaking process as akin to buying a car: while states were allowed to decide what color fabric was in the interior, they were not allowed to choose the make, model or any other details of the car. Nothing in the intervening years has made the process

significantly more flexible, and it is unlikely the $200 million is enough to entice new state-based entities.

As an alternative, our report suggested some common-sense solutions to improve the market.

1. Over the next three years, transition to a privately-operated exchange model and eliminate funding for activates unrelated to the federal data hub in the HealthCare.gov program;

2. During scheduled downtime, HHS should direct all traffic to private enrollment web sites;

3. Transition an increasing number of APTC eligible enrollees into privately operated exchanges, starting with at least 10 percent in the enhanced direct enrollment pathway in 2019;

4. Congress should enable all beneficiaries to use their premium tax credits off the public exchanges, to also be used in the privately-operated exchange model when fully implemented; and

5. Reduce or eliminate the 3.5 percent premium tax that funds public exchanges.

Conclusion

CAHC is very concerned about diminished affordability since enactment of the ACA, and the lower enrollment on exchange plans may be a warning sign of a market in the midst of a death spiral. Even with subsidies, many of those enrolled may remain functionally uninsured due to increasing cost sharing. Increasing subsidies, enacting new reinsurance programs and setting up new government-run monopoly web sites will not fix the underlying problems in the market.

Only by addressing the underlying conditions that are producing high and growing premiums and cost sharing obligations will markets stabilize and affordability become a reality for most people. Already, the typical family spends 30 percent of their income on health care. If current trends continue, that family will spend more than 40 percent of their income on care within 14 years. Congress can help families avoid this future, but you must be ready and willing to act.

Thank you for the opportunity to testify today. I am happy to answer any questions.