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Mr. Chairman, Ranking Member Cummings: thank you for inviting me to testify today. My name is Edmund F. Haislmaier and I am a Senior Research Fellow in Heath Policy at the Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

My testimony today focuses on the issue of limited provider networks in the new exchange plans.

In the last several months there have been numerous reports of insurers limiting the provider networks for plans they offer through the exchanges. Reviewing the media stories on the subject from various parts of the country indicate that the phenomenon is both widespread and significant. Even so, we do not yet have a complete picture. In part, that is because some insures appear to still be in the process of negotiating and contracting with providers.

Of course, health insurers and medical providers negotiate contracts all the time, and provider access under any health plan depends on the results of those negotiations.

However, the exchanges are a new market, so there is considerable public interest in the coverage that will be offered through them. Even though we do not yet have a complete picture, the accumulating evidence indicates that provider access through many exchange plans will be more restrictive than in other markets. That is particularly evident in those instances where an insurer is offering exchange coverage with significantly fewer participating providers than in the plans it sells off the exchanges.

Many reports attribute the more limited provider networks in exchange plans to a desire by insurers to limit premiums and the expectation that exchange enrollees are likely to be more price-sensitive consumers. However, limited provider networks are also the product of the way that the subsidies for exchange coverage are designed.

The Patient Protection and Affordable Care Act (PPACA) 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 Federal Poverty Level (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. 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. The accompanying Table 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 the Table 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 the PPACA's complicated subsidy scheme will reimburse insurers for the extra cost of those features.

TABLE 1

Sliding Scale Benefits (Single Person)

Percent of FPL	100%–150%	150%–200%	200%–250%	250%–400%
Annual Income	$11,490–$17,235	$17,235–$22,980	$22,980–$28,725	$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 Copay	No cost	No cost	No cost	No cost for 1 annual visit
Primary Care Visit Copay	$3	$15	$40	$45
Specialty Care Visit Copay	$5	$20	$50	$65
Urgent Care Visit Copay	$6	$30	$80	$90
Lab Testing Copay	$3	$15	$40	$45
X-Ray Copay	$5	$20	$50	$65
Generic Medication Copay	$3	$5	$20	$25
Emergency Room Copay (waived if admitted)	$25	$75	$250	$250
Emergency Medical Transportation Copay	$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 copay amount	$250, then pay the copay amount	$250, then pay the copay amount
Preferred Brand Copay 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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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.

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. The Department of Health and Human Services also recognizes that enrollees in plans with very low cost-sharing are likely to consume more services. That is why the formula HHS created for calculating cost-sharing subsidy payments to insurers includes an "induced utilization factor." Essentially, HHS estimates that the very low cost-sharing amounts for enrollees with incomes between 100 percent and 200 percent of the FPL will induce those enrollees to consume an average of 12 percent more medical care, relative to higher income enrollees charged normal levels of cost-sharing.[1]

[1] Department of Health and Human Services, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014," *Federal Register*, Vol. 78, No. 47, pp. 15410- 15540, March 11, 2013.

However, even with such adjustments to the cost-sharing subsidies, insurers recognize that the only way they 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.

Given that dynamic, it is not surprising that in analyzing insurer exchange participation patterns I found that, among the 254 insurers participating in the exchanges, 50 of them (or 20 percent) had Medicaid Managed care as their current principle business in the state in which they are offering exchange plans.[2]

However, 14 states do not have Medicaid manage care and, hence, have no carriers currently offering such coverage. 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. Thirty-one states will have at least one insurer with Medicaid managed-care business in the state offering coverage on the exchange, and 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.

It appears that those insurers saw in the PPACA'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, the CEO of Molina, one of the larger Medicaid managed care insurers, 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."[3]

The PPACA's reduced cost-sharing design also likely explains why exchange participating insurers that do not currently operate Medicaid managed-care plans are also 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. 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

[2] Edmund F. Haislmaier, "Health Insurers' Decisions on Exchange Participation: Obamacare's Leading Indicators," Heritage Foundation *Backgrounder* No. 2852, November 12, 2013, http://thf_media.s3.amazonaws.com/2013/pdf/BG2852.pdf.
[3] 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.

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.

Given the parameters set by the PPACA, 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.

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. The Table 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. The Table 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 the PPACA'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.

To the extent that limited provider networks in exchange plans are a function of the structure of the PPACA's cost-sharing design, it is difficult to see how any additional regulatory actions might produce expanded provider access.

For example, some state lawmakers, of both parties, are now considering enacting so-called "any willing provider laws." Such laws require insurers to contract with any medical provider willing to accept the insurer's rates and terms. Yet, enacting such laws would likely make little difference. That is because, under any health plan, access to specific providers is as much a product of provider decisions as of insurer decisions. So, while any willing provider laws require the insurer to offer contracts to all providers, those providers could still decline to participate if they were not satisfied with the rates and terms offered by the insurer. Thus, even with an any willing provider law, an insurer that believes that the financial viability of its plan offering depends on providers accepting lower payment rates could still end up with a narrow network plan if a significant number of providers refuse to accept the insurer's rates.

Another option would be to exclude from the exchanges insurers that offer plans with only limited provider networks. However, such a move would further limit the, already limited, coverage options available to exchange enrollees.

For example, back in August Washington State's Insurance Commissioner declined to certify four Medicaid managed care insurers seeking to offer coverage on that state's exchange due to the Commissioner's concern that the provider networks for the plans those carriers intended to offer would be too limited. However, that prompted a strong push back from the members of the state's exchange board who were, naturally, focused on having more carriers participate in the state's exchange. In the end, the four carriers and the Commissioner were able to resolve their differences sufficiently so that the carriers were allowed onto the exchange.[4] However, Washington State has three other carriers participating in its exchange (for a total of seven). It would be much more difficult for officials to exclude carriers with limited networks from the exchanges in the 23 states that have three or fewer participating carriers.

I sum, there is no way for government to either force providers to accept lower rates, or conversely, to force insurers to offer money losing plans. As long as the federal government insists on exchange plan designs that restrict the ability of insurers to use meaningful copays to induce enrollees to be prudent consumers of medical services, insurers will, of necessity, rely on restricting enrollee access to the subset of providers willing to accept lower reimbursement.

[4] Amy Snow Landa , "Kreidler approves Coordinated Care plans for insurance exchange," *The Seattle Times*, September 5, 2013, http://blogs.seattletimes.com/healthcarecheckup/2013/09/05/kreidler-approves-coordinated-care-plans-for-insurance-exchange/

Mr. Chairman, this concludes my prepared testimony. I thank you and the Committee for inviting me to testify before you on this issue. I will be happy to answer any questions that you or members of the Committee may have.

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He is the author of over thirty papers and studies on topics including; health care financing and tax policy, health insurance regulation and markets, pharmaceutical policies and health care price controls. In addition, Haislmaier has assisted federal and state lawmakers in designing and drafting more than a dozen pieces of health care legislation including, most recently, heath insurance market reforms enacted in 2006 in Massachusetts.

Haislmaier is a member of the Board of Directors of the National Center for Public Policy Research and holds a B.A. in History from St. Mary's College of Maryland.

Committee on Oversight and Government Reform
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