**Hearing on Rising Health Insurance Premiums Under the Affordable Care Act**

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HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

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C O N T E N T S



**WITNESSES**

**Hearing on Rising Health Insurance Premiums Under the Affordable Care Act**

U.S. House of Representatives,
Committee on Ways and Means,
Washington, D.C.

The committee met, pursuant to call, at 10:10 a.m., in Room 1100, Longworth House Office Building, Hon. Kevin Brady [chairman of the committee] presiding.

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Chairman Brady. The committee will come to order.

Welcome to the Ways and Means Committee hearing on the rising cost of health insurance premiums under the Affordable Care Act.

Over 6 years have passed since President Obama and Democrats in Congress drafted the Affordable Care Act behind closed doors and forced it into our homes, our workplaces, and doctors' offices. Since then, the law has been one broken promise after another, starting with the promise in its very title "affordable."

Millions of Americans have seen the cost of health care increase to astonishing levels, while quality, choice, and access have hit new lows. Meanwhile, the White House refuses to acknowledge that Obamacare is simply failing ahead of schedule and that the pain it has inflicted so far may be nothing compared to what lies ahead for millions of Americans and their families.

So we are holding this congressional hearing today to make clear that Obamacare's broken promises have real impacts on real people. And because we care deeply about providing Americans with access to high quality affordable health care, House Republicans have released a detailed credible plan for repealing the ACA and bringing patient focus care back to the American people. The truth about this law, it has never expanded access to affordable high-quality health care of an individual's choosing and it never will.

Estimates show that increases in 2017 could be double what we see this year, and in several States, these costs could spike by more than 50 percent with no end in sight. A 50 percent increase is outrageous. Americans simply cannot afford to pay 50 percent more for their premiums. One reason costs are skyrocketing, enrollment is far lower and far more expensive to cover than projected. That is why, in addition to raising premiums,

many insurers have shrunk their provider network, so for individuals and families to purchase coverage, it costs more, and with that more expensive coverage, they get fewer choices and less access to doctors and providers who best meet their needs.

Even after raising premiums and narrowing provider networks, many insurers are still struggling to shoulder the cost of doing business in the Affordable Care Act's mandate-ridden marketplaces. Every month we learn of more insurers who decided to leave the flawed Obamacare exchanges altogether. In April, United Health Group announced that it would be forced to exit many of the exchanges it was participating in because it couldn't sustain the crushing losses. After United leaves, 1.8 million Americans will have only two insurers to choose from, and over a million will only have one.

And some Americans, including thousands in my home State of Texas, may not have any insurers to choose from at all. In fact, BlueCross/BlueShield of Minnesota has announced their exit from the State after suffering more than a half a billion dollars in losses over just 3 years.

I, like many of my colleagues, have heard countless stories from families who are deciding it is just not worth paying the high prices to get Washington-approved coverage. Instead they are choosing to pay a stiff tax penalty rather than buy a plan they can't afford and don't want. And it is not just a few Americans. In States like New York, Iowa, Colorado, Arkansas, Minnesota, and South Dakota, more than three out of four people eligible to purchase exchange plans have found a way not to be covered in Obamacare.

I have no doubt we will hear today about families getting health insurance under Obamacare, but the reality for many of my constituents is that now they have to worry year to year about access to the right plan, access to the same team of specialists, and changes to their out-of-pocket costs. What is the point of expanding coverage if you can't afford or get access to care?

Over the past year, I have received letters from Texas families that are caught in the middle of the downward pressures of Obamacare's regulations and mandates. For example, especially hospitals my constituents rely on are being squeezed out of network. I would like to enter into the record two Houston Chronicle articles highlighting the struggles of families to get the specialized treatment they need. This is a direct result of Obamacare's mandates and rigid rules.

Americans have had enough of the Obamacare experiment and government-run health care. That is why we are dedicated to repealing this flawed law in advancing patient focused solutions that truly expand choice and access to high quality affordable health care.

I want to thank all the witnesses for being here today. I look forward to hearing your thoughts on how we can work to make our healthcare system work better for the American people.

People across our country all want the certainty of knowing they will have access to the care they need when they need it most. This is what Americans deserve, and it is what our committee will keep fighting to deliver. I now yield to the distinguished ranking member from Michigan, Mr. Levin, for the purposes of an opening statement.

[The statement of Chairman Brady follows:]

Mr. Levin. Thank you, Mr. Chairman. Essentially what we have heard is the campaign message of the Republican party against ACA, and that is the purpose of this hearing today, essentially bringing the campaign attack of the Republican party within the halls of Congress, and we look forward to that debate.

We had a situation, 50 million people in this country without any healthcare coverage. We had skyrocketing costs of health care, we had skyrocketing increases in premiums, and essentially what was decided after 50 years of inaction, we decided to do something about it, and what we decided to do was experiment with a combined program of expanding Medicaid and other government-based programs with the private sector of the United States of America.

We expanded Medicaid, and in Texas, because of the action of the leadership there, well over a million people did not benefit from the expansion of Medicaid in your State, Mr. Chairman. While in the State of Michigan, a Republican governor decided to take advantage of the expansion of Medicaid and brought real healthcare coverage to hundreds of thousands of people in this country in the State who needed it.

The Republicans have never come up with a comprehensive substitute for ACA. Instead, attack after attack, repeal effort, after repeal effort, and the number now is what, well over 60, and so you essentially can mark up today as whatever the number is, the next effort in the Republican party to attack and to try to undo the healthcare structure that has brought coverage to millions of people in this country and also brought down premiums.

So the experiment, as I said, was with combining public and private sector. It is controversial, even at times within the Democratic party. The Republicans essentially wanted to have a totally private system in this country, including to privatize Medicaid, privatize everything, and now, essentially, this hearing is being held to attack what is happening in the private portion of healthcare reform. Ignoring the millions of people in this country who have benefitted from the expansion of health care, millions, millions.

So this debate, this hearing is nothing more than another part of the political debate in this presidential year. And we understand the need to address issues relating to premiums. Mr. Lee will give some background on this, and we will continue to address this issue.

The Republican party has failed to take steps that would have been able to address the issue of premium cost where they are going higher, up higher in some States than in most others. They fail to do this, and so therefore, they essentially now are attacking some of the results of their own making.

So take this for what it is worth, we welcome you. We don't say that you gentleman here today are part of the political process. You have a distinguished background, but you should understand, the hearing today is part of the political debate of this year, and we Democrats welcome the opportunity to tackle this issue as to how, after 50 years, we began to address this issue while the Republican party, for all these years, has been bankrupt and remains bankrupt as to how they would undertake a major change that would benefit millions of people who today can go to sleep knowing that they will have healthcare coverage. I yield back.

Chairman Brady. Without objection, all the members' opening statements will be made part of the record.

Today's witness panel includes four experts, Joel White is president of the Council for Affordable Health Coverage; Christopher Condeluci is a principal of CC Law & Policy, PLLC; Tom Harte is president of Landmark Benefits representing the National Association of Health Underwriters; Mr. Peter Lee is executive director of Covered California.

The committee has received your written statements, and they will all be made part of the formal hearing record. You each have 5 minutes to deliver your oral remarks. We will begin today with Mr. White. You may begin when you are ready.

**STATEMENT OF JOEL WHITE, PRESIDENT, COUNCIL FOR AFFORDABLE HEALTH COVERAGE**

Mr. White. Chairman Brady, Ranking Member Levin, members of the committee, I appreciate the opportunity to testify today. My name is Joel White. I am the president of the Council for Affordable Health Coverage, which is a broad based alliance with a singular focus, and that is, bringing down the cost of health care for all Americans.

Our membership reflects a broad range of interests, organizations representing patients and consumers, small and large employers, insurers, and physician organizations. We are concerned that healthcare costs are too high and are rising too fast. In fact, costs continue to outpace GDP, the economy, and premiums are increasing about three times as fast as wages. As a result, by 2030, the typical American family will spend more than half their income on health care.

As we all know, the ACA made massive changes to health markets, some positive and some negative. It created new consumer protections, corrected market imbalances, and reduced the number of uninsured Americans to historic lows. Yet overreach by the ACA

has also contributed to high and growing health insurance premiums marked by average double-digit price increases both this year and next.

For example, this year, average premiums for both bronze and silver plans, which represent 92 percent of the market, increased by double-digit rates. Next year, the requested weighted medium premium will increase 19.2 percent based on rates already filed. This ranges from a high of 56 percent in Tennessee to a low of 3.6 percent in Rhode Island.

In addition, cost sharing, including copayments, coinsurance, deductibles, and the use of these strategies and formularies is increasing faster than premiums. For example, in 2016, the average silver plan had a $3,000-plus deductible. That reflects an increase of about 20 percent from 2015. The factors impacting premium rates and cost sharing increases include rising medical costs, mandated benefits and regulatory changes, and a risk pool that is smaller, older, and sicker than originally projected.

Despite the broad array of available plans on exchanges and a tax for being uninsured, many of those who have been expected to sign up for coverage, even those eligible for subsidies, have not done so. Why? I think simply the point is people don't want exchange plans at the prices they are being offered. They are too expensive and have too significant cost-sharing requirements. In fact, a study that CAHC released last month shows participation rates vary with the generosity of subsidies.

Eighty-one percent of those receiving a full premium subsidy signed up for a plan. Just 2 percent of the nonsubsidy eligible population enrolled in exchange coverage this year.

As a result, enrollment is only about half of what CBO originally projected. ACA risk pools are thus smaller and sicker. So while many Americans with significant health needs or lower incomes have greater access to coverage now, the reality is that for millions of others, health coverage is less affordable and more out of reach than when the ACA was created 6 years ago.

The fact, this fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making healthcare more affordable and accessible for all Americans. Increasing premium subsidies to encourage enrollment is not the answer in my opinion. This approach will shift costs, not contain them. Remarkably, some are even proposing fewer choices and less competition through public options and standardized benefit designs.

The fact is, we have tried the top down approach that relies on mandates and penalties, and costs have increased unsustainably as a result. CAHC believes that it is time to try market-based solutions that expand choice and competition to lower costs. One of most effective ways to lower premiums on the exchanges is by broadening and improving the risk pool. Greater participation rates in exchanges would lower average costs by spreading risk across a bigger population.

In my written statement, I outline 13 policy proposals to help achieve these goals. Briefly, these approaches would create competition across public and private exchanges, allow subsidy portability so consumers can use their support for plans they want and need, allow more flexibility for plans and employers, address medical cost growth, and promote transparency for plans and providers. I look forward to responding to any questions you may have. Thank you, Mr. Chairman.

Chairman Brady. Thank you. Mr. Condeluci, you are recognized.

**STATEMENT OF CHRISTOPHER CONDELUCI, PRINCIPAL, CC LAW & PUBLIC POLICY PLLC**

Mr. Condeluci. Thank you, Chairman Brady, Ranking Member Levin, and members of the committee for the opportunity to speak with you today. My name is Chris Condeluci --

Chairman Brady. Mr. Condeluci, could you pull that microphone down just a little bit closer.

Mr. Condeluci. Yes, sir.

Chairman Brady. Perfect.

Mr. Condeluci. My name is Chris Condeluci. I am the sole shareholder of CC Law & Policy, a legal and policy practice that focuses on issues relating to the Patient Protection Affordable Care Act, the ACA. Prior to starting my own practice, I served as counsel to the Senate Finance Committee where I participated in drafting portions of the ACA, including the ACA exchanges, the State insurance market reforms, and all of the taxes under the new law.

In my practice, I provide legal counsel to stakeholders ranging from employers to insurance carriers to the ACA exchanges and private exchanges. I also provide policy analysis on the implementation of the ACA.

It is important to emphasize at the onset of my testimony that there is no one single event or ACA implementation decision that has contributed to increased premium rates. Instead, there are a number of contributing factors that, when added up in the aggregate, can objectively be viewed as the causes for the rise in premiums. These factors include but are not limited to, first, the statutory requirements under the ACA itself. In particular, the new minimum insurance standards in addition to the adjusted community premium rating rules.

These statutory requirements constrain an insurance carrier's ability to develop plan designs for a specific niche of consumers in the market; for example, young and healthy consumers who may want coverage of a limited number of medical services at a very low

price tag, along with high risk individuals with specific chronic illnesses like diabetes or health disease -- or heart disease, excuse me. These statutory requirements also push premiums higher, discouraging younger healthier individuals from entering the risk pool.

Second, two ACA implementation decisions that have been made by the Obama administration. In particular, the administration's transitional policy, which segmented the risk pool in certain markets and which has prevented healthier risks from entered the ACA's newly reformed risk pools. This also includes HHS' and other State-based exchanges limited enforcement of the eligibility criteria for enrollment during certain special enrollment periods.

Third, the failure of the individual mandate penalty tax having its intended effect of encouraging younger healthier individuals to purchase insurance coverage. These factors, when aggregated together, are resulting in an unbalanced risk pool, and the consequences of an unbalanced risk pool are increased premiums.

What does it mean to have an unbalanced risk pool? In short, an unbalanced risk pool arises when the pool is made up of a number of less healthy, heavy medical utilizers, and a smaller number of younger healthier individuals. Is the ACA's newly reformed individual market unbalanced? Data from HHS indicates that only 28 percent of individual market exchange plan enrollees are between the age of 18 and 34.

Actuaries have suggested that 40 percent of exchange enrollees in this age cohort are needed to ensure a balanced risk pool. The IRS has also indicated that 45 percent of the 7.9 million people who paid the individual mandate penalty tax in 2014 were under age 35.

Objective analysts have also observed that less healthy heavy medical utilizers have been attracted to the exchanges, and much of the increased medical claims in 2014 and 2015 came from individuals who have enrolled during certain special enrollment periods.

One logical solution to balancing out the risk pools attracting more younger and healthier individuals into the market; however, due to the manner in which the ACA constrains insurance carriers in developing plan designs that may appeal to younger and healthier individuals, these consumers are less likely to enter the market.

In addition, the three to one age variant now required when developing premium rates increases premiums for younger healthier individuals, which discourages these good health risks from obtaining coverage.

Another solution is allowing the individual mandate penalty tax to achieve its intended result. Unfortunately, to date, objective analysts have not found that the individual mandate is causing younger healthier individuals to purchase an individual market plan, evidenced by the HHS and IRS data that I referenced earlier. And while the individual mandate penalty tax increased by 600 percent in just 3 years, the penalty tax will only be indexed to CPI in 2017 and the 2.5 percent of income threshold will remain constant. It

is unlikely that the slow growing penalty tax will have a substantive impact in future years.

If younger and healthier individuals do not enter the market, the risk pool will remain unbalanced, which will cause insurance carriers to continually increase premiums. Although I have laid out some of the factors that have led to an unbalanced risk pool in the individual market, which have contributed to premium increases, these are solvable problems.

I look forward to working with the witnesses who appear in front of you today as well as you, Mr. Chairman, Mr. Levin, and all the members of the committee. Thank you for your time. I look forward to answering any questions you may have.

Chairman Brady. Thank you. Mr. Harte, you are recognized.

**STATEMENT OF TOM HARTE, PRESIDENT, LANDMARK BENEFITS, NH**

Mr. Harte. Good morning. Thank you, Chairman Brady, Ranking Member Levin, and distinguished members of this committee.

As I mentioned earlier by the chairman, my name is Tom Harte, and my company is Landmark Benefits. I am an employee benefits broker. I own a small business. I deal with hundreds of employers throughout the year on their health insurance benefits, hundreds of individuals trying to access health insurance, so I come here today with a very unique perspective, with conversation I have with my clients every day, every year with regard to the continued challenges that they have with access to health care as well as access to affordable plans.

I am also here representing the National Association of Health Underwriters, which represents well over 100,000 employee benefit professionals like myself that are in the trenches every single day trying to find these affordable solutions.

Before I jump into some of my comments with regard to the challenges that I am seeing, I want to also share with you some of the successes that we have seen over the past 12 months, that are welcome from me on the frontline of marketplace, things like passing the PACE Act. In New Hampshire, that made a big difference. By allowing our State the opportunity to determine what size group is best for our insureds, but also avoiding, as Mr. Condeluci referred to, the rate grids and three to one ratios by allowing my insurance commissioner to determine what is the best size group for my State, that has significantly helped us with was with rate grade overload.

Also, the moratorium on the medical device tax, the suspension of the health insurance tax, as well has the delay of the Cadillac tax, those are all very welcome from the clients that I represent every day.

Ranking Member Levin, you also talked about the uninsured rate. We love the fact that more people are getting insured. We love the fact that healthcare trend is coming down. Those are all welcome signs to us in the industry.

But at the same time, when I talk to my clients, what I thought it would be helpful for you is if I went to some of the renewals that we are experiencing over the past couple of months in 2016, my renewals for my clients in the past couple of months that we looked at have ranged anywhere from just over 11 percent to just shy of 30 percent. Now, these are small businesses like mine. I have 20 employees, but some of the clients that I represent have thousands of employees. Those 30 percent rate increases are not just for a select group of small businesses. They are also affecting large businesses that we represent in the New England area.

In addition to that, when I look at my clients and where their health plans have been over the past few years, I have seen plans transform themselves. And in my written testimony, you will see that some clients 10 years ago had $1,000 deductible and today they have a $5,000 deductible. So when I look at healthcare trend, and again, I welcomed healthcare trend to continue to come down, healthcare trend does not necessarily represent the renewals that I am delivering to my clients.

So if the healthcare trend is, let's just say it is 8 percent, because there is different arguments out there with healthcare trend, that doesn't take into account utilization, demographic trends, pooling charges, risk adjustments, and many of the fees that my clients are paying through the passage of these premiums.

In addition to that, every single client I sit down with, they are having a reduction in benefits not by their own decision. They are seeing primary care office copays go from $25 to $50, specials copays go from $50 to $100. Some are paying $500 a month for a 30-day prescription at a retail pharmacy, and that is unacceptable. So what has happened is, with our uninsured rate falling, we are seeing a greater issue of the underinsured.

Now, what I mean by that -- and again, in my written testimony, I provided you several graphs, but I wanted to do, and I did this over the weekend for you, was to show you the growth in deductibles for some of my clients. Now, I took one of my account managers at my company and I took their book of business, and I said: Over the course of a 9-year period, what has happened to the deductibles for these particular clients.

So I picked them at random, and what I saw was from 2006 to 2015, over a 9-year period, the deductibles for those clients increased by 479 percent. Over a 5-year period, they have increased by 329 percent. Over a 3-year period, 137 percent. So I am submitting to you that a lot of the employees that we insure every single day could not afford, 9 years ago, $1,000 deductible, and today, they certainly can't afford a $6,300 deductible. And I have to submit to you also that many of our larger clients have moved to these higher deductibles, putting their employees in a place where they can't afford to access basic general health care.

What I will say to you last, and that is one of the greatest problems that I have in the health insurance industry is a lack of transparency. Now, I am fortunate. On my iPhone, I have access to an app that will show me how much it costs to have access to health care from one facility to the next. But what will alarm you is that when you look at the statistics, and you can look at my home State of the New Hampshire, and all I did was a 30-mile radius from my hometown of Windham, New Hampshire, and I found that an MRI of the spine has a 436 percent difference from the least expensive facility to the most expensive facility. And I can name for you several different medical procedures that have similar differentials in healthcare costs, but one of the challenges that we need to focus is transparency in health care. Thank you.

Chairman Brady. Thank you. Thank you. Mr. Lee, you are recognized.

**STATEMENT OF PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA**

Mr. Lee. Good morning, Chairman Brady, Ranking Member Levin, and distinguished members of the committee. It is a pleasure to be with you today.

My name is Peter Lee, and I am the executive director of Covered California, the State of California's marketplace implementing the Affordable Care Act.

And what I would like to speak to briefly, and it is in more detail in my written remarks is first how the Affordable Care Act is working today; second, taking a look at what are the prospects for health insurance premiums in 2017; and third, some of the tools we are using in California to bring competition and affordability to California's consumers.

So first, the Affordable Care Act is working on many levels. Nationally, the share of Americans of all ages who are uninsured has fallen to the lowest level in history. 9.1 percent at the end of 2015. In California, 8.1 percent.

In addition, Americans have reported that they are spending less of their money, less struggling to meet their healthcare expenses than ever before. Now, this means 16 percent of Americans say they have trouble meeting healthcare bills. That is still a lot of Americans having trouble, but it is lower than it has ever been.

As we look ahead, it is important to remember that before the Affordable Care Act, consumers in the individual market regularly saw double-digit rate increases, saw increases that we just heard employers are seeing today, up to 30 percent. But in the old days, consumers couldn't change, couldn't shop, couldn't move plans. They now can.

The Affordable Care Act has slowed rate increases, creating competitive markets that are giving consumers the power to shop for better value.

Now, in California, last year, our rate increase was, on average, 4 percent. But if consumers shop to find the lowest cost plan available to them in their area at the same level, they would have reduced their cost by 4-and-a-half percent. That is the power of a marketplace working.

In addition, through the expansion caused by the Affordable Care Act, of 10 million people having subsidies, those are generally healthy people lowering costs to all Americans because they are now part of the risk pool, as you have heard many of the speakers speak to the importance of the risk pool.

So 2017, let's look ahead. It is going to be a transition year, and I think that it is important to know the main factors for that. First, the temporary reinsurance program is going away. That has been a program that has helped keep premiums low the last few years. It will have a 1 year impact. Experts estimate between 4 and 7 percent one time, and then that goes away.

Second, plans have had trouble pricing, and you have heard this from a number of the witnesses already, in particular, States that did not transition to a common risk pool, plans did not know how to price, to get pricing right is difficult, and there is a number of plans that are adjusting this year, but by the end of next year, those transitional plans are going to be gone, all one risk pool.

Third, a number of plans have struggled with understanding this special enrollment people coming in. We have seen that issue being unforeseen by plans. We have also seen new guidelines and processes, both Federal and State level that should mitigate those problems in the future.

Trends are going up because healthcare costs are going up, and a key part of that, especially drug costs and pharmaceutical costs.

But finally, what is keeping rates down is competition. Competition drives pricing. Let me speak to you briefly about what we are doing in California to make sure that consumers are the drivers of the healthcare marketplace.

First, in California, we actually actively solicit health plans to participate in our marketplace, but we don't take everyone. They have to agree to play and try to improve healthcare delivery. They need to offer standard patient-centered designs, that make sure when consumers have a deductible, that deductible doesn't stand in front of a consumer in getting their primary care, which is never the case in our standard benefit designs.

It also means, those patient-centered designs, consumers can truly shop for what they really care about, which is the networks, the prices, and which doctors are in those networks. That is what consumers care about. They are able to shop in California, and that shopping is driving plans to put better prices on the table.

Now, I would note that, in California, we actually have from the most recent study from CMS, the lowest risk score, meaning we have the healthiest risk mix in the Nation. Risk mix is a core part of what we all have to be doing. That requires extensive marketing like we are doing, working with insurance agencies we have been doing, and having the subsidies that bring people to the table. But also, we have to be changing the underlying cost of health care.

The fundamental issue we have is health care is too expensive in America. Covered California has as part of our contracts with our health plans, requirements that they do things like make sure a consumer has a doctor within 60 days. That is a new requirement starting this next year. Making sure that they are paying differently to align with that work to actually improve the quality of care, which is the real driver of health care.

Our job is not done. I look forward to taking your questions now, but I also look forward to the work that we are all doing to improve on the Affordable Care Act. Thank you very much.

Chairman Brady. Thank you all for your excellent testimony. We will now proceed to the question and answer session, and I will begin.

I know it is sort of common to just claim Republicans are fighting against Obamacare, but in our view, we are fighting for patients and local businesses who have been hurt by this law. I have a constituent in Huntsville purchase coverage for his family on the Federal exchange. He wrote to me: My health insurance costs $989 a month. That is almost a 1,000 percent increase in healthcare costs. So much for being affordable, but what can we do?

Another constituent from the Woodlands where I live writes: The second year in a row, BlueCross/BlueShield is canceling my policy. Further, for 2016, no insurance carrier in Texas is offering individual PPO policies. So much for choice. My insurance premiums for the closest of coverage to what I have now, going up $200 a month after going up $900 a month in 2015. So much for insurance rates going down. So much for more choice.

Now, look, many of my constituents are worse off now than they were before this law was passed. Certainly those who like their healthcare plan, many of them couldn't keep to them at all. Mr. White, some of the work your organizations have been done, I think it is worth highlighting, when the ACA was being debated, we were told by CBO that over 20 million people would want to enroll in the individual exchanges. That has not proven to be true at all. It is less than half of that number who actually enrolled.

We also were told young healthy people are signing up much lower levels than expected. As you pointed out, only 37 percent of people, of those who enrolled, were under the age of 34.

So why are so few people enrolling in these plans? And in New York, one out of five that could get help in those exchanges are in the exchange, one out of five are in there.

Mr. White. I believe it is a combination of factors, but we believe the primary factor is cost. These are just not producing the value for people in ways that they want to sign up for these plans. They are very high deductibles, very high cost-sharing amounts, and coupled with the premium, I mean, in your example, the $900 a month, that individual is spending more than $10,000, right, a year on the premium, probably with a significant deductible. Some of what we are seeing in the marketplace is 5, 6, 7, $10,000 deductibles. So if you are paying $10,000 on the premium and a $10,000 deductibles, you wonder does that actually make sense, or would I just pay the individual mandate tax penalty and self-insure us, in effect.

Chairman Brady. Yeah. Thank you. Mr. Condeluci, do you think -- are you surprised enrollment was so much lower than predicted? Do you see any change?

Mr. Condeluci. I think there is two reasons for the lower than anticipated enrollment. One is the transitional policy that I cited, as Mr. Lee spoke about. In short, the transitional policy allowed not only individuals in the individual market but employees of small employers to stay on nonACA compliant plans.

So while the Congressional Budget Office, for example, expected a number of smaller employers to drop coverage, those small employers did not drop coverage and send their individuals to the individual market exchange market due to the fact that they could stay on their nonACA compliant plan.

Now, not every State has adopted this transitional policy, but for my count, there is about 35 to 40 States that have indeed adopted a transitional policy both in the individual market as well as the small group market. So I think that is one of reasons why you are not seeing as much enrollment.

The other is, we touched on it, I spoke about it in my testimony, is the younger and healthier folks are not finding insurance appealing, and the minimum insurance standards and the adjusted community rating rules, while consumer protections that were arguably needed in the marketplace are carrying with them higher costs. It is just the nature of how it works. If you have a health plan that is covering more benefits for medical services, that is going to become more expensive. So the carriers, in an effort to try to develop premium rates that are reasonable, had to increase the cost sharing, so shift more costs onto the policyholder, as well as narrow the networks by pushing out some of the providers or reducing the provider payments for those doctors and hospitals that are in that network. And those actions are making insurance unattractive, in addition to the cost increases that you might see.

The last point is, I do recognize that the premium subsidy for those folks who are subsidy eligible, between 100 percent of the Federal poverty level and 400 percent of the poverty

level, do get a premium subsidy if they are purchasing an individual market plan through an exchange, and that does blunt much of the premium increases.

But younger folks are still paying a percentage of income out of their own pocket for a policy. That is what the statute requires, and that also is not enough to convince a younger, healthier individual to purchase a plan when you are balancing that or balancing that up against a fairly low individual mandate penalty tax.

Chairman Brady. Thank you. Mr. Harte, you looked at trends with your real world people that you are trying to cover in their plans. So do you see anything changing? I mean, do you see costs continuing to increase? Do you see networks continuing to narrow going forward?

Mr. Harte. Even if we just looked at medical trend and just said that premium increases were a direct correlation to medical trend at 8 percent, that means that health insurance premiums will double in about 7 -- I am sorry, 9 years. That is unacceptable. So I have always preached from the choir. I have talked so much about it. Health insurance is expensive because health care is expensive.

Now, within the ACA, medical loss ratio is built in there, and it was a safeguard from insurance companies, from taking and collecting too much in premium and not paying enough out in health care. So when I talk to folks all over the country, I say, well, why don't we start focussing in on, as ACA determined, the 80 to 85 percent of premium dollars that go to pay for health care.

So when I talk about transparency or when I talk about wellness initiatives and other ways to reduce the cost of health care, that is the real solutions for us to start considering in having a long-term impact on employer solutions.

So in answer to your question, Chairman Brady, I don't see any light at the end of the tunnel based upon current regulations, current legislation, current environments, and on all the issues that this panel has talked about today with losing carriers and increased premiums, I, myself, see my clients continue to be faced with double-digit rate increases for the next 5 years.

Chairman Brady. Yeah. Well, we were promised that families would have lower premiums by $2,500 a year. I haven't found one family in my district do that. When medical trend costs are 8 percent but some States are facing 50 percent increases in premiums, there is a deeper problem here, in my view.

So I now recognize the distinguished ranking member from Michigan, Mr. Levin, for your questions.

Mr. Levin. Now, Mr. Chairman, remember that 85 percent of the people in the marketplace are receiving some assistance to obtain health care. So for them, their premiums are lower than it otherwise would be.

Mr. Condeluci, you are shaking your head yes. I mean, look at the whole picture. Look at the whole picture. You don't want to do that, including in Texas. And you said the number of people in the marketplace is less than expected. There were various estimates. But how many people are in the marketplace who otherwise would not be? We are talking about what, 10 million? And the majority sat here for years in the majority and never did anything at all to address the disgraceful fact in this country, 50 million people going to sleep every night without any healthcare coverage in terms of insurance.

And how much were premiums going up before ACA, Mr. Harte? How much were they going up annually, before ACA?

Mr. Harte. Before ACA, double digits every year.

Mr. Levin. Okay. So you just do that over your 5-year period. So you had premium increases before ACA, double digit, they were something like 14, 15 percent a year on average, right?

Mr. Harte. Yeah.

Mr. Levin. And yet the Republican majority sat here doing nothing. So let's, Mr. Lee, talk a bit about the risk pool issue, because we all knew it was a factor, and in fact, when we had whatever you want to call it, the penalty or the provision, there was debate as to where it would set to try to stimulate people to be covered.

We also should remember, in terms of younger people, how many people are now covered through their parents' insurance who were not covered before. Anybody know, on the panel, the number of people covered as a result of that? Mr. Lee.

Mr. Lee. I believe about 2-and-a-half million? Under 26-year-olds are on their parents' policies.

Mr. Levin. So Mr. Lee, you want to comment on this issue in terms of the risk pool and others, because my guess is, at least in terms of some of you, you might be willing to sit down and discuss how we make ACA work even better. I am not sure how much you are part and parcel reel of this repeal or rip up ACA effort by the majority here. So let's talk for just a minute. I have just under 2 minutes.

Mr. Lee, how do we address the issue of more and more younger people coming in? There has been some discussion, eliminate the minimum standards. I don't think you want to do that entirely. Right, Mr. Condeluci, you don't want to do that?

Mr. Condeluci. Yes, sir. I am not suggesting that you eliminate the minimum insurance standards, but from at least my perspective, my opinion, of course, those minimum standards are a bit constraining. The essential health benefits, for example, and the actuary value requirement, which is tied to the essential health benefits, essentially

require plans to cover benefits and services that many policyholders don't want or need, depending on the type of individual, but those individuals still have to pay for those services.

Mr. Levin. Okay. So as we continue to improve ACA, we will discuss that. Mr. Lee, you want to comment?

Mr. Lee. Yeah, a couple of things. One is it is really important for, in the marketplace, where we are providing subsidies, as you know, to California, about 90 percent of the people that enroll, it is about affordability, and we are still new in this venture of educating and doing outreach.

We spend, in California $100,000,000 to do marketing and outreach. We are selling insurance. Because even with the subsidy, people are making a choice to use some of their hard-earned dollars to buy insurance.

And the issue about the penalty has come up, but I want to be clear. We have done a lot of market testing, surveying, the big issue is can people afford it on a day-to-day basis, and the penalty is part of the equation, but I think the issue about affordability is critical, the issue about doing effective marketing and outreach is vital.

In California, last year, 38 percent of our enrollment was in that targeted age range. It takes time to change from a culture of people just coping and thinking they cannot get coverage to having a culture of coverage, and that is what we are moving into, and it is going to take ongoing effort.

Mr. Levin. Thank you.

Chairman Brady. Thank you. All time is expired.

Mr. Johnson, you are recognized.

Mr. Johnson. Thank you, Mr. Chairman. You know, thanks to Obamacare, my constituents are facing rapidly rising health insurance premiums, as well as, problems accessing care.

Earlier this year, NBC 5 in Dallas ran a story about a Plano couple by the name of Cris and William Lyle who bought health insurance through healthcare.gov. Their plan cost $435 a month, but here is the thing. The Lyles had a problem finding a doctor according -- and that is happening again today. According to the news piece, they reached out to about 20 doctors, but not one of these docs took their insurance. Ultimately they were able to find a doctor, and they were also concerned about finding a specialist.

Mr. Condeluci and Mr. White, the Lyle story is becoming all too common as health insurers are narrowing their networks in an attempt to keep costs down. In fact, a recent

study found that over half the plans on the exchanges were narrow network plans like HMOs.

So first with you, Mr. Condeluci, doesn't that make it harder for consumers, such as the Lyles, to actually see the doctors they want and get the care they need in a timely manner?

Mr. Condeluci. I will answer your question, sir, and say yes, generally speaking. The other kind of caveat to that is, you know, some folks don't mind, let's say, handcuffing themselves to a particular provider or a particular health system. So in that case, maybe that consumer is okay with having a narrow network which does carry with it lower cost. But there are other policyholders, and as we all know, everyone has different needs, different desires, different aversion to risk, and those individuals might not want to handcuff themselves to just that particular health system or healthcare provider, and that limits the choice for that particular individual, which then, I would argue, makes insurance unappealing. If you add the added cost, as we have discussed, and just as a followup to Mr. Levin's question, with these minimum standards, again, they carry with it increased cost.

There are new premium rating rules that actually increase cost for younger healthier individuals. It is those type of new minimum standards, while very good consumer protections, are a bit constraining that if they were loosened up, could allow an insurance carrier to let's say offer more broad networks at a reasonable price point as opposed to being forced into the position to narrowing that network in order to lower cost to offer it to consumers.

Mr. Johnson. Mr. White, do you agree with that?

Mr. White. I do agree with that. I think this is a logical response to the constraints of the law. The Affordable Care Act basically says you have got to cover all these benefits, you have got to offer it within these metal tiers, and you can't use the premium rating tools that you would normally use pre-ACA. And so there are only a few places that the insurers could go to compete based on a premium price point, and that was largely on a cost-sharing side and then on the narrow network side.

And so they tried to use those tools to negotiate rates through the narrow networks, and that was an important tactic, I think, early on in the ACA.

What we are seeing now is fewer PPOs on the exchanges, so there are more narrow networks definitely emerging, and then off exchange, we are seeing a lot more broader networks, a lot more access to specialists and other types of providers.

So this is a logical response to the law. It is unfortunate, but you know, we believe it can be addressed through additional flexibility on the exchanges.

Mr. Johnson. Is it true, in your opinion, that some people may only have access to one insurer or access to a plan with limited networks?

Mr. White. Yes, sir. What we are expecting, according to a Kaiser analysis, is about 650 counties, maybe more, with only one plan. One plan is not a choice of plans, and so that is very concerning. As competition decreases, we see premium rates increase.

Mr. Johnson. Is that getting better or worse?

Mr. White. Excuse me, sir?

Mr. Johnson. Is it getting better or worse?

Mr. White. That is a worsening development. We are seeing these counties with one plans emerge, largely in rural areas, and is not good for consumers. It is not good for competition. It is its not good ultimately for costs for subsidies, and for the U.S. Treasury.

Mr. Johnson. Thank you, sir.

Chairman Brady. Thank you. Mr. Rangel, you are recognized.

Mr. Rangel. Thank you so much, Mr. Chairman, and thank you for calling this hearing.

I was wondering why we were having this, but then I recognize we are about to have our national conventions, and so I assume this is to sharpen up our skills for the convention.

First of all, if there is a problem with the Affordable Care Act as it relates to premiums, it would just seem to me, it would make a lot of sense to have the administration here to explain why we have this problem, but since you saw to select three witnesses that are not a part of the administration, let's find out who they are.

Now, Mr. White, you used to work for the leadership in the Senate, the Republican leadership doing what? Mr. White, did you work for the House, the Senate or --

Mr. White. I worked for this committee for 6 years, sir.

Mr. Rangel. Under whose -- what committee?

Mr. White. The Ways and Means Committee.

Mr. Rangel. Who was the chairman?

Mr. White. Chairman Bill Thomas, from 2001 to 2007.

Mr. Rangel. Okay. Now, what did you before you came to work for the Ways and Means Committee?

Mr. White. Before that, I worked for 2 years with Congressman Jim Greenwood from Pennsylvania, and before that, I worked for Congressman Chris Shays for 4 years from Connecticut.

Mr. Rangel. All Republicans, right?

Mr. White. All Republicans, correct.

Mr. Rangel. Okay. Now, you are in charge of a -- president and counsel for Affordable Health Coverage?

Mr. White. Yes, sir.

Mr. Rangel. Is that a for-profit organization?

Mr. White. It is a nonprofit 501(c)(6).

Mr. Rangel. And how long did it take before you left the Congress that you head up this organization?

Mr. White. I left in January of 2007, and I became president of CAHC in December of 2008, so that was --

Mr. Rangel. So it wasn't you went from the Congress to this organization.

Mr. White. Right.

Mr. Rangel. Now, Mr. Condeluci, is your outfit a for-profit or not-for-profit?

Mr. Condeluci. I run my own practice, sir, which is a for-profit legal and policy practice.

Mr. Rangel. What did you do before you ran this outfit?

Mr. Condeluci. Prior to that, I was an attorney with a law firm, and prior to that, I was counsel to the Senate Finance Committee. Prior to that --

Mr. Rangel. How long were you with the Senate Finance Committee?

Mr. Condeluci. April of 2007 to September of 2010.

Mr. Rangel. Who was the chairman?

Mr. Condeluci. Chairman Baucus was -- or Max Baucus was the chairman at the time. I was on the Republican professional staff, and at the time, Senator Grassley was the ranking member.

Mr. Rangel. So okay. You worked for Republicans. How long was it before you left the Congress that you joined the PLLC in Washington?

Mr. Condeluci. When I left the committee in September 2010, I went back to the law firm to practice law.

Mr. Rangel. How long was it before you went from the time I am talking about leaving the Congress and --

Mr. Condeluci. I started my CC Law & Policy practice in --

Mr. Rangel. How long was it?

Mr. Condeluci. -- September of 2014, so 6 years.

Mr. Rangel. Thank you. Mr. Harte, you were president of some National Association of Health Underwriters.

Mr. Harte. That is correct.

Mr. Rangel. Is that insurance agents?

Mr. Harte. Yes.

Mr. Rangel. Brokers?

Mr. Harte. Yes.

Mr. Rangel. So you represent the insurance business, right?

Mr. Harte. We like to say that we represent the American consumer for health insurance, but our membership is predominantly agents, brokers, and consultants who represent corporations.

Mr. Rangel. But you were lauded for what you were doing for the brokers and insurance company when you got elected, right? I mean, for --

Mr. Harte. I believe I received recognition for addressing the escalating cost of health care. That is what I am known for is dealing with health insurance premiums.

Mr. Rangel. Well, anyway, with all due respect to you gentlemen, I really don't see how we can get to the core of the problem we face as a Congress and as a Nation.

Mr. Chairman, it would seem to me that these are qualified people respecting their constituency, but our constituency are not insurance agencies, they are not employers, it is the people that are trying to gain access to health care. If for any reason we find higher premiums than we expected, I really don't expect these gentlemen to have the answers to the problems.

The answer has to be with who made the mistakes and how can we correct it, and it would seem to me it is done by law and not by those people that are engaged in for-profit for good reason and mature-ish reasons, efforts. So I am ready for Philadelphia, I hope you are ready for Cleveland, but I just don't see what relationship this hearing has for improving the quality of care for American citizens. Thank you. I yield back whatever balance of the time I have remaining.

Chairman Brady. Thank you for establishing the credentials of our witnesses, and God forbid we hear from real people about real problems in health care because they are serious ones.

Mr. Tiberi, you are recognized.

Mr. Tiberi. Thank you, Mr. Chairman. And thank you for having this hearing today. You know, if I am back home watching, I can't imagine what our constituents think.

It would have taken us back to when we were the majority and then in the minority, and you all passed the Affordable Care Act, I sat down there, and we talked about those 40 to 50 million people who didn't have health care, we talked about the fact that they access the most expensive coverage by walking into an emergency room, and that the Affordable Care Act was going to help them. We also talked about, or the President talked about if you like what you have you can keep it, okay. And I sometimes get frustrated because I know in my heart that when the Affordable Care Act was passed, it was done with good intentions. I really believe that.

But I also know and have seen that a lot of Americans actually like the health care they have -- they had and now don't, and we simply have a difficult time communicating with each other to recognize the challenges of what the new law created to try to help the 40 to 50 million people who didn't have health care.

The irony is, as chairman of the health subcommittee in visiting hospitals in is my district, there are still people who are accessing the emergency room as their primary care, which is the most expensive care.

We have a building boom of emergency room departments freestanding in America today, which is a whole other discussion. But I want to associate myself with the chairman's remarks because real people are experiencing problems in their health care who didn't have problems before. You have created new problems because of the health care bill, all maybe unintentionally, by the way.

Let me tell you about Mr. and Mrs. Dean Wagner of Westerville, Ohio. They worked their entire lives. They both retired, and since the Affordable Care Act has passed, they have experienced 75 percent -- 75 percent increase in premiums, 75 percent. Ms. Dianne Smothers in Johnstown, Ohio sacrificed higher premiums in order to keep the doctor she wanted to keep, and then she finds out that her doctor was suddenly canceled with no warning when a coop in my district, and now a majority of coops have failed, coops created by the Affordable Care Act. When that coop failed, she and her husband's out-of-pocket expenses were $16,500 more than they had ever been before the Affordable Care Act had passed. These are regular middle class folks.

Unfortunately, for the Wagners and the Smothers, they are not the only constituents that I have talked to who have contacted my office that are facing outrageous premium increases, outrageous out-of-pocket expenses like they have never experienced before, and now going to a doctor that they didn't want to go to because they can't go to the doctor they had, which they were promised over and over again.

Mr. White and Mr. Condeluci, I wanted to ask you about a specific failure of the ACA that has been reported widely now. The coop program. I was here when that was discussed, and it was a nod to the public option for some Democrats who wanted the public option. I believe 8 of the 23 that began remain, and one of those, as I said, was InHealth that failed in Ohio. 22,000 lives were covered, and these people were left devastated.

So instead what was supposed to happen with these coops was to create competition. It seems that the coops badly mispriced premiums, artificially creating a lower market, underpricing the market, and in doing so artificially, did it hold down premiums initially? Meaning, you know, there was a lot of ballyhoo about premiums didn't go up immediately. Is that because the coops provided this artificial floor?

Mr. White. I will take the first shot at this, I guess.

So according to the Government Accountability Office, they did a report, they looked at the premium rates and basically said that in about half the rating areas the premium rates were substantially below market rates. So they were coming in with a below market rate. Of course, they had significant taxpayer support in establishing the coops and getting off the ground, but were trying to attract enrollment through those lower premium rates.

And I think what happened was the premium rate, the experience, cost experience, quickly outpaced the premiums that they were charging, and the vast majority of the coops, as you know, have since failed. And the insurers that remain in the markets had to pick up and cover those folks who lost their coverage through the coops. Significant problem in Ohio, Iowa, other areas, as the committee knows.

Chairman Brady. Thank you. Dr. McDermott, you are recognized.

Mr. McDermott. Thank you, Mr. Chairman. I always love to come to these propaganda hearings before the elections, and it is obvious we are trying to hold the insurance companies harmless here. Premiums go up because of the Affordable Care Act, that is why they go up.

But I lived for 45 years with a father who was an insurance underwriter, so I know a little bit about what goes on.

Mr. McDermott. And if you look at why the premiums go up, it is either because the company misjudged and made a bad rate to charge people or the costs of the medical profession have gone up uncontrollably.

Mr. Lee, what percentage of those two things do you think is bringing the premiums up? Is it misjudgment by the insurance companies or is it that medicine is jacking up the costs?

Mr. Lee. I think it varies by locale. I think in much of the country, it is because the plans, whether co-ops or for-profit or nonprofit plans, got their risk mix wrong, and they underpriced and are now jacking it up to catch up on the real costs.

But underlying this, and we have heard this from all the witnesses, the driver of healthcare costs is the underlying cost of what it costs to deliver health care to Americans. And that is one of things I think the Affordable Care Act provides some tools for, but we need to be focusing on.

In California, we have not seen consumers whipsawed by big price changes. They have been pretty constant. But costs are still going up and we need to address those with tools of transparency and others.

Mr. McDermott. Let me take an example, because we hear a lot of examples given up here. They give these horror stories of Mr. Johnson or Mrs. Williams or whatever and her problem.

Let's take Texas. Now, if you were an insurance company in Texas and you were trying to set the rates for Texas, and you had 1,314,000 people uncovered by insurance in your market who have access to the emergency rooms, and they go in, they get sick, and they get taken care of and their costs are unpaid for by any insurance company, how does an insurance company factor in that number of people? I mean, the Governor of Texas said: I don't care about those people. I am not going to take Medicaid for them. They are floating around in Texas.

How does the insurance company take that into account?

Mr. Lee. Again, how insurance companies I believe take that into account is by what they are going to get charged by providers. And what happens with uncompensated care is hospitals or doctors make it up on the other side. So those costs for the uncompensated

care is right now being paid in Texas by employers, by individuals, et cetera, where those costs are being spread.

Where you have expanded coverage, like in California and the 35 other States or more that have expanded Medicaid, is every American is benefiting by having coverage, because you aren't then having the cost shift, which it is called, of everyone, employer-based, people, individuals, picking up the costs of the uncovered, which hospitals pass that through to the health insurance companies and their rates.

Chairman Brady. Mr. Lee, you might be confused. Dr. McDermott asked about those who would be covered by Medicaid. They aren't in the exchanges. Why would an insurer plug that in if they are covered by Medicaid?

Mr. McDermott. Reclaiming my time, Mr. Chairman.

Mr. Lee. My point is, as I was understanding the example of Texas of a million people that do not have coverage, when they show up at an ER at a hospital, they are uncompensated care, and that cost is passed on to insurance companies or employer-based coverage, et cetera.

Chairman Brady. But you agree those who aren't covered on Medicaid are not in the exchanges, they are not factored in.

Mr. Lee. Absolutely right. Absolutely right. That is what I understood the question to be. Did I get the question wrong?

Chairman Brady. We will give you some more time, Dr. McDermott.

Mr. McDermott. I think the chairman has really put a sharp point on it. The Governor of Texas decided he didn't want health care coverage for 1.2 million or 1,314,000 people. So they still get sick, and their costs are factored into the system, and the insurance company jacks up the prices to cover for what isn't paid for in other places.

Chairman Brady. That is not accurate, Dr. McDermott.

Mr. McDermott. I mean, hospitals do that. They add a couple of dollars on the room rate to cover for their unaccounted costs.

Now, I have another question, though. We have in the Part D, we had risk corridors to control the costs for the drug companies or the people who were putting out the drug coverage. We had it also in the ACA. In the Part D, it is still working. In Part A they have cut it out. It seems to me that we have undermined the ACA by cutting out that money in those risk corridors.

I yield back the balance of my time.

Chairman Brady. I just want to clarify, those who are in Medicaid are not in the exchanges, they are not factored in the insurance premiums. Now, the more than a million Texans who decided to pay the tax rather than go to a plan they don't want and can't afford, that is another story.

Mr. Levin. Can he answer that since you took the time?

Chairman Brady. Sure. Are those who are covered in Medicaid factored into the insurance exchanges?

Mr. Levin. Of course they are factored in.

Mr. Lee. The cost of uninsured are basically borne by everyone, both in marketplaces and in employer-based coverage, because the hospitals pick up those costs and others can --

Chairman Brady. We are not taking about employer-based. We are talking about the exchanges and the insurance premiums. They are not covered in that package? Are they reflected in the Medicaid rates?

Mr. Lee. The uninsured that have uncompensated care, hospitals, other providers, build that into their rates that are charged to people in marketplaces or in employer-based care, and that is a factor in terms of raising costs.

Chairman Brady. You are confusing the Medicaid populations with the insurance agents.

Mr. Levin. No, he is not. You are the one who is confused, Mr. Chairman.

Chairman Brady. Mr. Reichert, you are recognized.

Mr. Reichert. Thank you, Mr. Chairman.

So let's deal in some facts. ObamaCare has proven time and time that promises made were not kept. The President promised affordability, yet the law continues to drive up premiums and deductible costs.

We need to look no further than my home State for evidence. Insurers in Washington have requested an average of 13.5 percent increase. That is for individual plans for next year, with at least one insurer requesting increases of almost 20 percent.

The President promised Americans that if they liked their plan they could keep it, if they liked their doctor they could keep their doctor. Well, that turned out not to be true.

And I was in a meeting 6 years ago, as were a lot of the Republicans, when the President was asked to come and speak to us, and he was asked the question: Can you keep your health plan? Can you keep your doctor? And he said: Well, you know, there might have

been some language snuck into the bill that runs contrary to that promise. The President said that.

Premera Blue Cross and LifeWise Health Plan of Washington, a subsidiary of Premera, announced that they will completely withdraw from Washington Health Benefit Exchange in 12 counties in Washington State. The result is thousands of my constituents will lose their health plan and be forced into another whether they like it or not or they will be taxed for failing to sign up for a healthcare plan.

So my question is for Mr. White. What do you think is causing insurers to exit the market? And how do you think that will impact the choice and access to care for constituents like mine, especially in rural communities?

Mr. White. I think your experience is not unlike other State experiences in terms of the double-digit premium increases and the exit of certain insurers from the marketplace. I think the insurers are leaving the marketplaces because they are losing money. And probably the most prominent example of that is United Health Group. But there are other insurers in the marketplace who are looking at various geographic-based markets and saying: We can't afford to stay there.

Now, Congressman McDermott made the comparison to Part D and having risk corridors and risk adjustment and reinsurance, and I would note, in the Part D market, where the model is based on a competitive model, there are 800 or so plans available nationwide. In the average marketplace you have approximately a choice of about 34 plans. The ACA experience is opposite that. It is marked by fewer plan choices, plans exiting markets, and premiums that are not stable but are going up significantly.

Mr. Reichert. So you said there were 600 counties in the country that will be down to one choice?

Mr. White. According to a Kaiser Family Foundation analysis.

Mr. Reichert. Three of those will be in the district that I represent. What is the answer to --

Mr. White. Well, it raises interesting questions, right? Like the subsidy is supposed to be tied to the second-lowest-cost Silver plan under the law. And if there is only one plan, what is that second-lowest-cost option? The other thing is that having a choice of one is no real choice at all, right?

So in my opinion, flexing up the market, allowing some competition in the exchanges, and perhaps allowing consumers to take their subsidy, make it portable, and allow them to leave the ACA exchanges to buy a plan off exchange, I think Chairman Brady has called this concept like a subsidy backpack, but being able to carry that outside to really use that subsidy and that assistance off the exchange we think is a very important reform

that would generate competition and hopefully encourage more insurers to get back in the market.

Mr. Reichert. Current law doesn't allow that to happen.

Mr. White. Current law does not allow the subsidy to be used off exchange. There is some flexibility --

Mr. Reichert. I am sorry. The ACA, then, is in violation of its own law which requires that you have at least two choices. Is that what I heard you say?

Mr. White. I would defer to maybe Chris or, you know, a legal opinion on that. But it creates some interesting questions, let's say, in the various marketplaces.

Mr. Condeluci. Sir, in the exchanges, if a carrier is participating, the statute does require the carrier to offer a Silver-level plan, as well as a Gold-level plan. So that is just a requirement that a carrier wanting to participate in the exchange has to meet.

But when it comes to other carriers being a part of that market, there is not that similar requirement. Carrier Chris might say: Hey, I am fine, I will offer a Silver and a Gold. Carrier Joel might go: You know what? I don't want to enter the market for a myriad of reasons.

So that, I hope, is an explanation of that.

Mr. Reichert. All right. Thank you. I yield back.

Chairman Brady. Thank you.

Mr. Lewis, you are recognized.

Mr. Lewis. Thank you very much, Mr. Chairman.

Mr. Lee, 20 million people have been covered by the Affordable Care Act and we have a historically low number of uninsured Americans. How does reducing the number of uninsured impact premiums in the employer-sponsored insurance market?

Mr. Lee. The relationship there is that providers, in particular hospitals, will take uncompensated care and build that into the rates they charge individuals or people that have employer-based coverage. And so that raises the cost of insurance, whether it is in an individual market or in employer-based coverage. So the expansion of coverage that we have seen through both exchange coverage and through the Medicaid expansion has been a factor in lowering what premiums would have been otherwise.

Mr. Lewis. Mr. Lee, could you tell us what is the impact of competition on insurance rates in your State, the State of California?

Mr. Lee. Yeah. We think competition is vitally important. I think everyone up here on this panel would agree with that, is that for the 90 percent of Americans that have three plans or more to choose from -- and in California it is far more than 90 percent -- plan competition is what drives premiums. The plans know that consumers want the lowest price plan, and they will shop for that. And that is the main driver of keeping costs down.

And so I think everything we can do to foster a competitive marketplace and to give consumers an ability to make informed decisions between plans is vital. In California, we have had both of those. We have had a vibrant competition across the vast majority of the State. And consumers know when they are choosing plan A versus plan B it is not because of some quirk on deductibles. It is because of a different network. So they know what they are buying. We think that has contributed to our good risk mix.

Mr. Lewis. Mr. Lee, in my district, in the city of Atlanta, HIV infection rates are very concerning. From your testimony, it seemed that you have experience in reducing healthcare and insurance costs to consumers. What action or policies can make it easier for people, especially those living with HIV and AIDS, to access and afford the medication they need?

Mr. Lee. Well, I think one of the most important things the Affordable Care Act has done is change the rules of the game for insurance companies to not be about avoiding sick people, but now getting people who are sick the care they need when they need it.

Part of what we have done in California is have in our patient-centered benefit designs limits on cost of high-cost specialty drugs, which are a major concern into the drive in expense, but we want people that have to get specialty drugs to not have their copay be a barrier between them and getting those drugs.

So we both require for people with HIV a mix of drugs at lower formulary tiers, but also for the most expensive drugs, that may cost $60,000 a year, that a consumer would only have $250 a month they would need to spend for their share of the costs.

And this is part of the balancing act we need to wrestle with as a Nation, is we need to be addressing the rising costs of pharmaceuticals, the rising cost of specialty drugs. But let's not do that in ways that don't give lifesaving drugs to consumers because of their high cost. And that is a balancing act we have struck in our patient-centered designs in California.

Mr. Lewis. And, Mr. Lee, I for one want to thank you for all of your great and good work, and for your vision in helping to provide health care, not just for the people of California, but for the people of our Nation.

I yield back, Mr. Chairman.

Chairman Brady. Thank you.

Dr. Boustany, you are recognized.

Mr. Boustany. Thank you, Mr. Chairman.

Mr. White, I am going to step back and ask some very, very basic questions. Do you believe we have a functioning market in health care today? Is it a functional market?

Mr. White. I believe there are a lot of warts in the market. It functions for some people and I think it doesn't work for a lot --

Mr. Boustany. Okay. So it is a poorly functioning market.

Mr. White. Poorly functioning would be the phrase I would use.

Mr. Boustany. Poorly functioning market.

I noted that the President just within the last 24 hours, I believe, admitted that it is a poorly functioning market as a result of this law, ObamaCare, when he called for a renewed effort to put forth a public option and to raise subsidies. I think that is a pretty tacit admission that the market is failing. Is that correct?

Mr. White. I think it highlights some of those warts. And I think other people have suggested that we need to expand cost-sharing subsidies to fill in these very large cost-sharing requirements on the exchanges. And that also is a recognition that these things are growing like crazy.

Mr. Boustany. And just a moment ago you referenced the fact that we are seeing significant consolidation in the insurance marketplace, which means fewer choices, correct?

Mr. White. It may mean fewer choices. It may not. So what we are seeing in the exchanges right now is there are choices of plans available in most markets. I think the average is somewhere around six or seven. It may be different in California.

So there are still choices. What I am suggesting is that there is consolidation on both the insurer side and the provider side --

Mr. Boustany. Correct.

Mr. White. -- and that those raise trend on medical costs questions in different directions.

Mr. Boustany. Exactly. And if you have a functioning market, there are certain characteristics that are required -- information, transparency about provider quality, about cost, about insurance coverage. I see contraction in what is going on there as a result of fewer choices, less information. We still don't have the kind of information we need to

really have a good functioning market, both on the provider side and on the insurance side.

And then information choice and control ultimately. Shouldn't the consumer decide and have the information to be able to make decisions to have a really truly functioning market?

Mr. White. Yeah. I think information is the lifeblood of a functioning marketplace. We don't see those on exchanges today. In December of 2015, we did a report card on exchanges and graded the exchanges from A to F. We looked at all the State exchanges in healthcare.gov, and healthcare.gov was solidly at a C level, which hopefully they will improve next year. But they are not providing basic information on is the provider in the network, is the drug on the formulary, how much is the patient facing out of pocket for that formulary drug, is there is a smart plan sorting tool, et cetera, et cetera, et cetera.

So we need better information on the exchanges. For example, with these very high deductibles, can we say the plan is HSA qualified or not. We need better information on the providers as well. Are they high quality? Are they efficient? Can I pay lower costs if I go to provider Chris versus provider Boustany.

Mr. Boustany. So the trend lines in all these areas are very disturbing, in my mind, as a physician who has been around health care for quite a long time. And if you agree that coverage, for whatever it is worth or whatever it is, is the gateway to the service, high-quality health care, and I think the focus needs to be on quality, then we have a poorly functioning market that is rapidly failing. And I think the President's admission just in the last 24 hours sort of verifies that in my mind.

We have to take substantive steps to change this. Less choice, less information, less control. This is disastrous for health care. I think it is truly pathetic. I am really upset. I am angry about what is happening to my beloved profession, medicine. And at the same time, as a patient, the husband of a patient, the father of patients, I am really worried about what this is doing.

And we are seeing the costs going up. And of course what the President is proposing is higher taxpayer liability on top of this, on type of higher premiums, higher copays, out-of-pocket expenses.

We are going in the wrong direction. This is a failure. And we better recognize it as such and take steps.

Mr. White. I agree, Congressman. We have presented 13 different policy options in our testimony to you today. We want to work with both sides of the aisle to see if we can make some improvements here, because the market is not working the way it should.

Mr. Boustany. Thank you. I yield back.

Chairman Brady. Thank you.

Mr. Neal, you are recognized.

Mr. Neal. Thank you, Mr. Chairman.

Just quickly a response to my friend, Dr. Boustany. I think there is general agreement from all the panelists here that conventional economics don't work when applied to health care. People age, people get sick, and sometimes they get sick in a catastrophic manner, and the rest of the system, in terms of implied shared risk, is what is supposed to absorb some of those costs. That is the whole notion of the ACA.

And I think that one of things that is left out conveniently in the argument is the ACA was really a compromise in the sense that you were going to try to keep the private sector alive to discipline price. That was the idea. And I think just to discuss that with the suggestion that somehow that it is a poorly functioning market, how would we have described it before the ACA? An efficiently functioning market?

I mean, the reason that we have Medicare and Medicaid is because conventional economics don't apply to health care. People simply get old and they get sicker as they get older. That is part of the challenge that we face.

But in any event, Mr. Lee, when Massachusetts implemented our State-level healthcare reform plan, or as we fondly called it those days, RomneyCare, we recognized that that consumer education and outreach were key to the success of the program. Community assistance programs made this work. It was not just getting consumers in the door, but having them find value in the insurance product and to use the healthcare system in a new, thoughtful way.

The State partnered with the Red Sox, as one example, to educate residents about the new law and to entice them into enrollment. Then the State partnered with issuers and local organizations to educate newly covered individuals about how to use coverage and access services with the new plan for insurance.

Just before you talk about how California has done this, Mr. Lee, in terms of educating its citizens, in Massachusetts it really was Governor Romney, the whole notion of the Heritage Foundation's mandate. I mean, David John's picture is at the end of that photograph. Governor Romney signs the legislation. Ted Kennedy is standing behind him. But it was the business community in Massachusetts that put the plan together with Governor Romney.

So perhaps in the 2-1/2 minutes you have in response to my question, Mr. Lee, could you talk about what California has done to educate citizens about these opportunities?

Mr. Lee. Thank you very much. I just do need to underscore your initial comment, if I may, about the prior market failures in health care. Because before the Affordable Care

Act, remember, the individual market was one where insurance companies could and did turn people away regularly. And once you were in, you couldn't shop and choose. It is absolutely an imperfect market today, but I think it is a vastly improved one that needs to be built upon.

And California did a lot of learning from Massachusetts, actually, and I think we learned from other States, we learned from the Federal marketplace. We are seeing across the Nation efforts to make sure we get everyone enrolled.

And a couple of examples I would give are, first, in California there are more than 500 storefronts, huge stores with our logo, Covered California, on it. Those aren't State stores. Those are stores run by insurance agents who are members of CAHU, I mean the California Association of Health Underwriters. These are individual small-business people who are members of their community saying: We want to use this platform to sell insurance, to make insurance available.

Because it is about not just signing people up for insurance. It is then helping them understand how to use it. And I think that question is spot on, because what we have seen from many of the people coming into exchanges across the Nation is getting in is only the first step.

And this is why we in California believe patient-centered designs are so important. If you have not had insurance before or you are a young healthy guy and you show up at the doctor and say, "Sorry, you have got $3,000 you have got to spend before you get this as a covered benefit," are you going to leave coverage? Absolutely.

Patient-centered design is part of the education to say, when you get sick, you go see a primary care doc, it is a covered benefit right out of the gate. And that is part of the reason we have patient-centered designs, because we think educating people about how to use insurance is also having an insurance design that works for all consumers.

Mr. Neal. Thank you, Mr. Lee.

Thank you, Mr. Chairman.

Chairman Brady. Thank you.

Mr. Roskam, you are recognized.

Mr. Roskam. Thank you, Mr. Chairman.

A quick word about today, a quick look back, and then a question.

Mr. McDermott suggested that this is a hearing today about holding the insurance companies harmless. That hearing was last week when the administration came before the Oversight Subcommittee and essentially was arguing for subsidies through the Cost

Sharing Reduction Program for the insurance companies. So the administration was here advocating for insurance subsidies last week.

A word about maybe why we don't need to hear from the administration on every problem and that we can hear from four fresh voices is this. Last week at the same subcommittee meeting on Thursday, we heard from the administration. Mr. Mazur, the Treasury assistant secretary for tax policy, said this about a very controversial thing that they are doing. He said this: If Congress doesn't want the money appropriated, they could pass a law that specifically says don't appropriate the money from that account.

So that is the wisdom and constitutional insight. Of course that runs completely counter to the explicit language of the Constitution that says: "No money shall be drawn from the Treasury but in consequence of appropriations made by law."

So, look, the administration has a very big microphone, and they can fend for themselves.

A quick look back. 2008, the country had made up its mind, I think, after President Obama was elected, around two things as it relates to health care. The first was that health care was too expensive. And the second thing, we were scandalized, basically, as a country with the fact that preexisting conditions precluded people from having access to an insurance pool. That, I think, was the opportunity. That is where the national consensus was, to move forward on that basis. I think it would have been the smart move all the way around. And I think the nature of the discussion that we would be having to day would be fundamentally different.

But the administration made a different decision. It is their prerogative. But they decided to go basically all in on the Affordable Care Act. And that is where the problem happened.

Now, this business never works when an expectation is created here and the result is here. So the chaffing, the level of anxiety, and the feeling that people have right now is like: Oh, no, no, everyone said this was going to be great. So when Mr. Lewis is talking, for example, about HIV problems in the inner city of Atlanta, no, it was basically ObamaCare was the remedy, this was all going to be great.

And I think, Mr. Lee, part of the challenge now is you talked about something like a culture of coverage. Even a culture of coverage is a suggestion that somehow this gets better the longer we wait. So I am not encouraged by that.

And I want to get to the coverage question. I actually have a question for Mr. Harte. So there is an illusion here, and I think the illusion is that coverage is the goal. Well, coverage is simply: I will do this. You can get a library card that says: Here is a library care. But you walk in to try and check books out of the library and there is no books.

Can you speak to this notion of coverage versus access and give us some word about how we should be evaluating the concept of coverage as opposed to actual access to health care? Mr. Harte, do you have an insight on that?

Mr. Harte. Absolutely. You will all define access completely differently. Some of you may say access is about being able to have access to a health insurance plan. And as Mr. White has indicated, in several States we have lost a lot of health insurance companies and co-ops are failing. So a lot of your constituents across the country are losing access to those plans.

Some may also say: I don't have access to my doctor, for many reasons. Number one, maybe it is just too expensive, maybe access to an MRI, they simply can't afford it, or, as we have talked about earlier, these bifurcated networks.

So I live in New Hampshire and all of the health insurance plans on the marketplace are limited networks. All of my health care is being done in Boston. All of my surgical procedures are done at Mass General or Brigham and Women's. I do not have access to care in Boston under a marketplace plan. And that is a huge problem if you want to cross the border and get into Massachusetts or, quite frankly, in any other state where you may want to have access to better care.

So in answer to your question, access to health insurance plans is a huge challenge. Access to affordable plans, access to affordable health care, and access to your own doctor is a continued problem in the post-ACA world.

Chairman Brady. Thank you.

Mr. Doggett, you are recognized.

Mr. Doggett. Thank you so much, Mr. Chairman.

And to each of our witnesses, I believe that there are many factors contributing to these hikes and surges in health insurance premiums, and one of the major factors is the failure of this House and this Congress to do anything but engage in obstructionist tactics concerning the Affordable Care Act.

Whenever there is the discussion of the slightest improvement -- how can we make the Affordable Care Act work more efficiently, how can we make it more fair, how can it be better -- there is nothing but repeal, repeal, repeal. And that has some effect on the administration, because instead of noting an area where there is a shortcoming and a need for legislative action, the administration is placed on a defensive posture with now over 60 attempts to repeal.

And of course the original cry in this committee when it acted back in January of the new Congress coming into effect was that it would repeal and replace. But it never offered

any replacement in a meaningful way to address these needs. So that failure, that obstructionism certainly has an impact on premiums.

The second aspect of this that has already been referred to that I have seen personally is the impact of the indifference of the State of Texas and a number of other States to the needs of its poorest citizens; in all, 1.3 million Texans. And this indifference and this refusal to take 100 cents on a Federal dollar to pay for the expansion of healthcare coverage has been a subject that has been raised by business leaders, by hospitals, by elected officials, all saying how important it is to achieve the full promise of the Affordable Care Act by including those citizens who would be covered through Medicaid.

I have looked personally in the eyes of families who have come in San Antonio in order to sign up for the Affordable Care Act and to have to tell them: I am sorry, you are too poor to achieve access to the Affordable Care Act. You cannot sign up in the exchange. Your remedy is through Medicaid, which they have been denied.

And anyone who thinks that denying health insurance coverage in the hope of getting for the first time a family doctor to these families means that they do not have an impact on health insurance premiums is ignoring reality. Yes, actually, in many cases these folks do not receive the healthcare coverage they need. And so eventually, when things get so bad, they are forced into the emergency room.

We had estimates before the Affordable Care Act that the impact of the unpaid-for care of the poor was hiking insurance premiums for the family that has an insurance policy by over $1,000 a family. That has an impact for employer-provided care, but it absolutely has an impact on the premiums being paid through the exchanges. They are not excluded from the impact of the cost of covering the uninsured poor people, many of whom I have seen personally denied the opportunity we thought would be forthcoming, and paying for it both in pain and in the cost to health insurance premiums.

There is another factor, Mr. Lee, we haven't touched on that I think is really significant, you refer to it in your testimony, and that is the impact of pharmaceutical prices and price gouging by pharmaceutical manufacturers. This committee, just as with improvements to the Affordable Care Act, has refused to even conduct a hearing about this problem and it has been ignored.

You referred to the discussion of Express Scripts on the impact on specialty drugs. But they have also reported that in 2015 alone, that increases in the average price of brand name drugs were at about 16.2 percent. That is consistent with other reports of organizations, like Kaiser Family Foundation, that prescription drug costs now amount to 19 percent of health spending by employer health insurance plans. On brand name drugs, we don't have the transparency or the competition that you have suggested is a problem with some health insurance markets.

Do you believe, Mr. Lee, that pharmaceutical prices are contributing to premium increases and that more transparency and competition here would help us address premium increases?

Mr. Lee. There is absolutely no doubt that a significant factor in California and across the Nation of rising healthcare costs have been pharmaceutical costs increasing at a far higher rate than underlying medical trend, in particular, the cost of specialty drugs, which in 2015 rose by about 18 percent. But we are seeing this in our discussion with our health plans in California. They are highlighting the fact that those costs are a major driver. And for many consumers, it is as very opaque market. Transparency would be a huge boon for consumers.

Mr. Doggett. Thank you.

Chairman Brady. Thank you.

Dr. Price, you are recognized.

Mr. Price. Thank you, Mr. Chairman.

Look, let's be clear. The reason that we are here today is not because of all these wonderful stories that the other side tells. The reason that we are here today is because the American people are hurting because of the healthcare program that the Federal Government put in place.

Twenty-six percent of the American people say they have been harmed by this law. If we had any other law where one out of every four Americans said they had been harmed by it, we would be having hearing after hearing after hearing and bill after bill after bill to fix it. Four out of 10 Americans say that they have a positive view of this law. That means 6 out of 10 say: No, help us.

Now why is that? Our job as policymakers is to figure out the why. And let me suggest that the why is because this law violates the principles that every American holds dear when it comes to health care. We all want a system that is accessible for everybody. We want a system that is affordable for everybody. We want a system of the highest quality. We want a system where patients have choices. The fact of the matter is that this law violates those principles, regardless of what your ideological stripe is.

Mr. White, you said that the current law has made health care less affordable and more out of reach than before. Affordability, accessibility, significantly harmed.

Mr. White. Yes, sir.

Mr. Price. This hearing is about increased premium costs.

Mr. Harte, you were asked a question about what the premium increases were before ObamaCare, and you said that there were double-digit increases every single year. So what was ObamaCare supposed to do? What was the ACA supposed to do? Stop that, right? That is what the President said. Costs won't be going up, they will be going down.

The fact of the matter is that the administration spent over $1 trillion on a broken Medicaid system and on subsidies that are forcing people to buy insurance that they don't want, raiding Medicaid for $800 billion, increasing taxes by a trillion dollars. And what do we have? We have double-digit inflation in premiums.

And it is not just premiums. The deductibles are out of site. Mr. Harte, you identified that. I was stunned by your figures. Four hundred and eighty percent increase over the past 9 years in deductibles, 140 percent over just the past 3 years, which means people have coverage, but they don't have care.

I used to practice orthopedic surgery. My former colleagues call me and they are distraught because of the patients who come into their office, they recommend something that needs to be done, and the patient says: I am sorry, Doc, I can't afford that, my deductible is thousands of dollars. This is a system that is not working for the American people.

A fellow in my district, Mickey Roberts, 59 years old. In 2013, his premium was 500 bucks a month -- 500 bucks a month. Now it is 1,200 bucks a month. Example after example after example. I have a cancer survivor who can't get a screening MRI following her cancer because you have non-medical people making medical decisions. That is part of ObamaCare.

Families harmed. Family of five in my district whose premiums just 3 years ago, premiums were 330 bucks a month. Now they are 1,365 bucks a month. I have another family whose premiums have increased 30 percent over the past 2 years. Deductible went from 6,500 to 12,500. And now their health insurance costs are higher than their mortgage. The highest cost that they have in their family budget is their health insurance. This is craziness.

So what we invite our friends on the other side of the aisle to do is to please recognize that there are people that are hurting, and that they need help, which is why what we have tried to do is to put forward positive solutions. Our friends say we don't have a plan. We have put forward A Better Way, a better way to address the challenges that we face in all sorts of areas, not the least of which is health care. And in health care, a better way means that patients and families and doctors are making medical decisions and nobody else.

Mr. Lee, you highlighted this cost shifting that you talked about. Cost shifting ended decades ago. There is no cost shifting anymore. I am a third-generation physician. The fact of the matter is that cost shifting doesn't exist. The government is setting the

prices. Physicians, hospitals, they aren't able to pick the prices that they charge. In fact, what they are being paid today for Medicaid and Medicaid services oftentimes doesn't even cover the cost of the service being provided.

This is a system that is broken, and it needs to be fixed. And I urge my colleagues on the other side of the aisle to join us in A Better Way.

Chairman Brady. Thank you.

Mr. Larson, you are recognized.

Mr. Larson. Well, thank you, Mr. Chairman.

And certainly I want to thank our witnesses here today, because I really did appreciate the comments that you made, the thoroughness, and a number of the good ideas that you are suggesting. But you, of course, know that you are part of theater. You are not part of getting anything done. This is all about messaging. It has nothing to do with solving the problems that the American people face.

This matter has been taken before the public in 2010, in 2012, in 2014, and it again will be front and center in 2016. Fifty-eight times or more in the Congress this act has been repealed by the House of Representatives. There is no substitute, there is no alternative, there is no score that has been given to any meaningful program that would address the issues as you have thoughtfully outlined or as California is diligently doing, because this is a farce, it is a play that we have all become a part of. Where is the solution?

Yeah, there are a lot of things that are wrong about the Affordable Care Act that need correcting, and when thoughtful people put their minds together and are able to address these issues, you can make these changes. But there has been no serious attempt to make any change other than to message against this bill and its flaws, its warts and blemishes, instead of looking at the constructs of the bill, as Mr. Neal outlined, and how they can be successfully managed, as they are in California and as they were by the business community in Massachusetts, as they are being done in Connecticut.

Instead, we are like this great ostrich with our head in the sand here, prevailing upon you to come before the committee so that we can try to convince the public that people are hurting out there. And they are. But this Congress isn't doing anything about it.

It is no different than leaving Congress this week without doing anything about gun violence. It is happening all around us. It is happening at a devastating rate. It is happening in a way that we should be ashamed of ourselves. We will message on it, but we won't take a vote, we won't sit down and constructively work towards coming up with a solution for the American people.

And that is what the American people are fed up with. That is why the American people believe that there is a wall that is going to be built and the Mexicans are going to pay for

it. And that is why people believe in these promises that are never going to come to fruition.

It is long overdue that we, as Americans, roll up our sleeves and sit down. This committee is fully capable and talented on both sides of this aisle of resolving these issues in a nanosecond by coming together and working through these concerns. But it is more convenient to have a message that you can pound home in a campaign. Very successfully done in 2010. A Presidential campaign was waged on it in 2012. And ever since 2010, 2012, 2014, and now in 2016, the American people have been told this is a God-awful plan, but they haven't had one solution from the other side.

I apologize to you for being here today, not because you haven't provided thoughtful information, you have, but you must understand by now that you are just part of theater.

I yield back.

Chairman Brady. Mr. Smith, you are recognized.

Mr. Smith of Nebraska. Thank you, Mr. Chairman.

Thank you to our panel as well.

Listening to all of the various comments here, it is quite interesting. It is frustrating. I hear some of the messaging from my colleague who spoke just previous to my remarks here. These are serious issues. I don't have to tell any of you that.

I get frustrated when we hear that competition is alive and well from Mr. Lee, and that is not what I hear from my constituents. I hear from constituents, for example, one of them, one of my constituents who has lost her coverage three times. And they had a plan that they wished they could have kept, and of course they were promised they could keep it. I won't belabor that point too much, Mr. Lee, but that is one of those promises that is very frustrating.

I know you worked for Secretary Sebelius. Is that accurate? And we hear various numbers of individuals who are now covered with insurance who didn't previously have insurance. That makes me wonder how accurate those numbers are when I hear from constituents who have lost their plans, who had a plan, obviously. And so maybe the constituent who lost her coverage three times, has she been counted three different times as though the plan is wildly successful because she signed up for three different plans on three different occasions, and not by her own choosing?

But I worry that there are fewer choices for consumers out there rather than more choices. I worry that there is less competition. I worry that we have the risk corridor issue that is out there. The assumptions were that there would be a balance between plans losing money and plans making money. That hasn't taken place obviously. The co-ops, I mean, the Nebraska, Iowa CoOpportunity Health was the first co-op to collapse,

120,000 people. I wonder how many times those people have been counted in these numbers we hear tossed around in terms of the number of individuals covered.

We have also seen how many insurers are choosing to pull out of various markets, not just the failure of co-ops, but various markets that insurers are pulling out of.

Mr. White and Mr. Condeluci, how were the bill's drafters and HHS so wrong about the risk corridor program?

Mr. Condeluci. I will jump in to say, when the drafters were drafting the ACA it was well established that the individual market pre-ACA was dysfunctional. So the drafters endeavored to incorporate minimum standards, a guarantee issue which allows access to folks with preexisting conditions, to make the market a much more functional market.

Sadly, as I think has been established by the witnesses here and the discussion today, it is not a functional market. It is functioning, but it is not a functional market, even post-ACA.

But to your question, and the reason why I bring up the drafters, is due to the reforms, the drafters knew that there would be significant disruption in the individual market. So as a result, they created the stabilization programs, the risk corridor, risk adjustment, and reinsurance program.

Risk corridor, the drafters did expect, and I believe, as did HHS expect, that there would indeed be the same amount of carriers asking for a risk corridor payment or making a request for a risk corridor payment due to their losses associated with insuring higher risk individuals, which would be balanced out by carriers that would be insuring younger, healthier individuals. And due to the fact that, as we have established, younger and healthier individuals have not entered the risk pool, the insurance carriers had suffered the losses, and more significant losses compared to insuring those better risks.

Mr. Smith of Nebraska. Okay. Shifting gears just a little bit because of the interest of time here, we now know that the President is calling for a public option. Secretary Clinton is now calling for a public option.

With the wild failure of the co-ops within ObamaCare occurring, I mean, is there any reason we would believe that somehow that would be a better situation? I struggle to think that it would be. I mean, with the Federal backstop that was out there spending gobs of money, taxpayer dollars, to try to prop up these plans, I just fear that we would see a different kind of failure within a public option.

My time has expired. I regret that. But if you would care to respond in writing, perhaps, I would be happy to hear each of your perspective. We have folks on both sides of the issue here. I would love to hear more in terms of what your perspectives are moving forward. Thank you.

Chairman Brady. Thank you.

Mr. Pascrell, you are recognized.

Mr. Pascrell. Thank you, Mr. Chairman.

A couple of points before I ask the question. A, we can't blame, and I don't think any of you are, every problem in healthcare costs on the ACA, I think we have to make that very clear, like we came from a perfect system to an imperfect system. In fact, as I recall, your history shows that regardless of what party you are affiliated with, which is immaterial to me right now, that you were all advocating some changes because the system was broken. It was broken. So that is A.

B, in order to change anything here, whether you are talking about trade, whether you are talking about anything, you need bipartisan support to make a lasting change. We have done that in Medicare, we have done that in Social Security, and we have done it in Medicaid, with very different parties at the helm at the White House. It can be done.

I didn't hear from any of you, through the chair, that we should dump the ACA. Am I mishearing? Before I go on to my next question, is anyone here advocating on the panel getting rid of the ACA altogether as it now is?

Mr. Condeluci. From my perspective, sir, no.

Mr. White. We are not.

Mr. Harte. I am not.

Mr. Lee. No.

Mr. Pascrell. Let's make that clear, Mr. Chairman. Let's make it clear. Very important. Very significant. You not only have good panelists, you have honest panelists. They are dangerous. No question about it.

Mr. Condeluci. If you will indulge me, sir, there are some caveats.

Mr. Pascrell. Of course. You want to have some changes and so do I.

Now, some of you emphasized the unbalanced risk pool. Major problem. How do you get those 18 to 35s into the pool? You can't arrest them and put them into the pool. We need to do something about that. California has, and we will get to that in a second.

So the unbalanced risk. This is something we need to take a look at very, very, very closely. All of you have mentioned other things that are contributing to the cost. There are no two ways about it. How do you track younger, healthier individuals?

And the last point I would make before I ask the question is, the uninsured rate -- Mr. Harte, you mentioned this -- the uninsured rate is falling, but there is an increase in deductibles. That, you said, was one of the main reasons -- many of you said this -- what those deductibles were before the ACA, what the deductibles percentage-wise are now. We need to take a look at that. There is no question. Transparency, you talked about it also.

So I would like to add just one thing, by the way, to the cost, and that is we have a growing emphasis in this society of consolidation and merging. In fact, there was a report out last December about how that is contributing to the higher cost of health care.

So now we have 250 million people that are covered either by their employer, by the ACA, Medicaid, whatever. Have 250,000.

And I want to ask this quick question. Are we simply talking about then, if 85 percent of the people are covered in the ACA, these 20 million people, they get subsidies, are we basically talking about the 15 percent that don't get subsidies? Is that how I understood all of you saying?

Mr. Condeluci. I would offer this, sir, that in the individual market there are about 20 million people. Right now there are about 11.1 million who are enrolled through an exchange, and 85 percent of that 11.1 million are receiving subsidies. So that is 9 million people receiving subsidies.

So you take, let's say, the 9 million people who are not in the exchange, and you can make an argument that that is a population that is experiencing these premium increases without any subsidization, and you hear the stories that you have heard.

Mr. Pascrell. I would be happy, and my last question is this. Mr. Lee, my time has run out, what I like you to discuss, you can't do it now, some of the tactics that Covered California has used to limit out-of-pocket costs. I find them to be very interesting. Perhaps you could share them with your colleagues here and the rest of us in dealing with a very important issue. This is important for everybody.

And, Mr. Chairman, let me conclude by asking how in God's name do we have a panel without the HHS Secretary.

Chairman Brady. Thank you. Ms. Burwell has been invited a number of times to discuss the Affordable Care Act with us, including the shifting of money illegally to fund health insurance companies, which the hearing was last week.

All time has expired.

We will be going to two to one to make sure we can cover all the members here.

So, Mrs. Black, you are recognized.

Mrs. Black. Thank you, Mr. Chairman. I appreciate your having this very important hearing.

The issue of rising premium costs is something that, unfortunately, our constituents are facing every day. I certainly hear it constantly in my district. And across America folks are being forced to choose between paying more for less coverage in smaller networks or just foregoing health insurance altogether. Again, this is what I am hearing in my district continuously.

And it is hard for me to believe that my colleagues across the aisle aren't hearing a very similar story. And if they are not hearing any of this, I am really curious about what is going on in their State that is causing them not to hear from their constituents that the Affordable Care Act has impacted the quality of care, the accessibility, the sustainability of health insurance in this country.

So in my home State of Tennessee, premium rates in the marketplace are expected to increase by 62 percent -- 62 percent in 2017. So for anybody to say, "Well, costs aren't going up, they are being contained," it just amazes me. I expect the Obama administration would tout this as a nonissue, however, since 80 percent of the marketplace enrollees in Tennessee are eligible for subsidies.

But I have to ask, is this how we want our health care system to work, with costs rising astronomically for this mediocre care that is being given, where you can't choose your doctor, you can't choose your facility, you can't choose your specialty? ObamaCare is forcing more and more Americans to accept the government subsidies to afford even the most basic coverage.

Now, I want to read to you very quickly a letter that I just received this week, which is not uncommon to get this kind of letter.

"Hello, Mrs. Black. I am 32 years old. I am a married mother of three. I have no preexisting conditions, I don't smoke, and I live a very healthy lifestyle. Why, then, with the Affordable Care Act, is my insurance company canceling my great low deductible, low premium multibenefit plan next year and forcing me to choose a plan that offers less coverage, triple the deductible, triple out-of-pocket expenses, with a much higher premium?

"Now it will be less expensive for me to pay a yearly tax fine, and I will have to give up my insurance that I have had for 7 years that I am happy with. I am well aware of the so-called tax credit available to people such as myself, but I have paid for my own insurance for many years without the government's help, and if my premiums were to remain reasonable, I wouldn't need a tax credit."

So my question is, is it the role of the government to force people out of the health insurance that they like and that they can afford and they have used for years into a plan that would require taxpayer-funded subsidies to afford the most basic

coverage? Shouldn't we be removing those barriers and mandates to encourage people to actually control their own health care and allow the open markets to keep the plans competitive and affordable and accessible?

Mr. While, I would like to start with you. I know I only have 2 minutes left. So if you could address those.

And then, Mr. Condeluci, and then, Mr. Harte, if you would address those, I would appreciate it.

Mr. White. Yeah, I think the scenario that you outlined in that letter is exactly the scenario that a lot of people are facing in deciding whether or not to enroll in the exchanges. And a lot of those people are saying: No, it doesn't make sense for me financially or otherwise, with or without subsidies.

So CHAC is advocating for market-based reforms that improve flexibility, that create additional options for consumers, using those subsidies on and off the exchanges to create a market for competing for those lives.

Mrs. Black. And it will allow people to get what they want and what they need as opposed to what the government is telling them they want or need.

How about you, Mr. Condeluci?

Mr. Condeluci. As I have suggested, the minimum insurance standards, the adjusted community rating rules, the new rules that came in to make the individual market a much more functional market are driving up cost. That is just the nature of how these reforms have impacted the insurance market.

Mr. Condeluci. I would suggest that insurance carriers be allowed additional flexibility to come up with more creative plan designs, creative plan designs that could be targeted to different cohorts of the population. As I indicated earlier, obviously the young and healthy, but, in addition, folks that have chronic illnesses, like diabetes, heart disease.

If carriers were able to better manage that care, that helps folks across the board from an insurance perspective, but the drafters of the ACA wanting to, let's say, require that everyone have an adequate level of coverage, has, I don't want to use the word "overreached," but it just has increased cost.

And if you pull that back, I am not suggesting that we get rid of the minimum standards or guaranteed issue, for example, which I am a fan of, if you loosen them up, I believe you can reduce premiums.

Mrs. Black. Mr. Harte, you have 15 seconds. I apologize.

Mr. Harte. Thank you.

All I will say to you is, we have to look through a prism of are the decisions that we are making going to make health insurance more affordable? I don't know if it makes you comfortable or uncomfortable, but I deal with the issues of plan changes every single day, and I have to share those changes with thousands of people every year. So you are not alone, and that is what we need to focus on.

Mrs. Black. Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

Mr. Kelly, you are recognized.

Mr. Kelly. Thank you, Chairman.

Thank you all for being here.

I come from the private sector, and I was not here whenever the healthcare law was debated and then passed, but I can tell you as a person who actually provides insurance for the people that I work with, we have seen premiums -- this is for a family, a mom and dad with a couple children -- it has gone from about $800 a month to $1,150 a month. That is the premium.

Now, maybe you all can explain this, because I am just looking at this as a business model right now. When you take in $1 premium and pay out a $1.20 in claims, that is not a sustainable business model. So I think, rather than going after the insurance companies and saying, "Hey, you guys are trying to make money," I mean, if you don't make money, you go out of business, I kind of get that from my life experience, but the copays and the deductibles are also part of health care.

So when I talk to people -- and with ours right now it is $3,000 in deductibles before insurance kicks in -- they have heavy copays. And if you go to the emergency room, that is another charge on top of it. So most of the folks I talk to back home are saying: Yes, I do have insurance, but I don't have coverage until I go past a certain point.

Now, I am understanding some of the people that I represent, some of their increases are going to be 38 to 40 percent. That is what they are going to ask for it. They are not going to get that, but they are going to get something. And then the question comes down to, well, that is not as big of a problem on the premiums because there are going to be subsidies that are going to take care of that.

So Mr. White, Mr. Condeluci, Mr. Harte, Mr. Lee, who is going to pay for the subsidies?

Mr. White. Taxpayers will. And that is the problem, right? We are shifting costs, we are not lowering them. We need some strategies to lower the costs.

The other issue I would say on the deductibles is that only half of Americans have enough liquid assets to meet higher deductibles, according to the Kaiser Family Foundation.

Now, the problem with the ACA exchanges is that in many instances they are masking the availability of account-based plans like health savings accounts. If people knew and were informed that HSAs could help them fill in deductibles on a tax-preferred basis, we might get some help in meeting some of those deductibles.

Unfortunately, we are also seeing some policies come out in the regulatory front that are discouraging the use of HSAs on the exchanges, either healthcare.gov or at the State level.

And so there are tax tools that we can use to help fill in these deductibles. They are just not being employed very effectively.

Mr. Kelly. Mr. Condeluci.

Mr. Condeluci. Briefly, the premium subsidies, as we all know, shield some of the policyholders from the premium increases, and that has been established --

Mr. Kelly. If I can interrupt you one second, though. But the subsidy doesn't change the actual cost.

Mr. Condeluci. It does not.

Mr. Kelly. I think that is the problem, we get into this idea that somehow the subsidy is going to make it okay. Because at the end of the day, somebody still has to pick up the tab on it.

Mr. Condeluci. Right.

Mr. Kelly. The answer is hardworking American taxpayers.

Listen, oftentimes our hearts are willing but our wallets are weak. We are putting such a heavy burden on the private sector right now and the people that provide this, believe me, because I am one of them. I provide that for the people I work with.

See, the sustainable business model is the thing I think we are turning away from. It is not that we don't want to make sure that people have health care.

By the way, we are not talking about sick Republicans, sick Democrats, sick Independents, or sick Libertarians. We are talking about sick Americans that need help. I want to make sure that we don't make it a thing about our parties, but about our people.

So the sustainability of it is where we have to go on this, and that is where I am seeing the disconnect.

Mr. Condeluci. Because as the premiums go up, the government shields those premium increases in the form of higher government spending, which is the form of the of the premium subsidy, that is. So there is a tension between increased premiums, how the subsidy works, and how they shield consumers from those premium increases.

It is not the consumer that has generally experienced that premium increase, instead it is the government, and at a point you might have an unsustainable situation from a spending perspective.

Mr. Kelly. We keep using the term "the government." The government doesn't pick up the tab on anything. The government collects money from hardworking American taxpayers and redeploys it where the government thinks it should go.

So we take the decision out of the individual's hands of how they are going to purchase products, and we say this is how you are going do it, and if it is too steep, we will subsidize it without saying: By the way, you are going to pay for the subsidy.

Mr. Harte, if you could just weigh in. I am almost out of time. But this is critical people understand. This is an unsustainable business model. It has nothing to do with wanting to provide people with health care. It is to the point that it is going to reach that we can't do it and taxpayers can't be burdened every time we want to do something.

Mr. Harte. They simply can't afford it. You are absolutely right. Those subsidies are coming from my business, from my employees, from your employees, and everyone across the country to pay for these taxes.

But you are actually pretty lucky. For someone in your company to have a $3,000 deductible and an $1,100 premium, that is pretty good. Where I come from, where healthcare costs are soaring, we have to pay three times that. We have families who are paying over the Cadillac tax limit already for an average health insurance plan. So you are right, I am concerned just like you, very concerned.

Mr. Kelly. Thank you.

Chairman Brady. Thank you.

Mr. Condeluci. To clarify, Mr. Chairman, my reference to government was taxpayers.

Chairman Brady. Thank you.

Dr. Davis, you are recognized.

Mr. Davis. Thank you very much, Mr. Chairman. And I certainly want to thank our witnesses for being here today.

Mr. Lee, opponents of the Affordable Care Act have been trying any tactic that they can think of to discredit the law or to make consumers look unfavorably on it. One of the red herrings opponents have used is try to make consumers think that the law is unaffordable due to premium increases. It is my recollection that premiums were going up, increasing before the Affordable Care Act. Is that not true?

Mr. Lee. That is definitely true.

Mr. Davis. Now we have, with the ACA, what I would call a pretty significant improvement. For example, consumers are guaranteed critical protections when they purchase insurance, limits on rating based on age, requirements insurers must spend a certain amount on care. And also State officials have stronger tools to review unreasonable rate increases, along with transparency, so that the public knows which insurers are jacking up prices and why.

Could you comment on this environment?

Mr. Lee. Yeah. The main comment is that it is absolutely the case that the post-Affordable Care Act insurance marketplace is a reformed but still imperfect marketplace, but it is in a marketplace now where insurers have to compete on price to get consumers who cannot be turned away. It is a different marketplace, and there is transparency. And many consumers -- not all -- have many choices that they can exercise to make that marketplace work.

It is also the case, if I may, that many of the problems we are hearing about are not Affordable Care Act problems. They are health care in America problems. Issues of rising healthcare costs, as we heard from Mr. Harte, of rising costs of up to 30 percent on people's employer-based care. This is the range of what small businesses, large businesses, individuals are facing that we all need to get our arms around.

Mr. Davis. While we laud the California experience, Illinois hasn't done too badly itself, the State that I come from. What caused California to be able to accomplish what we all know and believe it has accomplished?

Mr. Lee. I think, well, first, I want to be very clear, there have been a number of States that have been very effective in implementing the Affordable Care Act. You can look at the State of Connecticut, you can look at Illinois, you can look at Washington. There are a lot of States.

The thing that they have in common is -- and I know this is a hard thing to say in this environment -- but they put politics to the side. And in California, our working has been with Republican members of our State legislature, have been with every single district elected office, it is with people who have said this is the law now, let's make it work.

And so the issue of having effective outreach and education. I have said this a couple of times, but health insurance doesn't sell itself. And we are out there spending a lot of money because people that need to sign up for health insurance say: Maybe I don't want to.

The ones we need to convince most are the ones who need it the least who will benefit the risk pool, which requires ongoing, very significant marketing, outreach, partnerships with agents, et cetera. And that is something that the States that have been most successful have consistently leaned in on those outreach efforts.

Because those people that get subsidies, which in California is about a million, and there are about a million people in the individual market without subsidies, those nonsubsidized people benefit from the people who get subsidies because they are part of the better risk pool, they are part of keeping premiums down for everybody.

So it really is a win-win when we get subsidized people in to help keep the premiums down for those even that don't have subsidies.

Mr. Davis. Thank you very much. And I think that was part of the intent from the beginning that many people discount. I think the reality is that it is working much better than many people would have us believe.

I thank you, Mr. Chairman, and yield back the balance of my time.

Chairman Brady. Thank you, Doctor.

Mr. Renacci, you are recognized.

Mr. Renacci. Thank you, Mr. Chairman.

And I want to thank the witnesses for being here with us here today and presenting the information. This hearing is really extremely important, and I appreciate your expertise.

I, like one of my earlier colleagues, believe that when those that voted for the Affordable Care Act, they sincerely believed they were helping. Let's face it, I am sure that was their thought process when they voted for it. But it is disingenuous today to ignore the fact that there are problems.

Unfortunately, since the passage of the Affordable Care Act the access to affordable care has significantly dropped. There is no denying that since the ACA premiums are rising, deductibles are rising, and many people can no longer afford their healthcare plans. And we are hearing the proposed rate filings for 2017 on the Federal marketplace are projected to increase a median of 19 percent.

I go back in my district and I have meetings with employees. Every time I meet with an employer, I want to meet with the employees. I ask the same question: Are you happy

with the Affordable Care Act? Are costs okay? How are things going? I am going to have to bring some of my colleagues from the other side with me because I get very few people put up their hand and say they like it.

Now, some people do. I am not going to lie and say it is not 100 percent. But it is a very, very small portion of the people in the crowd, and I am talking about hundreds and hundreds of people. So I always ask them a question: Tell me what tissues are. Tell me what the problems are. I try and learn from it.

Look, no law passed is going to be 100 percent perfect. But I go back to my colleague last year, John Carney. He tried to pass H.R. 4414, which was a fix to the Affordable Care Act, and we got that passed. The sad thing was that the majority of Democrats, over 133 Democrats, even came to the floor and said: We can't change anything because if we change it, we are going to open up the doors to changing more things.

So 133 people even voted against a simple change, ignoring the fact that there are problems, and those are the things we have to fix. Just last month, in my home State of over Ohio, we had the 13th co-op, InHealth Mutual, announced it was going out of business. This was 1 of 23 co-ops created under the ACA, had received 129 million in taxpayer funds, had left nearly 22,000 Ohioans with fewer choices and, unfortunately, once again, searching for new health insurance.

So again, we know there are problems out there. We can say we don't, we can talk about how great the Affordable Care Act, it has problems, and we have to start looking at those problems.

I have had people in my district, Brian from Westlake, saying he has lost his choices. I have another constituent, Scott from Dalton, saying his plan jumped from $314 in 2013 to $920 in 2016. He simply couldn't afford to continue with this plan and he had to go to a higher deductible. I had another individual, John, a registered Democrat from Brewster, who said he now calls the ACA the Unaffordable Care Act. So these are real people, real lives, real things affected.

But the saddest story I ever had was a woman walking up to me at a restaurant saying: Congressman, I just had my hours reduced to 29 hours, and now my premiums are going up and I have a deductible I can't afford. Help me. That was the saddest moment when it came to the Affordable Care Act -- help me -- and that is what we need to do.

So I want to talk a little bit about this deductible, because we have talked about premiums. Nobody can argue that premiums are going up. They are going up. Everybody knows that. They are going up again this year. But we are getting people insurance, and I have an individual in my district who has fully subsidized insurance, but came to me and said: Congressman, thank you for allowing me to get insurance.

I said: Well, I wasn't part of the vote for the Affordable Care Act. But she says: I can't use it anyway because I have a $6,000 deductible that I now can't use. The insurance is worthless for me. I need surgery, and I can't get it done because I can't afford that.

Mr. White, can you talk a little bit about the deductibility, how this deductibility is affecting people and the size of it and how that hurts people getting health insurance?

Mr. White. It is massive, and it is not just the deductibles. So the deductibles are increasing on average by about 20 percent, or they increased 20 percent this year. So the average Silver plan has about a $3,000 deductible, the average Bronze plan has about a $6,000 deductible, but $10,000, $12,000 deductibles are not uncommon.

And the reason these deductibles are at that level is that it allows the insurer to lower the price point, the premium rate that they sell on the exchange. A lot of consumers will shop for a plan based on the premium, not necessarily the deductible.

Mr. Renacci. So you would agree that, because of the Affordable Care Act and because premiums are going up, the only way to reduce the premiums is to raise the deductible, which in the end, who pays? The American people.

Mr. White. The consumer, absolutely. And it is not good, because, as you indicated, when you have these massive deductibles, you are not accessing care. So you are not getting maybe the diabetes care, the coach management, the preventive care, the well baby care, the things that you really need to stay out of the hospital, out of expensive settings. It is unsustainable over the long term.

Mr. Renacci. Thank you, Mr. Chairman. I yield back.

Chairman Brady. Thank you.

A vote has been called. We would like to finish with Mr. Meehan and Mr. Holding.

Mr. Meehan, you are recognized.

Mr. Meehan. Thank you, Mr. Chairman.

I just want to say at the outset, just to comment, I know some of the commentary from the other side of the aisle regarding that part of the problem is that insurers are miscalculating. We sat here last week and listened to the design of a plan in which over $7 billion was illegally transferred to the insurance companies and still not capable of holding down these costs. That was what the record demonstrated.

But I want to follow up on Mr. Renacci's questions with the panel because it is really going to the issue. We hear a lot about people saying we have more people insured. What I am seeing in mid district are the underinsured. These are people who are

working, who have been watching the explosion of the various factors. You named them. It is the copays, the higher premiums.

And the biggest problem is, just like many seniors now split their medications by taking half and do away with the effect, we are having people that won't use health care at certain times, and situations are getting worse.

Mr. White, I went back through the written testimony of each of you. I was very impressed with lots of it. You had some things to say about the special enrollment periods influencing this, Mr. White. And can you tell me about what you see as the reforms in the special enrollment periods quickly, if you can, and whether what the administration is currently doing is going to be sufficient to impact that?

Mr. White. I am not sure what the administration is doing is sufficient. I think what needs to be done is that you need to clamp down on some of the abuses that are taking place because of the special enrollment periods. People are jumping into and out of these risk pools, gaming the system in effect, and the enforcement is not rigorous enough to prevent that type of gaming.

So having prospective eligibility is probably -- let me put it this way. I think you don't automatically get the person in the plan until you can verify that they actually meet the requirements of the special enrollment period, and then you can make their coverage retroactive to cover the claims expenses. You don't just do that at the outset, though.

Mr. Meehan. You think it was a rush, so to speak, just to get numbers, but they are not appropriately overseeing the entrance into the program?

Mr. White. Yeah. It was a big problem. I think there were 40-some-odd special enrollment periods. One insurer that we work with quite a bit in our coalition said it, added about 3 percent to the premium that they have got to carry into next year. So this is a real impact on people.

Mr. Meehan. Thank you.

And, Mr. Harte, you spent some time, you laid out a number of things, but again, I go back to the issue of the uninsured. And this was the point that was being made, I think so eloquently, by my colleague Mr. Renacci.

I am watching in Pennsylvania, 21 percent reported that deductibles and 18 percent reported that premiums were their greatest financial challenge. So we are seeing that these are the things that are impacting people. The rate of uninsured is going down, but the costs associated with those that have it is skyrocketing.

So what combination of reform should be advanced to address the challenges of individuals and families with insurance? They have insurance, but they can't afford health care. What would you recommend?

Mr. Harte. So if I can first say, my clients, when I sit down with them and they are faced with a 29 percent rate increase, as I testified to earlier, my job with that client is to say: What can we do to cut costs?

So the first thing we have to look at is: Okay, you have a $3,000 deductible today, how much can we save to go to a $4,000 deductible? And that is about 10 percent. And then we say: What is it going to take you to go to a $5,000 deductible? It might be another 5 percent.

And then we start looking at the prescription drug costs, and the traditional drug plan would be $10 for generic and $25 or $40 for brand name. Today, the health insurance companies have moved away from that entire equation, especially for small employers, and told the employees that they insure: Well, you are now going to pay a percentage of the brand name prescription cost.

Now, this is New England, okay, but it is happening all over the country. Now they are having to pay 30, 40, 50 percent of the monthly cost of that prescription up to a monthly cost share of $500. That is significant.

So when you talk about the underinsured, we are not just talking about access to doctor's office visits or primary care, specialty care, physical therapy, emergency rooms, hospitalization, it is the entire healthcare equation that people are underinsured.

So the question is, what can we do, that is your final question. As I said earlier, health insurance is expensive because health care is expensive. And as much as we talk about the Affordable Care Act and that the issue is all about health insurance or health insurance companies, it is really a financing mechanism.

When you look at health insurance, we are taking 80 to 85 percent of that money and paying for healthcare expenses. So the reason why health insurance premiums continue to escalate at such an alarming rate is because healthcare costs continue to soar out of control.

Mr. Meehan. Thank you, Mr. Harte.

Thank you.

Chairman Brady. Thank you.

Mr. Holding, you are recognized.

Mr. Holding. Thank you, Mr. Chairman.

First, I would like to give a little state of play in North Carolina. Our largest insurer in the State has been approved for an average rate increase of 25 percent in 2015 and 34 percent in 2016 and 18 percent in 2017. But even with these consistent double-digit

rate increases, BlueCross BlueShield, the insurer I reference, has lost over $400 million in the last 2 years.

And even though they have been given these rate increases, yeah, it doesn't ensure that they are going to stay and continue to offer plans throughout North Carolina. And we are looking at a potential situation where 60 out of our 100 counties might be left without a single ACA plan offered.

I would like to pick up where Mr. Smith from Kansas left off. You hear this argument that, well, the public option, if that is put in place, it cures all these problems.

Mr. White, could you address the public option and whether or not it would cure the ills that we see with the ACA as it exists today?

Mr. White. I think the public option is a bad option. I think that it is government coming in to promote competition in a market in which they have basically evaporated competition.

So this is a problem that was caused by government inflexibility that made insurers leave the market. They are losing money. We are seeing it in co-ops. We are seeing it in North Carolina. We are seeing it in other markets across the country.

So the proposed solution is let's have the government run a plan in that marketplace so that people have choices. Well, they had choices before, right? So how do we flex up the market, how do we create a competitive environment so that the insurers will want to go back in? Tennessee had a very significant experience in this in the Medicaid market.

I mean, like, this isn't necessarily rocket science. We ought to let the market operate in a way that fosters competition and an environment to offer products.

Mr. Holding. Thank you.

Mr. Chairman, in the interest of time, I will yield back so that we are not late for our vote.

Chairman Brady. You are kind, Mr. Holding. Thank you very much.

I would like to thank our witnesses for appearing before us today. Please be advised, members have 2 weeks to submit written questions to be answered later in writing, and those questions and your answers will be made part of the formal hearing record.

Chairman Brady. With that, the committee stands adjourned. Thank you.

[Whereupon, at 12:32 p.m., the committee was adjourned.]

Member Submissions for the Record

Questions for the Record

Public Submissions for the Record