Consumer Experiences in the ACA Marketplaces, Marketplace Stability, and Remaining Challenges to Covering the Uninsured

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Invited Testimony

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EXECUTIVE SUMMARY

Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on the Advancing Patient Solutions of Lower Costs and Better Care. Three years after the Affordable Care Act's major health insurance expansions went into effect, 12.7 million people are estimated to have coverage through the marketplaces and 15 million more through Medicaid. There are 20 million fewer people uninsured since the law went into effect in 2010. Yet there remains considerable controversy over how well these reforms are working for consumers and whether the marketplaces are stable and competitive. The bills under discussion in this hearing are aimed at addressing some concerns that have been raised about the marketplaces and how consumers are using their plans. In this testimony, I review current evidence about the experiences of consumers in marketplace plans and Medicaid, the competitiveness and stability of the marketplaces, and ongoing implementation challenges. I also examine three of the proposed bills and their potential implications.

CONSUMER EXPERIENCES IN THE MARKETPLACE PLANS AND MEDICAID

- **The Coverage Expansions are Improving Americans' Access to Health Care**
  - The Commonwealth Fund ACA Tracking Survey February–April 2016 finds that majorities of people enrolled in either marketplace plans or Medicaid who have used their plans report they would not have been able to access or afford this care prior to getting their new insurance.
  - The ability of adults with marketplace plans and Medicaid to find doctors and get appointments is similar to that of U.S. insured adults overall.
  - Majorities of marketplace or Medicaid enrollees are satisfied with their insurance.
  - The early effects of the coverage expansions are also evident in nationwide declines in out-of-pocket spending growth, cost-related problems getting care, and medical bill problems**.**

- **Implementation Challenges Remain**
    - While the uninsured rate has fallen significantly among working-age adults, wide differences persist between lower- and higher-income adults.
    - This difference is driven in part by the fact that 19 states did not expand their Medicaid programs, as well as dwindling resources for and legislative barriers to outreach and enrollment in many states
    - Affordability remains a key issue for enrollees across the income spectrum.
    - Increases in the size and proliferation of deductibles in marketplace and employer plans may create more underinsured people.

PREMIUMS AND MARKETPLACE STABILITY IN 2017

News reports about double-digit 2017 premium requests by several insurers and UnitedHealth Group's decision to pull out of several state marketplaces next year have raised concerns about the ongoing stability of the marketplaces. There are several reasons why these developments don't portend disaster for the marketplaces.

- **Most Marketplace Enrollees Won't Pay Double-Digit Premium Increases in 2017**
    - Insurers' premium requests will be reviewed by state regulators and will be adjusted or even rejected in some states.
    - 83 percent of marketplace enrollees receive tax credits to help pay their premiums; most of the increases will be absorbed by those credits, so most people won't pay much more next year than they paid this year.
    - Marketplace shoppers are highly price-sensitive and will likely not buy the higher-cost plans.
    - At the end of the open enrollment period, people who received tax credits experienced average premium increase of only 4 percent.

- **The Marketplaces Are Competitive and Creating Value for Consumers**
    - The marketplaces are promoting price competition among insurers.
    - Recent research finds that projected premium increases in 2016 were lower for health plans sold inside the marketplaces than for those sold by carriers exclusively outside the marketplaces.
    - The concern that UnitedHealth Group's departure from several marketplaces next year is a harbinger of more exits by insurers is overstated.
    - Insurer participation in the marketplaces was relatively stable between 2015 and 2016.
    - A recent review of first-quarter earnings calls by publicly traded insurers selling plans in the marketplaces suggest that most of these carriers remain committed to the marketplace in 2017.

- Many carriers report opportunities for growth; while the composition of risk pools remains in flux, there is variation across carriers, with some reporting healthier-than-expected pools.

- **Risk Pools Remain in Flux but ACA Premium Stabilization Programs Are Working**
  - Analyses of the risk-adjustment program have concluded that the program is working by transferring funds from insurers with lower-cost enrollees to insurers with enrollees who are sicker and have higher costs.
  - While there is room for improvement, the program appears to be fulfilling its intended objective of encouraging insurers to compete on value rather than risk.
  - The temporary reinsurance program is estimated to have lowered marketplace premiums by 10 percent to 14 percent in 2014, 6 percent to 11 percent in 2015, and by a smaller amount in 2016 as it phases out.
  - The complete phase-out of that program this year will almost certainly lead carriers to adjust their rates upward to accommodate the loss.

- **Ongoing Need for Ensuring Stability of the Marketplaces over Time**
  - The ongoing stability of the marketplaces and reasonable premium growth over time will continue to be dependent on covering the remaining uninsured and encouraging people to enroll in marketplace plans or Medicaid when they experience coverage gaps.
  - States will need resources to provide needed outreach to those who remain unaware of or reluctant to visit the marketplaces.
  - Affordability of health plans and health care for modest-income consumers will also be critical.

DISCUSSION OF PROPOSED BILLS

Three bills under discussion in this hearing are aimed at addressing recent concerns about the marketplaces.

- **Proposed Bill: Changing Permissible Age Variation in Health Insurance Premium Rates**
  - The proposed bill would increase the amount that carriers could charge older adults from three times to five times that of younger people.
  - The proposal also appears to provide an option for states to determine their own limits.
  - RAND researchers previously modeled a change in the ACA age band from 3:1 to 5:1.

- They found that while more—mostly younger—people would become insured under 5:1 rate banding, it would come with a price tag of $9.3 billion in additional federal spending and a loss of insurance coverage for 400,000 older people.
- The researchers estimate that the higher limits would increase annual premiums for the average benchmark silver plan for a 64-year-old from about $8,500 under current limits to $10,600 under the 5:1 rate bands, while lowering those for a 21-year-old from $2,800 to $2,100.

- **Proposed Bill: Requirement of Verification for Eligibility for Enrollment During Special Enrollment Periods**
  - The Urban Institute estimates that 33.5 million people are eligible for SEPs each year— the vast majority because of job loss, but only 15 percent use them.
  - The Centers for Medicare and Medicaid Services (CMS) has made adjustments to the special enrollment periods (SEPs), including a new confirmation process for SEPs that requires documentation to verify eligibility
  - People can still enroll in coverage while the verification process is being conducted, but there are deadlines for submission that trigger loss of eligibility or coverage if missed.
  - CMS is also adding an adjustment factor for partial-year enrollees to the risk-adjustment program for the 2017 plan year.
  - The proposed bill would require the Secretary to institute a verification process for SEPs, but people requesting a SEP would not be allowed to enroll in coverage until they have submitted documentation.
  - Tighter verification standards could lead to even lower enrollment through the SEPs.
  - Only the most motivated people eligible for SEPs—that is, those who are the most in need of health care—might enroll, leading to less healthy risk pools.
  - Given these potential adverse outcomes, it might be prudent to assess the effects of the new CMS verification process before imposing more restrictive requirements on those potentially eligible for them.

- **Proposed Bill: To Better Align the Grace Period Required for Nonpayment of Premiums**
  - Recognizing that people with modest incomes might struggle in some months to pay their premiums, the law allows a three-month grace period for someone who fails to pay their premium in a given month.
  - While some have suggested that people use the grace periods to game the system and get free coverage, the rules governing them are restrictive and aimed at discouraging such behavior.

- The proposed bill reduces the ACA grace period for marketplace enrollees from three months to one month.
- Such a policy change could mean a loss of enrollment in the marketplaces among enrollees of modest means and an increase in the number of people who are uninsured or have gaps in their coverage.
- The policy change would seem to also favor those who are most motivated to retain their coverage— those in poorer health.

CONCLUSION

- Overall, the insurance provisions of the Affordable Care Act have been successful in achieving a number of goals, including substantial declines in the number of uninsured Americans and improved access to care.
- The marketplaces are competitive and appear to be producing value for consumers.
- But challenges remain:
  - lack of Medicaid expansion in 19 states
  - need for ongoing efforts to reach uninsured people who are eligible for enrollment in Medicaid and marketplace plans
  - ensuring that consumers in marketplace plans and Medicaid have insurance that is affordable and designed with incentives and protections that encourage timely access to high-value health care;
  - ensuring the stability of the marketplaces and reasonable growth in premiums over time.

It is encouraging that the Committee is considering ways to improve the marketplaces. In the end, the fundamental purpose of the marketplaces is to provide coverage to those who lack health insurance and thus cannot get needed care, and are currently suffering unnecessarily as a result.

Thank you.

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Thank you, Mr. Chairman and members of the Committee, for this invitation to testify today on the Advancing Patient Solutions of Lower Costs and Better Care. Three years after the Affordable Care Act's major health insurance expansions went into effect, 12.7 million people are estimated to have coverage through the marketplaces and 15 million more through Medicaid.[1] There are 20 million fewer people uninsured since the law went into effect in 2010.[2] Yet there remains considerable controversy over how well these reforms are working for Americans and whether the marketplaces are stable and competitive. The bills under discussion in this hearing are aimed at addressing some concerns that have been raised about the marketplaces and how consumers are using their plans. In this testimony, I review current evidence about the experiences of consumers in marketplace plans and Medicaid, the competitiveness and stability of the marketplaces, and ongoing implementation challenges. I will also examine three of the proposed bills and their potential implications.

EXPERIENCES OF CONSUMERS IN THE ACA COVERAGE EXPANSIONS

Coverage Expansions Are Improving Americans' Access to Health Care

The most recent Commonwealth Fund Affordable Care Act Tracking Survey, February– April 2016 finds that coverage through the marketplaces or Medicaid is improving people's ability to

[1] By the end of The Affordable Care Act's third open enrollment period, marketplace plan selections had climbed to 12.7 million people and 15 million more people were enrolled in Medicaid compared to three years earlier. *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Period, ASPE Issue Brief* (Washington, D.C.: U.S. Department of Health and Human Services, March 11, 2016), https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf; *Medicaid & CHIP: February 2016 Monthly Applications Eligibility Determinations and Enrollment Report, CMS Report* (Washington, D.C.: U.S. Department of Health and Human Services, April 29, 2016), https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/february-2016-enrollment-report.pdf.

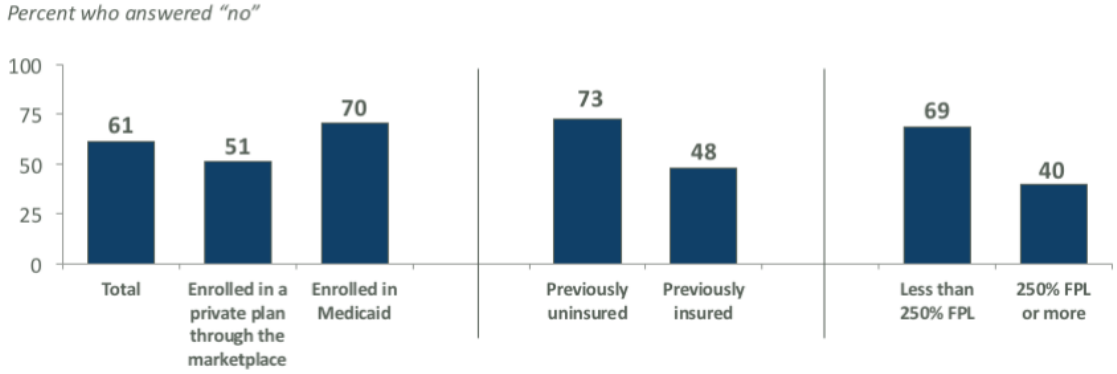
[2] R.A. Cohen, M.E. Martinez, and E.P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015* (National Center for Health Statistics, May 2016).

get health care.[3] More than 70 percent of enrollees in marketplace plans or Medicaid have used their plans to get care. Of those, 51 percent of those enrolled in marketplace plans and 70 percent of those newly enrolled in Medicaid said they would not have been able to access or afford this care prior to getting their new insurance (Exhibit 1). Enrollees say their ability to get the health care they need has improved or stayed the same since getting their new insurance (Exhibit 2). Those who have looked for new primary care physicians are finding them relatively easily (Exhibit 3). Wait times for doctor appointments are comparable to those reported in other surveys by insured adults (Exhibit 4). Majorities of marketplace or Medicaid enrollees are satisfied with their insurance (Exhibit 5).

Exhibit 1

Three of Five Adults with Marketplace or Medicaid Coverage Who Had Used Their Plan Said They Would Not Have Been Able to Access or Afford This Care Before

Prior to getting your Medicaid or health coverage through the marketplace, would you have been able to access and/or afford this care?



*Adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and have used their new health insurance plan**

* 72% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years reported they had used their coverage to visit a doctor, hospital, or other health care provider, or to pay for prescription drugs.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

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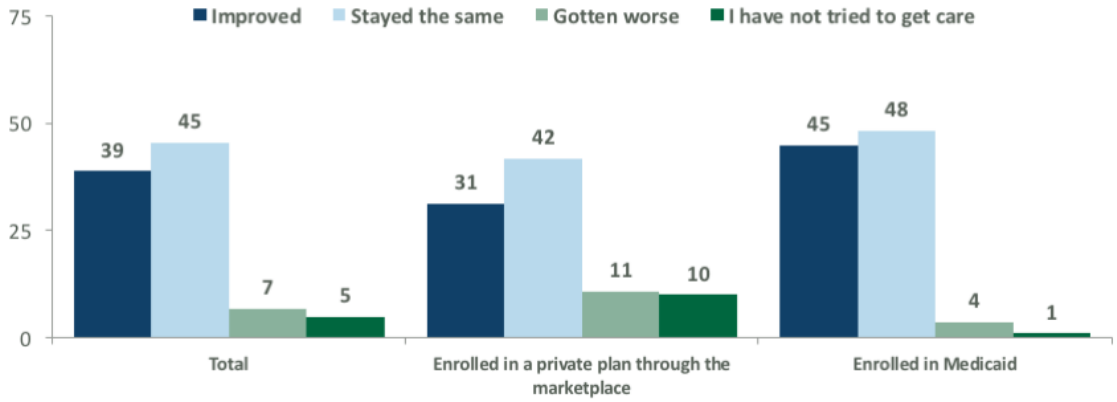
[3] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction, The Commonwealth Fund, May 2016, http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction.

Exhibit 2

Eight of Ten Adults with New Coverage Said Their Ability to Get Health Care Has Improved or Stayed the Same

Since obtaining Medicaid or health coverage through the marketplace, would you say your ability to get the health care that you need has improved, stayed the same, or gotten worse?



Percent of adults ages 19–64 who have had a private plan through the marketplace or Medicaid for two months or less

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

Exhibit 3

Three of Five Adults with Medicaid or Marketplace Coverage Who Tried to Find a New Primary Care Doctor Found It Very or Somewhat Easy to Do So and More Than Half Waited Two Weeks or Less to See Them

How easy or difficult was it for you to find a new primary care doctor or general doctor?

*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and tried to find a primary care doctor or general doctor since getting new coverage**

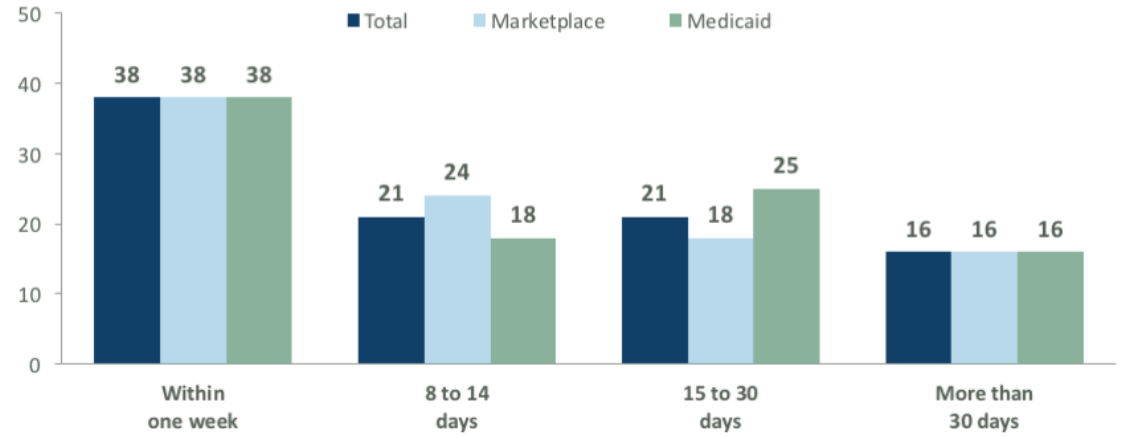
* 25% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years tried to find a primary care or general doctor. ^ Among those who found a primary care doctor.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

Exhibit 4

Three of Five Adults with Medicaid or Marketplace Coverage Who Needed to See a Specialist Waited Two Weeks or Less

How long did you have to wait to get your last appointment to see this specialist?



*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and needed to see a specialist**

* 41% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years needed to see a specialist doctor.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.–April 2016.

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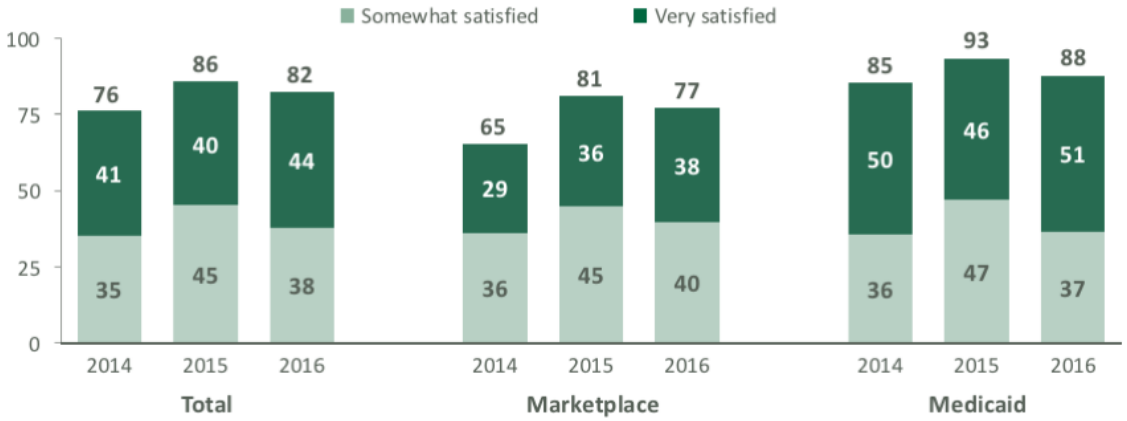
Exhibit 5

Most Adults with Marketplace or Medicaid Coverage Continue to Be Satisfied with It

Overall, how satisfied are you with your health insurance?



*Percent of adults ages 19–64 who are currently enrolled in marketplace coverage or have had Medicaid since expansion**

* For 2014 we included adults who had Medicaid for less than one year, for 2015 we included adults who had Medicaid for less than two years, and for 2016 we include adults who have had Medicaid for less than three years.

Note: Segments may not sum to indicated total because of rounding.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, April–June 2014, March–May 2015, and Feb.–April 2016.

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These reports of improved access to care are evident in national spending account data and populationwide trends in key measures of health care access and medical financial burdens. According to the Centers for Medicare and Medicaid Services (CMS), the annual rate of increase in household out-of-pocket health care spending slowed from 2.1 percent in 2013 to 1.3 percent in 2014.[4] Out-of-pocket spending on hospital services, a big-ticket item for uninsured families prior to the ACA, fell by more than 4 percent. CMS attributes these changes to increased insurance coverage through the expansions. In addition, federal and private consumer surveys show nationwide declines in reports of medical bill problems and cost-related delays in getting health care.[5] A recent analysis by the Federal Reserve Bank of New York found a decline in average debt sent to collections agencies among counties in states that expanded eligibility for Medicaid with high rates of uninsured people prior to the ACA.[6] These gains have occurred because millions more people have full protection against catastrophic health care costs. But they also likely reflect the fact that the ACA requires individual market and marketplace plans, as well as Medicaid plans, to cover a comprehensive set of services and places limits on annual out-of-pocket costs. In addition, more than half of marketplace enrollees have health plans with cost-sharing reductions that have substantially lowered the amount of their deductibles, copays, and out-of-pocket limits.[7]

Ongoing Implementation Challenges

Despite these substantial improvements in coverage and access, there remain obstacles to the goal of providing all Americans with access to high-quality care. Many adults and children who could benefit from the coverage expansions continue to be uninsured. While the Affordable Care Act has significantly reduced the uninsured rate among working-age adults, wide differences

[4] S. R. Collins and D. Blumenthal, "New U.S. Health Care Spending Estimates Reflect ACA Coverage Expansions and Higher Drug Costs," *The Commonwealth Fund Blog,* Dec. 4, 2015.; A. B. Martin, M. Hartman, J. Benson et al., The National Health Expenditure Accounts Team, National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending, Health Affairs, December 2015, http://content.healthaffairs.org/content/early/2015/11/25/hlthaff.2015.1194

[5] S. R. Collins and D. Blumenthal, "New Federal Survey Shows Gains in Private Health Coverage and Fewer Cost-Related Problems Getting Care," *The Commonwealth Fund Blog,* Feb. 24, 2016.

[6] N. Dussault, M. Pinkovskiy, B. Zafar, Is Health Insurance Good for Your Financial Health? Federal Reserve Bank of New York, June 6, 2016, http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V1lZNPkrK5s.

[7] S. R. Collins, M. Gunja, and S. Beutel,*How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016, http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-sharing-reductions.

persist between lower- and higher-income adults (Exhibit 6). This is driven in part by the fact that 19 states did not expand their Medicaid programs,[8] as well as dwindling resources for and legislative barriers to outreach and enrollment in many states.[9] The Medicaid expansion, premium tax credits, and cost-sharing subsidies have made coverage and health care affordable for low- and moderate-income families who were most at risk of lacking insurance.[10] But affordability remains a key issue for enrollees across the income spectrum.[11] Concern about affordability is the most oft-cited reason given by uninsured adults who either have not visited the marketplaces or have visited but not signed up for a plan.[12] Increases in both the size and proliferation of deductibles in the marketplace and employer plans can lead to people being "underinsured"—that is, they are insured but have high out-of-pocket cost exposure relative to their incomes.[13] New policy options are needed to encourage people to enroll in the coverage options for which they are eligible and to ensure all health plans, including those offered by employers, provide the right incentives to enable people to get timely, high-quality health care.

[8] S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, S. Beutel, and J. Kiszla,*The Changing Landscape of Health Care Coverage and Access: Comparing States' Progress in the ACA's First Year,*The Commonwealth Fund, December 2015, http://www.commonwealthfund.org/publications/issue-briefs/2015/dec/changing-landscape.

[9] B.D. Sommers, B. Maylone, K.H. Nguyn, R.J. Blendon, and A.M. Epstein. "The Impact of State Policies on ACA Applications and Enrollment Among Low-Income Adults in Arkansas, Kentucky, and Texas." *Health Affairs* 34.6 (2015). http://content.healthaffairs.org/content/34/6/1010.full. Web. June 8, 2016; A. G. Mosqueira and B. Sommers, "Better Outreach Critical to ACA Enrollment, Particularly for Latinos,"*The Commonwealth Fund Blog*, January 2016, http://www.commonwealthfund.org/publications/blog/2016/jan/better-outreach-critical-to-aca-enrollment-particularly-for-latinos.

[10] S. R. Collins, M. Gunja, and S. Beutel,*How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016, http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-sharing-reductions

[11] S. R. Collins, M. Gunja, P. W. Rasmussen, M. M. Doty, and S. Beutel, Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015, The Commonwealth Fund, September 2015, http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/are-marketplace-plans-affordable.

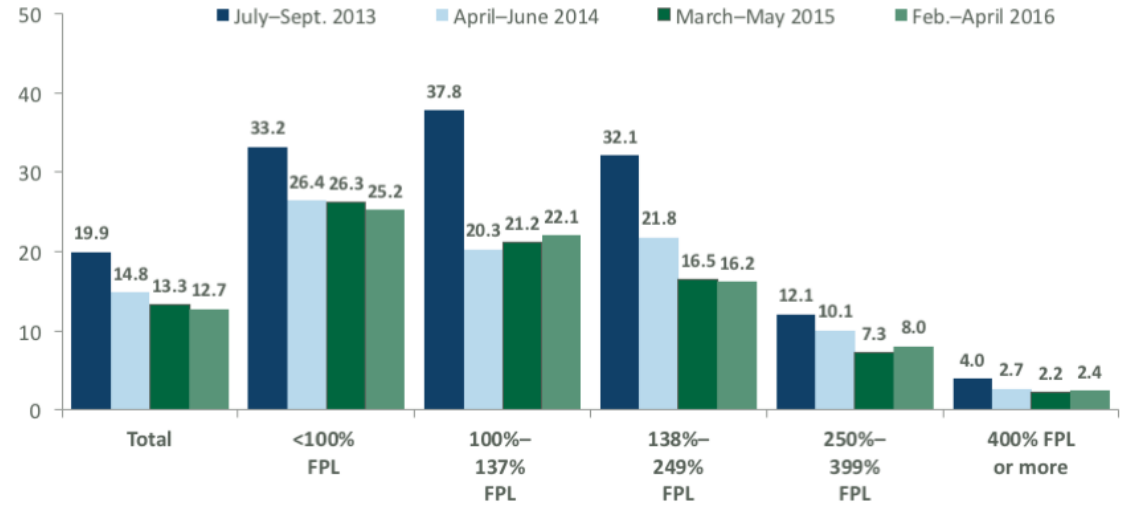
[12] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not,* The Commonwealth Fund, September 2015.

[13] S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey,* The Commonwealth Fund, May 2015, http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance.

Exhibit 6

Uninsured Rates Among Low-Income Adults Have Fallen the Most But Remain Substantially Higher Than Those for Adults with Higher Incomes

Percent of adults ages 19–64 uninsured



Note: FPL refers to federal poverty level.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, and Feb.–April 2016.

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PREMIUMS AND MARKETPLACE STABILITY

In the last few months, certain news reports have raised concerns about the ongoing stability of the marketplaces. These include stories about double-digit 2017 premium requests by several insurers selling plans in the marketplace and UnitedHealth Group's decision to pull out of several state marketplaces next year. There are several reasons why these developments don't portend disaster for the marketplaces.

Most Marketplace Enrollees Won't Pay Double-Digit Premium Increases in 2017

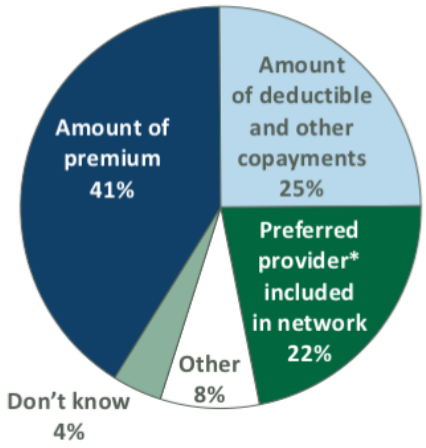
It is important to remember that most people who will enroll in marketplace plans in the 2017 open enrollment period will not pay the widely reported double-digit premium increases. There are a number of reasons for this. First, insurers' premium requests will be reviewed by state regulators and will be adjusted or even rejected in some states. Any many insurers in the same state are not requesting large increases. Second, 83 percent of marketplace enrollees receive tax credits to help pay their premiums. Most of the increases will be absorbed by those credits so people won't pay much more next year than they paid this year. Third, marketplace shoppers are

highly price-sensitive and will likely not buy the higher cost plans (Exhibit 7).[14] In the most recent enrollment period, 43 percent of returning marketplace enrollees switched plans. This rate is considerably higher than rates of plan switching in employer plans and among seniors in the Medicare prescription drug program.[15] Indeed, while many carriers last year also requested significant rate increases, and some early analyses predicted double-digit increases on average, at the end of the open enrollment period, people who received tax credits experienced an average premium increase of only 4 percent. [16] Premiums rose by 8 percent across the full group of marketplace enrollees. These increases are also lower than those that characterized the individual market before the reforms of the Affordable Care Act.

Exhibit 7

Premiums and Cost Exposure Were the Most Important Factors in Plan Selection Among Marketplace Enrollees

What was the most important factor in your decision about which plan to select?



Adults ages 19–64 who have had a private plan through the marketplace for three months or less or changed plans in the 2015 open enrollment period

* Actual question wording: preferred doctor, health clinic, or hospital included in plan's network.
Source: The Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015.

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[14] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not,* The Commonwealth Fund, Sept. 2015.

[15] *Health Insurance Marketplace Premiums After Shopping, Switching , and Premium Tax Credits, 2015-2016*, ASPE Issue Brief, U.S. Department of Health and Human Services, https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf; T. DeLeire and C. Marks, Consumer Decisions Regarding Health Plan Choices in the 2014 and 2015 Marketplaces, Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, October 28, 2015.

[16] *Health Insurance Marketplace Premiums After Shopping, Switching , and Premium Tax Credits, 2015-2016*, ASPE Issue Brief, U.S. Department of Health and Human Services, https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf.

The Marketplaces are Competitive and Creating Value for Consumers

The structure of the marketplaces and the designation of the second-lowest-cost silver plan as the benchmark for tax credits are promoting price competition among insurers. Research by Michael McCue and Mark Hall finds that projected premium increases in 2016 were lower for health plans sold inside the marketplaces than for those sold by carriers exclusively outside the marketplaces.[17] Carriers' profits and administrative costs were also lower inside the marketplaces than outside. Consumers who have plans purchased in the marketplaces are more likely to have plans with closed provider networks like HMOs and EPOs than those outside. These findings show that their premium dollars are providing them with greater overall value than is the case for consumers buying outside the marketplaces. While oversight is needed to ensure that consumers in narrow network plans have timely access to high-quality providers,[18] people in marketplace plans give their plans high ratings[19] and are satisfied with their choice of doctors and hospitals, [20] despite the proliferation of these plans in the marketplaces.

The concern that UnitedHealth Group's departure from several marketplaces next year is a harbinger of more exits by insurers is overstated. Insurer participation in the marketplaces was relatively stable between 2015 and 2016.[21] A recent review by Kevin Lucia and colleagues of first-quarter earnings calls by publicly traded insurers selling plans in the marketplaces suggest that most of these carriers remain committed to the marketplace in 2017.[22] Many report

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[17] M. J. McCue and M. A. Hall, *Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges,* The Commonwealth Fund, June 2016, http://www.commonwealthfund.org/publications/issue-briefs/2016/june/insurance-exchanges-promote-value.

[18] D. Polsky and R. Rosenquist, *Your Narrow Network Will Be 'Basic' But Will It Be Adequate?* University of Pennsylvania, Leonard David Institute of Health Economics, March 9, 2016, http://ldi.upenn.edu/healthpolicysense/your-narrow-network-will-be-%E2%80%98basic%E2%80%99-will-it-be-adequate.

[19] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, The Commonwealth Fund, May 2016, http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction.

[20] L. Hamel, J. Firth, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3,* Kaiser Family Foundation, May 2016, http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/.

[21] E. Curran, J. Giovannelli, and K. Lucia, "Insurer Participation in State-Based Marketplaces in 2016: A Closer Look," Commonwealth Fund Blog, January 2016, http://www.commonwealthfund.org/publications/blog/2016/jan/insurer-participation-in-state-based-marketplaces-in-2016.

[22] K. Lucia, J. Giovannelli, E. Curran et al., "Beyond UnitedHealthcare: How Are Other Publicly Traded Insurers Faring on the Marketplaces?" To the Point, June 1, 2016.

opportunities for growth, and while the composition of risk pools remains in flux, there is variation across carriers, with some reporting healthier-than-expected pools.

An Urban Institute analysis of marketplace competition in a select number of rating areas in 26 states suggests that carriers other than the large national insurers may be more significant drivers of competition in the marketplaces.[23] While UnitedHealth Group participated in more than half of the regions the researchers analyzed, its premiums were higher relative to their competitors in most markets. In 2016, United was one of the two lowest-cost insurers in 18.5 percent of the regions analyzed. This was true of Aetna in 16 percent of the regions and Humana in 6.2 percent. In contrast, Blue Cross–affiliated insurers, Medicaid insurers selling marketplace plans, provider-sponsored insurers, and regional insurers were far more likely to offer competitively priced plans. Blue Cross plans were one of two lowest-cost plans in 42 percent of regions analyzed. This was true of Medicaid plans in 54 percent of regions, provider-sponsored insurers in 28 percent, and local or regional insurers in 21 percent.

Risk Pools Remain in Flux but ACA Premium Stabilization Programs Are Working

The ACA's premium stabilization programs, including the temporary reinsurance and risk corridor programs and the permanent risk-adjustment program, were designed to mitigate uncertainty for carriers in the initial years of the marketplaces and encourage competition on value rather than risk. The reinsurance program is estimated to have lowered marketplace premiums by 10 percent to 14 percent in 2014, 6 percent to 11 percent in 2015, and by a smaller amount in 2016 as it phases out.[24] The complete phase-out of that program this year will almost certainly lead carriers to adjust their rates upward to accommodate the loss. Because the risk-corridor program was ultimately implemented without federal funding, payments to carriers are being prorated in each year based on the balance of funds collected from insurers.[25] Consequently, for plan year 2014, plans that expected to receive risk corridor payments only received 12.6 percent of what they were owed under the program.

[23] J. Holahan, L.J.Blumberg, E. Wengle, What Does the Failure of Some CO-Ops and the Possible Pullout of United Healthcare Mean for the Affordable Care Act? The Urban Institute, January 2016, http://www.urban.org/research/publication/what-does-failure-some-co-ops-and-possible-pullout-united-healthcare-mean-affordable-care-act.

[24] American Academy of Actuaries, Drivers of 2016 Health Insurance Premium Changes, August 2015.

[25] American Academy of Actuaries, Insights on the ACA Risk Adjustment Program, April 2016.

Recent analyses of the permanent risk-adjustment program have concluded that the program is working as it was intended to by transferring funds from insurers with lower-cost enrollees to those with sicker and higher-cost enrollees.[26] While analysts caution there is room for improvement, the program appears to be fulfilling its intended objective of encouraging insurers to compete on value rather than risk.[27] However, unlike the temporary reinsurance and risk-corridor programs, the risk-adjustment program is not intended to insure premium stability over time. The temporary programs were designed to address the likelihood that the initial marketplace enrollment would be sicker than average, given that many people were uninsured prior to gaining coverage and would have higher demand for care services. Over time as enrollment grew, the risk pools were expected to become more balanced with a mix of healthier and sicker enrollees. To the extent this has not yet happened, the phase-out of the reinsurance program in particular will lead carriers to set higher rates in 2017.

Ongoing Need for Ensuring Stability of the Marketplaces over Time

The ongoing stability of the marketplaces and reasonable premium growth over time will continue to be dependent on strong enrollment of a diverse group of people. To achieve this, given the large number of remaining uninsured Americans, states will need the resources to provide the necessary outreach and education to reach people unaware of or reluctant to visit the marketplaces. But more fundamentally, consumers will need to continue to view their plans as both affordable and providing high-value care through reasonable coverage of out-of-pocket costs and adequate access to high-quality providers.

ANALYSIS OF PROPOSED BILLS

Three bills under discussion in this hearing are aimed at addressing recent concerns about the marketplaces. This section provides some analysis of the proposals in the context of their ability to address key challenges: helping uninsured people who are eligible for marketplace and Medicaid coverage enroll, achieving balanced risk pools, and ensuring affordability of health plans and access to high-value health care for consumers.

[26] American Academy of Actuaries, Insights on the ACA Risk Adjustment Program, April 2016.
[27] Oliver Wyman, A Story In 4 Charts: Risk Adjustment in the Non-Group Market in 2014.

Proposed Bill: Changing Permissible Age Variation in Health Insurance Premium Rates

Prior to the Affordable Care Act, insurers in the individual market generally charged older people higher premiums than they did younger people because their expected medical expenses are higher. Similarly, insurance carriers charged higher premiums to small companies with older workforces. Premiums varied by age by as much as 25-to-1 in the individual and small-group markets, pricing many older adults and small businesses out of the market. [28]

While the ACA completely banned insurers from setting premiums based on health or gender, it allows carriers to adjust premiums based on age, tobacco use, family size, and geographic region, within defined limits. With respect to age, insurers are allowed to charge older people up to three times what they charge a younger person. This rule has had the effect of lowering premiums for older people who were at risk of exorbitant premiums in the individual market before the ACA, and increasing premiums for younger people who were viewed as far better health risks. In this way, the law has allowed risk to be shared in a reasonable fashion across the age spectrum, as intended by the principles of insurance generally. But also, by allowing rating on age, the law limits the extent to which younger people subsidize the costs of older people. [29]

There has been considerable focus on young adults in the marketplaces. On average they have fewer health problems than older adults and encouraging their enrollment may lead to more balanced risk pools. Despite early concerns that young adults might not sign up for coverage, enrollment of those under age 34 in both the marketplaces and Medicaid has been relatively strong. Recent data from the Commonwealth Fund ACA Tracking Survey indicates that among 19–64-year-old adults, about 32 percent of marketplace enrollees in 2016 are ages 19-to-34 which is comparable to their overall representation in the population.[30] Young adults are disproportionately represented among adults newly enrolled in Medicaid, comprising 46 percent

[28] National Association of Insurance Commissioners and Center for Insurance Policy Research, Health Insurance Rate Regulation, http://www.insurance.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.

[29] Eibner C and Saltzman E, Assessing Alternative Modications to the Affordable Care Act: Impact on Individual Market Premiums, Santa Monica, Calif.: RAND Corporation, RR-708-DHHS, 2014, www.rand.org/t/RR708.

[30] S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, The Commonwealth Fund, May 2016, http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction.

of enrollment among adults. The most recent HHS estimates of 2016 marketplace enrollment show that young adults comprised 28 percent of those who selected health plans in the last open enrollment period.[31]

The proposed bill would increase the amount that carriers could charge older adults from three times to five times that of younger people. The proposal also appears to provide an option for states to determine their own limits. The intent is presumably to increase enrollment of young adults in the marketplaces.

Christine Eibner and Evan Saltzman at RAND previously modeled a change in the ACA age band from 3:1 to 5:1, which is the change called for in the bill.[32] The researchers found that while more—mostly younger—people would become insured under a 5-to-1 rate banding, it would come with a price tag of $9.3 billion in additional federal spending and a loss of insurance coverage for 400,000 older people. Premiums would increase for adults over age 47 and decrease for those under age 47. The researchers estimate that the higher limits would increase annual premiums for the average benchmark silver plan for a 64 year -old from about $8,500 under current limits to $10,600 under the 5:1 rate bands, while lowering those for a 21 year old from $2,800 to $2,100. The higher premiums for older adults over age 47 would result in an increase in tax credits at a cost of $9.3 billion in federal spending. The lower premiums for younger people would increase enrollment in the marketplaces by 4.4 million, but 40 percent of those new enrollees would shift out of employer plans, mostly from parents' policies. The vast majority of new enrollees would have higher incomes and thus not be eligible for subsidies. The policy would lead to decline in employer coverage of 1.4 million, an increase in individual market and marketplace coverage of 3.3 million, with a net gain in coverage of 1.8 million.

While the proposed policy change might marginally increase enrollment of young adults in the marketplaces, it significantly increases federal costs while leading to a loss of coverage

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[31] *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Period, ASPE Issue Brief* (Washington, D.C.: U.S. Department of Health and Human Services, March 11, 2016), https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

[32] C. Eibner and E. Saltzman, "Charging Older Adults Higher Premiums Could Cost Taxpayers," The Commonwealth Fund Blog, Sept. 15, 2015, http://www.commonwealthfund.org/publications/blog/2015/sept/charging-older-adults-higher-premiums-could-cost-taxpayers.

among older adults. In addition, there is also no guarantee that these new enrollees will in fact be healthier than average. Since carriers are allowed to rate on age, but barred from rating on health, swapping out older adults for younger adults may in some cases leave them more exposed to risk. Prior research by Eibner and Saltzman finds that young adults are only slightly more likely than older adults to have a positive effect on risk pools. [33]

Proposed Bill: Requirement of Verification for Eligibility for Enrollment During Special Enrollment Periods

The Affordable Care Act's insurance market reforms have vastly improved the ability of older people or those with health problems to gain health insurance coverage. In 2010, the Commonwealth Fund Biennial Health Insurance Survey found that an estimated 9 million adults who had either purchased a plan or tried to buy a plan in the individual insurance market were turned down, charged a higher price, or had a service excluded from their policy because of a preexisting condition.[34] To prevent people from enrolling in coverage only when they most need it, the law also included an individual mandate and defined open enrollment periods. People who miss the chance to enroll during open enrollment have to wait until the following year.

But because most people continue to have coverage through an employer and millions lose it throughout the year because of job loss or change, loss of a spouse/partner or parent, and other life changes, the ACA included special enrollment periods (SEPs) outside the open enrollment period to provide a means for people to gain health insurance when they lose other forms of coverage or experience other life changes such as moving to a new state or a birth.

But a recent analysis by the Urban Institute suggests that only a fraction of people who are likely eligible for a SEP actually request them. The analysis estimates that 12.9 million people will experience a SEP-qualifying event in 2016, lose their coverage, and remain uninsured for the remainder of the year. Of those, 9.7 million would qualify for a SEP because of

[33] Eibner C and Saltzman E, Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums, Santa Monica, Calif.: RAND Corporation, RR-708-DHHS, 2014, www.rand.org/t/RR708.

[34] S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010, The Commonwealth Fund, March 2011, http://www.commonwealthfund.org/publications/fund-reports/2011/mar/help-on-the-horizon.

a job loss. An additional 20.6 million people this year are estimated to be able to use SEPs to prevent temporary coverage gaps. Of this group, the vast majority (18.2 million) qualify because of a job change and would otherwise be uninsured in the period between the end of one job and the beginning of another in same year. But based on 2015 CMS data, the Urban Institute estimates that fewer than 15 percent of uninsured people who are eligible for a SEP are enrolling through one.

The Department of Health and Human Services provided guidance for SEPs in regulations in 2012 and has amended them in each year since.[35] This year, CMS has made several adjustments to the SEPs in response to insurer complaints that people who enrolled through the SEPs had greater health care needs than average and that some stayed in plans only long enough to get the care they needed. CMS eliminated seven SEPs, narrowing the number to the current six. The six SEPS are for : losing other qualifying coverage; changes in household size like marriage or birth; changes in residence, with significant limitations; changes in eligibility for financial help, with significant limitations; defined types of errors made by marketplaces or plans; and other specific cases like cycling between Medicaid and the marketplace or leaving Americorps coverage. CMS also tightened some rules for SEPs including requiring that individuals who request a SEP because of a permanent move must have minimum essential coverage for one or more days in the 60 days preceding the move, unless they were living outside of the United States or in a United State territory prior to the permanent move. CMS notes that this ensures that individuals are not moving for the sole purpose of obtaining health coverage outside the open enrollment period. But such requirements would not apply to those who moved and were previously incarcerated or were in the coverage gap in a Medicaid nonexpansion state.

CMS this year has also introduced a new confirmation process for SEPs requiring all consumers applying through the most common special enrollment periods to submit documentation to verify their eligibly to use a SEP. This becomes effective June 17, and CMS has posted examples of the SEP eligibility notices that people will receive when they request one of five SEPs. These notices include the list of documents people need to prove they are eligible

[35] Timothy Jost, After Insurer Complaints, Small Steps to Toughen Special Enrollment Period Eligibility (Update), Health Affairs Blog, January 20, 2016.

for a SEP, such as letters from employers in the case of loss of coverage, leases or rental agreements in the case of a move, medical records in the case of a birth, adoption letters, and marriage certificates, among a long list of other documents. People can still enroll in coverage while the verification process is being conducted but there are firm deadlines for submission of the required documents that trigger loss of eligibility or coverage if missed.

In another adjustment that recognizes carrier reports of higher-than-average claims costs of those enrolling through SEPs, CMS is making a change to its risk adjustment program for the 2017 plan year that includes an adjustment factor for partial-year enrollees. As Tim Jost has pointed out, at least one of the SEP qualifying events—that is, birth—triggers higher than average costs by definition.

The proposed bill under discussion would also require the Secretary of HHS to institute a verification process for SEPs. The proposal goes a step further than the new CMS confirmation process: people requesting a SEP would not be allowed to enroll in coverage until they have submitted the required documentation.

CMS's tightened rules and new confirmation process should help allay insurers' concerns about abuse. The new 2017 adjustment factor in the risk-adjustment program for partial year enrollees should also help protect insurers for greater cost exposure associated with the SEPs. But it seems that the provision under the proposed bill that prevents people from enrolling prior to the provision of documents could unnecessarily discourage those qualified for a SEP from enrolling. This could have the effect of lowering potential enrollment in the marketplaces. Even the new CMS process could have this effect for many people. Ironically, by setting a higher bar for verification, both processes could discourage those who are the least motivated to gain coverage—the healthiest—from completing or even starting the enrollment process.[36] Both processes could also disproportionately affect people with low incomes and possibly multiple jobs. For such people, the process of producing the necessary documentation might be the most difficult.

[36] Sarah Lueck, To Make Marketplaces Work Best, Enroll More People – Not Fewer, Center on Budget and Policy Priorities, January 2016.

Tighter verification standards thus could lead to even lower enrollment through the SEPs and therefore lower enrollment overall in the marketplaces. Only the most motivated people eligible for SEPS—those who are the most in need of health care—might enroll, leading to less healthy risk pools. Given these potential adverse outcomes, it might be prudent to assess the effects of the new CMS verification process and narrower definitions of SEPs before imposing more restrictive requirements on those potentially eligible for them.

Proposed Bill: To Better Align the Grace Period Required for Nonpayment of Premiums

Prior to the ACA, the vast majority of uninsured Americans had low or moderate incomes. This is why the law's major coverage expansions with subsidized marketplace plans and broadened eligibility for Medicaid were aimed at making insurance and health care affordable for people with incomes under 400 percent of poverty. Accordingly, people with the lowest incomes have made the greatest gains in coverage, but, for reasons explained previously, the gap in coverage between low- and higher-income adults persists.

People enrolled in marketplace plans who are eligible for tax credits must pay monthly premiums to insurance companies that are defined as a share of their income. The federal government pays the balance of the premium to the insurance company in the form of an advance premium tax credit. Recognizing that people with modest incomes might struggle in some months to pay their premiums, the law allows a three-month grace period for someone who fails to pay their premium in a given month. While some have suggested that people use the grace periods to game the system and get free coverage, the actual rules governing the grace period are highly restrictive and are aimed at discouraging such behavior.

When someone with subsidized marketplace plan fails to pay their premium, it triggers a three-month grace period.[37] The insurer still receives the tax credit for the enrollee from the federal government and is responsible for any claims incurred in that month. But if the enrollee still fails to pay his premium in the second and third months, the carrier is not obligated to cover any claims costs. If the enrollee still hasn't paid premiums for months one through three, the carrier can retroactively terminate his coverage as of the last day of month one. When coverage

[37] Edwin Park, Key Facts You Need to Know About: Premium Payments and Grace Periods, Center on Budget and Policy Priorities, December 3, 2015.

is terminated at the end of the third month, the tax credits for months two and three are returned to the Treasury. The insurer keeps the premium tax credit for the first month when claims were paid, but the enrollee has to pay back the tax credit amount through the premium reconciliation process on his tax returns. He also still owes his share of the premium to the insurer for the first month.

The complexity of the grace period and the burden of the potential penalty for failure to pay (i.e., pay back of the tax credit while still owing his share of the premium) seems to provide a considerable disincentive for people to game the system. There is no publicly available evidence showing that people are using the grace periods to get free coverage. In fact, given the complexity of the grace-period rules, it is very likely that consumers with tax credits may not be aware of the three-month period and may assume that failure to pay in one month effectively terminates their coverage.[38] Data on grace periods also indicate that people often enter them unwittingly, such as through the failure to cancel a marketplace policy when one becomes eligible for Medicaid.

The proposed bill reduces the ACA grace period for marketplace enrollees from three months to one month. Such a policy change could mean a loss of enrollment in the marketplaces among enrollees of modest means and an increase in the number of people who are uninsured or have gaps in their coverage. Given the lack of evidence of abuse of the three-month grace period, the loss of enrollment might not be offset by any clear gains for insurers. And like the more onerous requirements in the bill proposed for new verification requirements, the policy change also would seem to also favor those who are most motivated to retain their coverage— those in poorer health.

CONCLUSION

Overall, the insurance provisions of the Affordable Care Act have been successful in achieving a number of goals including substantial declines in the number of uninsured Americans, and nationwide declines in out-of-pocket spending growth, cost-related problems getting care, and medical bill problems. The majority of enrollees in both marketplace plans and Medicaid are

[38] Edwin Park and Tara Straw, Center on Budget and Policy Priorities, personal communication.

satisfied with their health plans and their doctors. The marketplaces are competitive and appear to be producing value for consumers. The law's premium stabilization programs have mostly worked as intended with the exception of the risk-corridor program, which was barred from using federal dollars last year.

But challenges remain. They include:

- lack of Medicaid expansion in 19 states
- need for ongoing efforts to reach uninsured people who are eligible for enrollment in both Medicaid and marketplace plans
- ensuring that consumers in marketplace plans and Medicaid have insurance that is affordable and designed with incentives and protections that encourage timely access to high value health care
- ensuring the stability of the marketplaces and reasonable growth in premiums over time.

It is encouraging that the Committee is considering ways to improve the marketplaces and help consumers get affordable insurance and health care. In the end, the fundamental purpose of the marketplaces and the Medicaid expansion is to provide coverage to those who lack health insurance and thus cannot get needed care, and are currently suffering unnecessarily as a result.

Thank you.