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Testimony before the Committee on Ways and Means  
Subcommittee on Health

Challenges of the Affordable Care Act  
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Mr. Chairman Brady, Mr. Ranking Member McDermott: Thank you for the opportunity to testify today before the Committee on Ways and Means, Subcommittee on Health.

My name is Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute. I previously worked at the Food and Drug Administration as the agency's Deputy Commissioner and at the Centers for Medicare and Medicaid Services as a senior advisor to the Administrator during implementation of the Medicare Modernization Act.

I am on the policy advisory boards to the Society of Hospitalist Medicine and the Leukemia and Lymphoma Society; and a member of the advisory board to the National Coalition for Cancer Survivorship. I am presently a Clinical Assistant Professor at the New York University School of Medicine. I remain active in the capital markets related to healthcare, and I am closely engaged with a number of the life science and healthcare services companies through a variety of consulting relationships and board assignments.

Right now, all eyes are on healthcare.gov, the troubled electronic portal designed to let consumers purchase health plans sold on the various state exchanges. In time, the existing parts of this web site will be fixed. But more significant challenges remain. These lingering problems relate to issues around provider access and the quality of medical care.

Many consumers who enroll in these new plans will find themselves disappointed by the resulting health plans, or worse yet, get caught in difficult financial and medical binds.

I want to focus today on the medical care that the Obamacare health plans will offer. I want to focus on three significant but remaining challenges that I believe will lower the quality of the resulting care, and hinder consumer access to needed medical services.

I believe there are steps we can take today to mitigate the worst of these challenges. But unless we act quickly, the law as it's presently written (and the exchanges as they are presently designed) does not provide the flexibility to address these woes.

First, the information infrastructure required for reconciling someone's coverage with his health plan, or his providers, has not been constructed. It simply doesn't exist. As a result, it's likely that there will be delays in enabling premiums to be collected and paid to health plans, and in turn; health plans are likely to withhold payments to providers. People signing up for Obamacare coverage may not, as a practical matter, be covered starting January 1. This needs to be addressed by Congress immediately to avoid significant hardship.

Second, it's now well established that more than 50 percent of the plans sold on healthcare.gov (including the lower-cost plans that consumers are being most encouraged to purchase) are "narrow network" options that offer a very limited choice of providers. I don't think the full scope of how restrictive these networks have become is fully appreciated, or the extent of the costs that are going to get transferred to patients. This is going to put particular hardship on patients with special medical needs or serious illnesses. Once again, the statute and regulations do not afford easy ways to mitigate these challenges.

Third, and finally, there is already evidence that providers are reluctant to sign contracts with the Obamacare plans, and when they do, reimbursement is being reduced – even off of the levels that were initially negotiated under some of the early contracts. This is how the plans are going to accommodate the higher costs they are encountering as a result of the challenging risk pool that is taking shape in this market. There should be every reason to expect that the same sort of problems with access and quality that challenge the Medicaid program will also challenge Obamacare. In fact, participating health plans have been calling Obamacare “Medicaid Plus.” We ought to take these insurers at their word.

### **Reconciling Coverage with Medical Care**

It’s been revealed that the information architecture to enable reconciliation of the coverage that people sign up for with payment of premiums and subsidies to the plans they select (and in turn, the provision of payments to providers) hasn’t been constructed, or is not working.

Politico [reported Sunday](#) and the Wall Street Journal reported similarly on Monday, that the focus of efforts to fix the web site continue to be on getting the registration process resolved so that people can go on-line to enroll.<sup>1</sup> That decision has meant that insurers are still getting faulty reports on consumers who have signed up for coverage. Consumers may believe they have signed up for coverage, but are not actually enrolled into the plan.

Insurance industry sources say that they believe that they can receive the premium payments consumers have to make after they enroll, but that the system isn’t in place to deliver the federal subsidies to health plans for beneficiaries who are eligible for these payments.

The New York Times reported Monday that for insurers, the process is maddeningly inconsistent. Some people clearly are being enrolled. But insurers say they are still getting duplicate files and, more worrisome, sometimes not receiving information on every enrollment that’s taking place. “Health plans can’t process enrollments they don’t receive,” said Robert Zirkelbach, a spokesman for America’s Health Insurance Plans.<sup>2</sup>

This won’t be resolved by January 1. It raises a series of troubling question for consumers:

Will the insurers honor the coverage that consumers have purchased in situations where the companies have not been paid for providing those health plans? If the insurers do honor these contracts, what will they do about making payments to providers? It’s hard to imagine that the insurance companies will release funds to doctors, to compensate them for delivering care, in circumstances where the insurers themselves have not been paid. There are ways to address this, perhaps through government guarantees to backstop gaps.

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<sup>1</sup> Carrie Budoff Brown. Inside the War Room, Watchful Eyes as D-Day Hits. Politico, November 30, 2013. <http://www.politico.com/story/2013/11/obamacare-website-deadline-100486.html#ixzz2mBIO8UC5>

<sup>2</sup> Robert Pear and Reed Abelson. Insurers Claim Health Website Is Still Flawed. The New York Times, December 1, 2013

But right now, there is no obvious fix in place, and these problems will soon go live. One anonymous, insurance industry source [framed the problem this way](#) in a recent article published on Politico: “If people are enrolling, but the back-end systems are not working, their coverage could ultimately be disrupted. They may think they’re enrolled in a plan and they’re not. They may show up at the doctor’s office and not be covered.”<sup>3</sup>

### **Network Adequacy**

On the second point, the narrow networks that will be the hallmark of the majority of the Obamacare plans: A number of factors have encouraged very restrictive health plans that will place painful burdens on some consumers. It didn’t have to be this way.

At a high level, Obamacare effectively bars or restricts plans from engaging in the traditional tools that insurers use to manage trend (the cost of providing care under the terms of their contracts). These traditional tools include underwriting for risk (charging more to older members, or those with certain health risk factors); adjusting benefit design, or changing co-pays or premiums to modify consumer incentives and consumption of services.

All of these standard tools are tightly regulated under Obamacare. I don’t want to get into a debate on the merits of these decisions, but merely make an observation about one consequence of these regulations. The resulting benefits offered under Obamacare are largely prescribed by regulation. Co-pays and premiums are largely fixed. So there is only one cost-control tool that remains, that insurers are largely free to adopt: adjusting networks, and coinsurance. Since this is, for the most part, the only significant leverage that plans have to manage costs; they have used their discretion over provider networks to its maximum extent.

To give you some context for how this is playing out at a practical level, we are providing some data we developed on one BlueCross, BlueShield plan that operates in nine different states, where we compared the exchange network to their commercial or individual-market PPO for six specialist provider categories. We looked at the plans being sold in each state’s largest county. We consistently found that the exchange-based plans offered just a fraction of the specialists available in the PPO plan offered by the same insurer in the same region.

Among some of our other, anecdotal findings across different plans and different markets:

We found one low cost plan in Florida that currently only has seven pediatricians in its network, to service a county that has 260,000 children according to census data<sup>4</sup>.

In New York City, we found a plan that doesn’t list a single gynecologist in its current provider network<sup>5</sup>, and another plan that doesn’t have a single cardiologist.<sup>6</sup>

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<sup>3</sup> Jessica Meyers. Tech official: Up to 40% of Obamacare work left. November 19, 2013. <http://www.politico.com/story/2013/11/tech-chief-didnt-see-march-obamacare-memo-100058.html#ixzz2mBqhiiAJ>

<sup>4</sup> Humana Florida HMO, Bronze Plan

<sup>5</sup> Health Republic Insurance Primary Select EPO

<sup>6</sup> Emblem Health Select Care Bronze

In San Diego County, we found a health plan that doesn't have a single pediatric cardiologist in its network. In San Bernardino County, the nearest urologist offered by one plan is 80 miles away. The same health plan has 9 dermatologists but most of these doctors are at least 100 miles away and none appear to do specialized skin cancer surgery.<sup>7</sup>

Even in most cases where plans offer choice among a larger complement of providers, the networks are still granting their Obamacare plan enrollees access to just a fraction of the providers available in their commercial plans. Statewide in California, Blue Shield of California reports that its exchange customers will be restricted to about 50 percent of its regular physician network offered in its commercial plans.<sup>8</sup> This seems fairly consistent across different plans and different markets. Some plans appear to offer much less. The lack of contracted providers may strain the ability of patients to get non-urgent appointments.

In Kentucky, to take another example, Anthem BlueCross BlueShield offers consumers in the states third most populous county access to 141 cardiologists in a typical commercial plan. The Obamacare bronze plan only includes access to about 61 cardiologists. In the states most populous county (Jefferson) consumers enrolled in Anthem's commercial PPO will get access to a network that includes 113 different oncologists. Those enrolled in the company's bronze Obamacare plan can only access 52 of those providers.

With most of these plans, if consumers go outside their health plan's prescribed network of doctors, the co-insurance is very high. In some cases (especially with lower-cost "bronze" plans) consumers will be saddled with the entire bill when they go outside their network, and these outlays won't count toward their deductibles or out of pocket caps. It's now been well documented that specialty hospitals like cancer centers and most of the academic hospitals are being excluded from these networks, largely because these top tier institutions – which often deliver the highest levels of care – are nonetheless seen as too costly.

For routine health matters, this may be of less concern. But if patients develop more serious conditions requiring expert attention, the cost of going "out of network" to seek care at one of these specialty institutions is likely to be prohibitively expensive for many consumers.

It didn't have to be this way. Moreover, there are ways to alleviate some of these challenges. But as the law is now written, most of the problems will only grow worse next year, not only because of marketplace challenges, but also because of the way in which the plan subsidies get "re-priced" year-over-year – off the second cheapest silver plan that operates in a particular market (which may well be an extremely narrow network plan). Year over year, this will put substantial downward pressure on the pricing of the plans, and their quality.

There is a fundamental problem with how these plans were designed that leads to these narrow networks. By limiting the ability of plans to adjust other aspects of the coverage, the insurers are forced to ratchet down their networks (and cut reimbursement to providers) as

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<sup>7</sup> Molina Healthcare Covered California Bronze HMO

<sup>8</sup> Chad Terhune. Insurers Limiting Doctors, Hospitals in Health Insurance Market. The Los Angeles Times, September 14, 2013

their only tool to control costs. This is precisely how the economics of Medicaid operates, and there should be every reason to expect that the outcome for the Obamacare plans will be similar to the experience under Medicaid -- if not in magnitude, than certainly in scope.

Some states, such as Washington, are taking steps to try and ensure that consumers have access to a particular specialist when a doctor with the required skills or training isn't already included in their network. But the state is struggling to define in regulation exactly how such a safeguard would operate. For example, how would you define when a network doctor lacks the requisite skills – would it be by virtue of their training, or their practical experience?

The problems are made worse by the poor oversight that has been applied to the resulting plans. Review of plan design and network adequacy was rushed, and done poorly. The career staffs at CMS generally have incomplete criteria and argue that they don't have a basis to judge network adequacy given their lack of experience in commercial markets. It's an accurate self-assessment. CMS has imperfect criteria for ensuring network adequacy. They have little experience with these tasks, and have not had time to develop proper regulations.

With lax oversight, there is a risk that plans can inadvertently or intentionally game the risk pool by their choice of providers and their design of networks.

For consumers, information about the resulting networks is generally hard to find and many of the networks haven't been fully established, or are suffering from provider cancellations. The best news for consumers may be that they can probably enroll in a plan for January, and then cancel it once they test the network and enroll in another plan before the end of March. All they would lose in such a scenario is probably the first month's premium they paid.

Finally, keep in mind that these narrow networks don't just affect access to providers. The same constructs will also hamper patient access to specialty drugs. If you are on a non-formulary drug, you could be saddled with much (or all) of the cost of that medicine.

This is going to be a particular burden to patients with significant conditions like cancer, where the formularies are likely to be more restrictive and not include the full complement of new and costly drugs. Moreover, these out-of-pocket costs will not count against a patient's out of pocket limits, their deductible, or their lifetime caps.

Patients will have the option to appeal these non-formulary decisions, and if they win, the cost of the out-of-pocket spending will count against their deductible and out-of-pocket limits. But this is a last ditch reprieve that not many families are going to be able to take advantage of. For one thing, these appeals take time, and they may not be able to wait. The patient could be out-of-pocket for a significant amount of money before they win an appeal.

Moreover, even if there is a high chance that a patient might win an appeal, the prospect that they could lose might present such a substantial hardship that they will not be willing to take the risk. On a risk-adjusted basis, the costs will be too high. This is likely to be especially true for the lower-income families that will comprise the bulk of Obamacare enrollees.

In the end, many middle class consumers are being forced to make a choice that consumers already rejected in the 1990s when they jettisoned restrictive HMOs in favor of PPOs and

other more flexible arrangements. In making these choices, consumers demonstrated that they valued flexible networks over the breadth of benefits and, moreover, were willing to trade higher co-pays and deductibles to have access to a wider range of providers.

For patients who were previously uninsured, these narrow network plans may be a reasonable tradeoff for the promise of secure health coverage. There is no question that some people – particularly the uninsured or those who were episodically insured -- will benefit under Obamacare. This is especially true for lower-income families who will benefit most from the subsidies. But a lot of people will also be put at a significant disadvantage, especially many of those who were previously insured in the individual or small group markets, who find themselves moved from PPO-style plans to restrictive HMOs and EPOs.

Middle class consumers are also likely to face higher costs. By my rough calculations, unless you are below 250% of the Federal Poverty Level, then even with the benefit of subsidies, the Obamacare plans are likely to be more expensive than a comparable plan available in the individual market. This, of course, varies by state. But it is a reasonable rule of thumb.

Here in Washington we can talk in an abstract fashion about the advantages of the new plans that cover maternity care and pediatric dental and broaden the distribution of risk sharing, but for consumers who neither wanted or needed this coverage, these paper benefits cannot compensate for what they have given up. The simple question I think we all need to ask ourselves is whether it was necessary to degrade the opportunities enjoyed by some Americans, to improve the circumstances of others. I don't believe this is a tradeoff that was necessary, and I don't believe it is a tradeoff that we need to accept.

### **Challenges Facing Providers**

Challenges are also emerging in the provider space. These problems will, in turn, affect patient care. There's evidence that health plans are already reducing the rates that they pay to providers under the Obamacare plans, and trying to re-negotiate existing contracts.

On the one hand, these rates are generally being set low, typically as a discount to Medicare. In some cases, there are reports that the rates are commensurate with those paid under Medicaid. There should be every reason to expect that, as a consequence, the networks for these plans will suffer from the same access problems that plague the Medicaid program.

Worse still, there are some reports that health plans are seeking to re-negotiate some of the existing contracts with providers, and lower rates still further. No doubt, this is a response to the challenging roll out, and a perception that the resulting risk pool (and cost to insurers) will be higher than originally anticipated. Insurers are trying to offset some of the anticipated losses by reducing the amount of money they spend on their nascent networks.

For all of these reasons, we should expect that the networks will continue to erode. Doctors that have signed contracts with Obamacare plans will start to drop out. Estimating how many is difficult. Providers who have not signed contracts will be unlikely to do so, not only because of the low payment rates, and the uncertainty around that reimbursement, but the prospect that payments could be put on hold until the back-end problems with the web site and the reconciliation process are resolved; and because the risk pool is likely to be older,

more sick, and therefore more costly than anticipated. Providers who are being offered capitated contracts under HMO models are going to be rightly nervous about committing to these pools. They will be unsure of the eventual risk they are taking and the resulting costs.

### **Conclusion**

The rollout of Obamacare has been challenging. But the registration issues are likely to be resolved in time. The real problems will emerge once people try to access the health coverage, and seek care under these plans. For some, mostly lower middle class and lower-income consumers too wealthy to qualify for Medicaid, the chance to access affordable and durable private coverage will be an important opportunity. But for every consumer that is made better off under this scheme, there will be other consumers that are harmed.

These people who will make out worse under Obamacare – the Obamacare losers -- seem to be getting shorter shrift in political discussions. There's a perception among some policy observers that these folks are mostly wealthier, upper middle class families. That's not entirely true. Many of these families are solidly middle class, and many struggle financially. Nor are the miss-perceptions of their relative wealth an excuse to ignore their plight.

These problems are likely to get worse as this “market” evolves. The risk pool experience this year is going to cause premiums to rise next year. Even in California, which has been held up as a model of early success, there are some obvious challenges emerging.

Data released by Covered California shows that, so far, 34 percent of total enrollment is comprised of people aged 55-64, the highest mix among age brackets. Another 22 percent of enrollees were aged 45-54. Therefore, 56 percent of California's total exchange enrollment in October was people aged 45-64. Yet California's total population of residents that are aged 45-64 is only 25 percent. Individuals aged 34 or under comprised just 28 percent of October exchange enrollment. This is below the 49 percent of Californians in this age range.<sup>9</sup>

Even more worrisome should be the fact that the vast majority of people who are enrolling in the plans are not eligible for premium subsidies. So they are paying hefty fees for the coverage. It would seem to suggest that the older folks who have enrolled so far have concluded that they are especially likely to tap the healthcare services offered by the plans, making it worth the high cost. In total, only 16% of the people who enrolled in Covered California in October were eligible for premium and cost-sharing subsidies.

How much premiums will need to rise next year to offset the financial costs of the year-one experience is still a source of speculation, but its becoming clearer that the risk adjustment will not be able to fully offset the bad initial experience. The big commercial insurers have largely sat out this launch. There is no reason to expect that plans not entering the market this year will get into the market for 2015. The choices that patients have are not likely to

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<sup>9</sup> The figures include enrollment through October 31. The one piece of good news California officials were touting: 18- to 34-year-olds made up 22.5% of the enrollment in October. The same age group makes up 21% of the state's population.

change that much as a result. So far, it has mostly been the Blues and the Medicaid HMOs that have offered the most products on the exchanges. This will probably remain the case.

Among other things, there are incentives for private insurers to remain completely outside Obamacare. By doing so, they are able to adjust the premiums that they charge to the risk pools that they are able to solicit outside the exchanges. Middle class families that have been dropped from their existing coverage, and don't benefit from the subsidies, may do better by staying out of the exchanges. When the insurers start to adjust their financial models to accommodate this new reality, the costs of the exchange-based coverage could rise further.

The fact is that in aiding those who were burdened in the old insurance markets, it didn't require us to harm those who were doing reasonably well under those structures.

The biggest challenges lie ahead of us, when people start to tap their new coverage. Many of those who previously had commercial coverage will find the new arrangements constraining. Even those who were previously uninsured or only intermittently insured will find many of the bronze plans that they are being incentivized to join deliver low quality access.