STATEMENT OF

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ON

THE AFFORDABLE CARE ACT

BEFORE THE
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OVERSIGHT & GOVERNMENT REFORM

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Chairman Chaffetz, Ranking Member Cummings, and members of the Committee, thank you for the invitation to discuss the Centers for Medicare & Medicaid Services' (CMS') continuing work to implement the Affordable Care Act and provide consumers with affordable access to high-quality health coverage.

Thanks to the Affordable Care Act, Americans' access to the health insurance market has fundamentally transformed in only a few years. Before the Affordable Care Act, consumers were frequently denied health care coverage or charged exhorbitant rates if they had pre-existing conditions. People who managed to find insurance coverage often learned that it would not cover the care that they needed when they became sick—or that insurance companies could cancel their policies entirely. Annual or lifetime limits capped the value of coverage consumers had when they faced serious illness.

Since 2014, for the first time, we have a health insurance system that is providing access to quality care to all Americans regardless of their health or financial status. Millions who were previously denied or unable to afford coverage for chronic conditions or even routine care are now able to get the care they need. Pre-existing conditions no longer preclude individuals from gaining health insurance, and consumers have better access to comprehensive, affordable coverage. Consumers now have the comfort of knowing that if their employment changes or they lose coverage for any reason, they can purchase affordable coverage through the Marketplace—regardless of their personal health history. As of earlier this year, an estimated 20 million more people have coverage because of the law,[1] and at 8.6 percent, the uninsured rate for Americans is the lowest on record.[2] We achieved these remarkable results at a lower cost than the Congressional Budget Office (CBO) originally projected, with coverage provisions

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[1] https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf
[2] http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201609.pdf

costing 25 percent less than original estimates.[3] And, despite concerns about rate increases, premiums charged by Exchange health plans remain well below what CBO initially predicted. Overall, independent experts calculate that Marketplace premiums are currently 12 percent to 20 percent lower than CBO predicted when the Affordable Care Act was enacted.[4,5] If rates had come in as CBO predicted, and grown with medical trend, consumers likely would pay more next year than they actually will, even with this year's rate changes.

The changes the Affordable Care Act made to our health system are providing countless Americans with the security that comes from knowing they will have access to health care when they need it. At the same time, this fundamental shift—to a health insurance market that serves all consumers, regardless of their health history—is new for all involved—consumers, insurers, and state regulators, thus requiring all of us to learn from what has worked and build on these successes, while making refinements and adjustments when necessary. Health insurance issuers need to build new business models for the individual market, where they can be successful by providing the care people need and compete on cost and quality.

Many health plans are meeting this challenge with a variety of innovative approaches, with the Marketplace serving as a laboratory for innovations and strategies that are helping us build a better health care system. For example, Blue Cross Blue Shield in Florida closely analyzed its prospective Marketplace customers and learned that those purchasing coverage in the new market differ significantly from the consumers they served in the individual market before the Affordable Care Act. Based on this research, the company was able to tailor plans to meet the needs of different communitities, including innovative care delivery through interdisciplinary teams that that focused on improving care for high-risk populations in particular communities. In Massachusetts, Blue Cross Blue Shield of Massachusetts is using a payment model that pays doctors and clinicians based on the quality, efficiency, and effectiveness of the

[3] https://www.cbo.gov/publication/51385
[4] http://kff.org/health-reform/perspective/how-aca-marketplace-premiums-measure-up-to-expectations/
[5] http://healthaffairs.org/blog/2016/07/21/obamacare-premiums-are-lower-than-you-think/

care they provide. This approach is saving money while giving patients better care than similar patients in other states.[6]

While many issuers have adopted innovative, successful approaches to the significant changes in the market, it is not surprising that others have encountered more challenges. Many companies are adjusting their geographic coverage, provider network, care management, and pricing approach now that they have information about how Marketplace consumers are accessing care. The approaching fourth Marketplace Open Enrollment presents an opportunity to build on what we have learned and put the Marketplace on even stronger footing through a series of major outreach improvements and important policy changes.

Building on Successes in Open Enrollment Four

The Marketplace was designed to make it easy for individuals to comparison shop for health care plans that meet their needs, and research shows that the Marketplace is delivering on this goal. Consumers say they can now access primary care and prescription drugs they could not afford before the Affordable Care Act, and a majority are satisfied with their coverage.[7] More than 80 percent of consumers selected plans with primary care visits covered below the deductibles, and on average, nearly seven services—beyond preventive services—were covered below deductibles in the HealthCare.gov states in 2015.[8] J.D. Power and Associates found that consumers who bought coverage through the Marketplace in 2015 generally were more satisfied than those with other types of insurance, including employer coverage.[9]

Nonetheless, we know that premium increases are a challenge for families. Fortunately, as the market adjusts, the Marketplace is designed to insulate most consumers from large rate increases. As a result of financial assistance and the ability to shop around, the vast majority of

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[6] http://www.nejm.org/doi/full/10.1056/NEJMsa1404026
[7] http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction
[8] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-07-12.html
[9] http://www.jdpower.com/press-releases/2015-health-insurance-marketplace-exchange-shopper-and-re-enrollment-hix-study

HealthCare.gov consumers could still choose plans for less than $75 per month even if all plan premiums rose substantially next year.[10] Premium changes typically vary from issuer to issuer and even across plans offered by the same issuer, so the lowest-priced plan one year may not be the lowest-priced plan the next year.

CMS is hard at work preparing for the fourth Marketplace Open Enrollment, beginning on November 1. Earlier this year, we finalized several policy changes and enhancements,[11] including provisions to: (1) help consumers with surprise out-of-network costs at in-network facilities; (2) provide consumers with notifications when a provider network changes; (3) give insurance companies the option to offer plans with standardized cost-sharing structures called "simple choice plans"; and (4) in a pilot program, provide a rating on HealthCare.gov of each Qualified Health Plan's relative network breadth (for example, "basic," "standard," or "broad") or quality rating to support more informed consumer decision-making.

We have learned more about what kinds of outreach are most effective as we seek to reach out to the remaining Americans who are uninsured and eligible to enroll in Marketplace coverage. Our outreach efforts will put a special emphasis on communicating with those Americans who paid the Individual Shared Responsibility Payment for 2015 and on facilitating 26-year-olds' transitions from their parents' plans to Marketplace coverage.

We are making it easier for issuers to conduct outreach to young adults moving off their parents' plans. Specifically, new guidance from the Department of Labor makes clear that the sponsors of employer plans can – and are encouraged to – provide additional information that will help young adults understand their options and enroll in Marketplace coverage as appropriate. Along with issuing new policy guidance, we are strongly encouraging insurers to contact these consumers with targeted information about Marketplace options.

We also are undertaking smarter, more timely, and targeted email and other outreach campaigns. These efforts will complement our successful in-person outreach and assistance

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[10] https://aspe.hhs.gov/sites/default/files/pdf/206741/APTCMarketplace.pdf
[11] https://www.federalregister.gov/articles/2016/03/08/2016-04439/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2017

programs. Research during the 2016 Open Enrollment showed that young adults are almost twice as likely as older consumers to enroll when they receive an email about Marketplace coverage. During the upcoming Open Enrollment, we will draw on lessons learned this year about the ways to make email outreach more effective.

Additionally, this year we will be able to email consumers with important proactive reminders in near-to-real time if they open accounts to start applying or finish applications to select plans, and we will send each consumer a reminder after selecting a plan to pay their first premiums as the last step to gaining coverage. We've learned that sending an email with the right information, at just the right time, can make a significant difference in whether someone gets covered, and those are lessons we will act on this year.

Policy Changes to Build a Strong Marketplace for the Long-Term

CMS is committed to building a stable, sustainable Marketplace that serves consumers for years to come. One of the most significant things CMS is doing is making adjustments and refinements along the way. With the benefit of three years of data and experiences to analyze and inform our policies, CMS has proposed or taken a number of actions to: (1) better reflect the risk associated with high-cost enrollees; (2) better reflect the risk associated with enrollees who are not enrolled for a full 12 months; (3) strengthen the risk pool; and (4) support issuers in entering the Marketplace and in growing their Marketplace businesses. These actions, coupled with other related improvements already underway, will help to make the Martketplace an even more attractive market for consumers and health plans alike.

Supporting Issuers with High-Cost Enrollees and Updating Risk Adjustment

One of the core tenets of the Affordable Care Act has been that people with pre-existing conditions finally have access to the coverage they need. The law's risk-adjustment program plays an important role in providing issuers both the incentives and the financial support to design products to serve all Americans. By reducing incentives for issuers to design products that attract a disproportionately healthy risk pool, risk adjustment lets them design products that meet the needs of all consumers, protecting consumers' access to a range of robust options. Based on significant input from all marketplace participants, earlier this year, CMS made a

number of changes to improve the stability, predictability, and accuracy of the risk-adjustment program for issuers. These changes include better modeling of costs for preventive services, changes to the data update schedule, and earlier reporting of preliminary risk-adjustment data where available. CMS also recently proposed additional changes in the Proposed Notice of Benefit and Payment Parameters for 2018.[12] We are seeking comment on a number of approaches for addressing the costs of healthier enrollees. Our goal is to update risk-adjustment for all types of enrollees, to ensure that issuers can have confidence in the program as they design products to attract all types of consumers. These proposals could help to bring more certainty into the Marketplace, helping issuers account for the risk of all enrollees, while continuing to ensure that all Americans have access to the care they need.

Strengthening the Marketplace Risk Pool

Along with helping issuers cover enrollees with more serious health needs, we also recognize the importance of balancing the mix of enrollees in the Marketplace risk pool. CMS has undertaken a variety of efforts to help strengthen the risk pool, and is seeking comment on several additional proposed improvements.

Special enrollment periods (SEPs) exist to ensure that people who lose coverage or experience other qualifying events have the opportunity to enroll in coverage. We are committed to making sure that SEPs are available to those who are eligible and are equally committed to avoiding any misuse or abuse of SEPs. In 2016, we took a number of steps to ensure appropriate use of SEPs, such as introducing a confirmation process under which consumers enrolling through common SEPs are directed to provide documentation to confirm their eligibility.[13,14] Recently, we announced that we are planning a pilot to evaluate a pre-enrollment verification process.[15] Our intent in conducting such a pilot would be to evaluate the impact of pre-enrollment verification

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[12] https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018

[13] For more information on SEPs, visit https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/

[14] See https://blog.cms.gov/2016/01/19/clarifying-eliminating-and-enforcing-special-enrollment-periods/ and https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-02-24.html

[15] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/FAQ-Regarding-Verification-of-SEPs.pdf

of SEP eligibility on compliance, enrollment, continuity of coverage, the risk pool, and other outcomes. We continue to seek information on additional steps related to SEP outreach or policy we could take as soon as the 2017 plan year to strengthen the risk pool.

CMS also is reaching out to the small number of consumers enrolled in both Medicare and Health Insurance Marketplace coverage with financial assistance. We are doing this to make sure they end their Marketplace coverage with advance payments of the premium tax credit because they are receiving Minimum Essential Coverage (MEC) Medicare, and thus are not eligible for this financial assistance. In March 2016, we also added a pop-up to the Marketplace application with information about Medicare for Marketplace applicants aged 64 and over, to increase consumer awareness and understanding of the rules regarding Medicare enrollment and eligibility for Marketplace coverage. In summer 2016, CMS began sending email notices to existing Marketplace consumers who will turn age 65 the following month. This notice helps educate consumers about the eligibility rules pertaining to Medicare and Marketplace coverage with financial assistance and potential tax liability, and provides instructions on how and when to end a Marketplace plan with this assistance due to Medicare enrollment.

CMS is seeking information regarding concerns that some health care providers or third party entities may be inappropriately steering their Medicare and Medicaid patients into the individual market in order to receive higher reimbursement rates.[16] CMS's request for information and letters to providers informing them of this announcement focus on situations where patients may be steered away from Medicare or Medicaid benefits, which can, among other concerns, result in beneficiaries experiencing disruptions in the continuity and coordination of their care as a result of changes to their network of providers. These actions reflect ongoing efforts by CMS to address possible issues in the Marketplace that could affect the integrity of the programs for both consumers and issuers, and the costs of the individual insurance coverage, while at the same time help ensure patients are enrolled in the right plan for them. CMS also is seeking comments on a

[16] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-08-18-2.html

coordination of benefits policy that similarly is intended to ensure individuals entitled to Medicare and Medicaid are appropriately enrolled in those programs.[17]

Removing Obstacles to Issuer Entrance, Growth, and Innovation

As we look forward, it is clear that the issuers that will be most successful in the long term are likely to be those with innovative approaches to this new Marketplace and its consumers. CMS recently proposed new policies that would give issuers additional flexibility and freedom to offer innovative products and to remove obstacles to issuers growing their businesses and entering more markets.[18] For example, CMS proposed more flexibility for innovation around plan design by issuers, particularly around bronze plan offerings, while still protecting the coverage on which consumers rely. This proposal is intended to help ensure that issuers can offer bronze plans with at least one major service before the deductible, as well as offer high-deductible health plans (that can be paired with health savings accounts) at the bronze level of coverage. Enrollment data from the Federally-facilitated Marketplaces shows that consumers prefer plans that cover and pay for services below the deductibles.

We also have included proposals to give new and growing issuers more flexibility in calculating their medical loss ratios to be more accurately reflective of their experience, and to avoid instances where issuers who are adjusting their individual market or group market portfolios would inadvertently trigger bans on participating in the individual or group market. These measures generally would promote stability in the individual and small group markets, and would encourage issuers to enter or stay in the Marketplaces.

Moving Forward

Thanks to the Affordable Care Act, our country's health-insurance system has transformed from one that too often excluded the sick to a system that guarantees access to care for all, regardless of health status. This type of fundamental change rarely is easy, and from the outset, we knew

[17] https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018
[18] https://www.federalregister.gov/articles/2016/09/06/2016-20896/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018

that implementation of the Affordable Care Act would be a multi-year process. Every day we learn more to help us improve our operations and enhance the consumer experience by making the purchasing of health insurance easier and simpler for our customers.

As the Marketplace continues to grow and mature, our most important priorities include studying data, listening to a range of market participants, testing different approaches, and adapting to what we see and hear. We have a number of tools to make adjustments and are confident in our ability to make the Marketplace an even more attractive market for consumers and health plans alike. We look forward to continuing to benefit from suggestions from customers, assisters, brokers, issuers, and other key stakeholders on ways to improve our operations to ensure the American people gain the peace of mind that comes with health insurance coverage.

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Dr. Mandy Cohen, an internist, is the Chief Operating Officer and Chief of Staff for the Centers for Medicare and Medicaid Services. Dr. Cohen provides operational leadership and coordination across the Agency. Prior to taking on this role, Dr. Cohen was the Principal Deputy Director of the Center for Consumer Information and Insurance Oversight (CCIIO) at CMS overseeing the Health Insurance Marketplace and private insurance market regulation. Prior to her role in CCIIO, Dr. Cohen served as a Senior Advisor to the Administrator coordinating Affordable Care Act implementation activities across the Department and with external partners. Before that, Dr. Cohen was the Director of Stakeholder Engagement for the CMS Innovation Center, where she worked with the Innovation Center's many stakeholders to identify and test new payment and care delivery models. Dr. Cohen graduated from Cornell University, received her medical degree from Yale University, a Masters in Public Health from Harvard, and trained in Internal Medicine at the Massachusetts General Hospital. Dr. Cohen is married to Sam Cohen, a health care regulatory lawyer in DC, and has two daughters.