United States House of Representatives
Committee on Ways and Means
"Hearing on Rising Health Insurance Premiums Under the Affordable Care Act"
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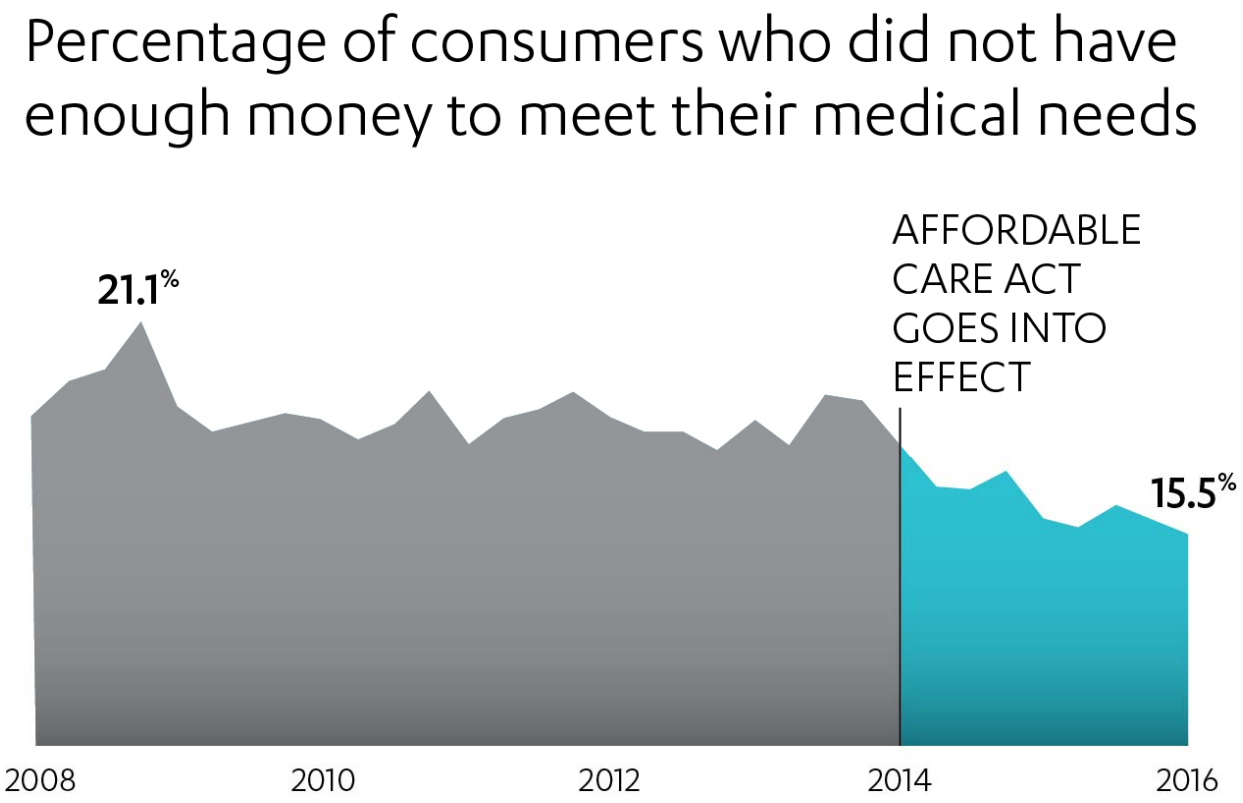
Good morning, Chairman Brady, Ranking Member Levin and distinguished members of the committee. My name is Peter V. Lee, and I serve as the executive director of Covered California. It is an honor for me to be here in Washington, D.C., before this committee, to speak with you about how the Affordable Care Act is working across the nation, specifically in California, and taking a look at the facts about potential changes to health insurance premiums in 2017.

Let me begin by saying that the federal Patient Protection and Affordable Care Act created a historic new era of health care that is working for millions of people in our country on numerous different levels. At the end of the most recent open-enrollment period, the Centers for Medicaid and Medicare Services (CMS) announced that 20 million people had been covered either through a Qualified Health Plan on a marketplace or through expanded Medicaid.[1]

Nationally the Centers for Disease Control and Prevention reported that the share of Americans of all ages who are uninsured had fallen to 9.1 percent by the end of 2015[2], down from 14.4 percent at the end of 2013. Last month, the Gallup-Healthways Well-Being Index reported that the number of Americans who reported not having enough

[1] Health and Human Services - http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates
[2] Centers for Disease Control and Prevention - http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf

money in the past 12 months to pay for necessary health care and/or medicines for themselves or their families had fallen to its lowest level on record.[3]



Source: Gallup-Healthways Well-Being Index

While these figures are impressive and provide a clear demonstration that the Affordable Care Act is working on many fronts, they also underscore the high cost of medical care continues to mean many Americans are struggling to afford the care they need. There are, however, several other important impacts on consumers across the nation and things we need to consider when looking at future rate changes.

Prior to the Affordable Care Act, consumers in the individual market regularly saw double-digit rate increases on an annual basis. According to the U.S. Department of Health and Human Services (HHS):

> *"Before the enactment of the Affordable Care Act, annual premium increases in the individual market were highly variable and increases often averaged 10*

[3] Gallup-Healthways Well-Being Index: http://www.gallup.com/poll/192914/healthcare-insecurity-record-low.aspx?g_source=CATEGORY_WELLBEING&g_medium=topic&g_campaign=tiles

> *percent or more at the state-level. From 2008 to 2010, the average annual rates of premium increases in the individual market ranged from 9.9 percent to 11.7 percent. In 2010, many increases were in the range of 9 percent to 15 percent, but a full quarter of issuers increased premiums by 15 percent or more. The average annual state-level increase was 10 percent or higher."*[4]

The HHS report revealed that once the Affordable Care Act was enacted, the new law had an immediate impact on the average rate changes in the individual market, which has saved consumers millions of dollars in health care premiums:

> *"Average rate increases in the individual market moderated to 7.0 percent in 2011 and 7.1 percent in 2012. The average rate increase was 10.3 percent in 2013, but would have been 8.7 percent if the high increases in one outlier state were excluded. This report shows that rate increases have remained moderate since 2013. The average rate increase in the individual market was 2.4 percent in 2014 and 6.9 percent in 2015."*

In addition to the double-digit rate changes prior to the Affordable Care Act, it's important to note that many consumers were essentially trapped into paying whatever increased costs were passed on by their health plan, because the health care system did not provide them with the protections, tools and transparency they needed to make well-informed choices about their coverage and they did not have the true power consumers need — the power to shop for a better value.

All that has changed now. Consumers are no longer locked into their health plan. Thanks to the Affordable Care Act, consumers have the ability to shop for the plan that best fits their needs and their pocketbooks. Data from CMS shows that of the 5.6 million people who actively renewed their coverage through the federal marketplace for 2016, 43 percent or 2.4 million people switched plans.[5]

This is key because the Affordable Care Act created a competitive market where the consumer is now in the driver's seat. Not only must insurers take all consumers, regardless of health status, the new reality is that consumers who face rate changes, which can vary from very little to substantial, can shop around for the best deal. The Affordable Care Act is designed to make the consumer the winner because they have the power to choose and they are receiving a product that is there when they need care.

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[4] U.S. Department of Health and Human Services - https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf

[5] Centers for Medicare and Medicaid Services - https://blog.cms.gov/2016/02/05/open-enrollment-trends-selected-healthcare-gov-statistics-prior-to-the-final-enrollment-deadline/

When we talk about rate changes, we need to focus on this reality. Insurance carriers who raise their rates do so at their own peril and risk losing customers because the consumer is now in control. The Affordable Care Act created a competitive market, where there will be winners and losers among insurers, depending on how those companies price their products.

To put the power of choice into context, in 2016 the average rate increase for Covered California consumers who decided to stay in their prior plan was about 4 percent, while renewing consumers could reduce the cost of their existing premium by an average of 4.5 percent if they shopped around and switched to the lowest-cost plan in the same metal tier. A total of 14 percent of Covered California's returning consumers ultimately made the decision to switch plans prior to the 2016 coverage year. We attribute the reason that this figure is so much lower than the national average to the fact that California's rate change for 2016 was substantially lower than those seen in most states across the nation. But the same dynamic is in play throughout the nation — consumers now have the freedom to choose and are shopping to get the best value.

Giving consumers the ability to understand their plans and options, which they could not have prior to the Affordable Care Act, is bringing market forces to bear and promoting choice and competition. This is a competitive market that works, and consumers are holding our health insurance carriers accountable for their rates by carefully examining their costs and choices.

2017 Will Be a Transition Year for the Individual Market

Looking ahead to the next year, we have known for some time that 2017 will be a transitional year for premium rates across the nation. There are four primary factors behind why rates may see significant adjustments than those we have seen in recent years:

- *The end of the federal reinsurance program*

The main factor driving these rate changes is the end of the temporary federal reinsurance program, which was designed to help keep rates down during the first three years of the exchanges. The program assessed a fee on all health insurance payers and distributed the proceeds to carriers with non-group enrollees who had enrollees with high medical expenses.

The reinsurance program succeeded in moderating health premiums and keeping rate increases lower than they would have been otherwise, which has helped attract more consumers to help build a healthy risk mix, while also stabilizing the marketplace by

providing a measure of certainty for health insurance carriers. The impact on rates has been most important for the millions of Americans who benefit from the competitive market for individual insurance, but do not benefit from the premium tax credit that has made health insurance affordable for the first time to so many. An independent analysis from the American Academy of Actuaries estimates the end of this program will cause a one-time adjustment that will add between 4 and 7 percent to this year's rate change.[6]

In addition to the end of the reinsurance program, 2016 also marks the last year of the risk corridor program, although most experts believe this will have little impact on most plans. The third of the "Three R's" — risk adjustment — will continue as a permanent program and provides a critical tool to move health plans away from believing the path to profitability is avoiding less healthy consumers. Finally, for 2017, insurance companies will have a one-year moratorium on the health insurer fee as a result of legislation approved by Congress at the end of 2015, which will have a one-year positive impact on premiums of about 1 to 3 percent.[7]

- *Adjustments for mispricing*

While pricing has not been a major issue in California, it has had an impact across the nation. We must remember that the Affordable Care Act brought millions of new consumers into the health insurance industry and carriers did not have any data on these new consumers. Consequently, insurers were forced to provide their best estimates when setting rates. While some carriers got it right and have been able to keep rates stable, others have experienced a wide fluctuation in cost. This problem has been particularly problematic in those states that did not transition the individual market to one common risk pool in 2014 — and will be finishing that transition in 2017 and 2018.

In addition, carriers now have two full years of data on the costs and health status of consumers who signed up for coverage during a special-enrollment period (SEP). Some carriers have identified concerns about whether some who have enrolled during SEP may not actually be eligible, causing unforeseen impacts to their health care costs. These issues will be mitigated in the future thanks to new guidelines and processes being implemented at both the federal and state level. New policies will ensure that only consumers eligible for SEP are allowed to sign up for coverage outside of the regular open-enrollment period.

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[6] American Academy of Actuaries - http://www.actuary.org/files/publications/IB.Drivers5.15.pdf
[7] American Academy of Actuaries - http://www.actuary.org/content/drivers-2017-health-insurance-premium-changes-0

- *Rising trend in health care costs*

Unlike the two items above, which are expected to be either one-time adjustments or corrected by newly implemented policies, the rising trend of health care costs remains a constant driving factor in health care premiums. "Trend" refers to the carrier's estimate of how health care costs will change in the coming year. Gary Claxton and Larry Levitt of The Henry J. Kaiser Family Foundation recently stated that while trend has been relatively low in recent years:

> *"Insurers have been warning that cost pressures are increasing and there has been some suggestion that trend may be a little higher in 2017 than last year. From looking at a handful of early rate filings, low end projections are in the 3 to 5 percent range while some insurers are projecting trend of 7 to over 9 percent."*[8]

Part of that "trend" is the ongoing increase in the cost of specialty drugs. A new report by Health Affairs shows that:

> *"The proportion of specialty prescription drugs (defined as those reimbursed at $600 or more per thirty-day fill) nearly quadrupled. Over this time period, fills for specialty drugs increased by 198 percent and spending for the drugs increased by 292 percent."*[9]

In addition, a recent report by Express Scripts[10] found that, "despite being used by only 1 to 2 percent of the population, specialty medications accounted for 37 percent of U.S. drug spend in 2015 and are projected to reach 50 percent by 2018. Spending on specialty medications increased 17.8 percent in 2015."

It's important to note that the high cost of "trend" and specialty drugs is not an "Affordable Care Act problem", rather it is a "health care in America problem", and one we believe needs focused attention by purchasers, health plans, consumers and policy makers.

- *Competition matters*

Finally, in order for rates to remain moderate, exchanges need a competitive market where carriers are forced to jockey for consumers by offering the best combination of price, network and products. A number of markets around the nation did not have

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[8] Kaiser Family Foundation - http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/#footnote-187632-5
[9] Health Affairs - http://content.healthaffairs.org/content/35/7/1241.abstract
[10] Express Scripts - http://lab.express-scripts.com/lab/drug-trend-report

competition prior to the Affordable Care Act — either among insurers or among health care providers — and they are still struggling today to increase choice in their markets. In California, we have more plans competing for consumers, they want to be in our market and they are aggressively pricing their products to attract as many consumers as possible. Exchanges that can address this issue by increasing choice will benefit consumers, because competition drives pricing.

Covered California is Using all the Tools of the Affordable Care Act

There is no question that the Affordable Care Act is having a positive impact on millions of Americans. There is also no question that implementing a law as big and as complex as this will take years and will not occur without variation across the nation, bumps along the way and lessons learned that can and should be used to improve upon the law going forward. This landmark legislation is about building a market that works for consumers and changing health care costs over the long-term. Let me tell you about where Covered California stands now and how we are seeking to use the tools of the Affordable Care Act and our state's enacting legislation to truly make a competitive market and build for a long-term future of health care affordability.

- *California Embraced the Affordable Care Act*

Following the passage of the federal Patient Protection and Affordable Care Act in 2010, California's then Governor Arnold Schwarzenegger and our Legislature created the California Health Benefit Exchange, the first state exchange under the new law. Since then, under the leadership of Governor Jerry Brown and a new Legislature, California adopted the Affordable Care Act's provisions to expand the state's Medi-Cal program.

Covered California's Board also adopted a policy that would be the driving force behind our creation of a competitive marketplace. While many other state exchanges and the federal marketplace sell any carrier that is compliant with the Affordable Care Act, Covered California actively works to create a market for consumers and carriers must compete to be a part of our exchange.

- *Building a Competitive Market*

Covered California puts every health insurance company that wants to be a part of the exchange through a rigorous review. Our health insurance carriers must meet high standards of quality, affordability and accountability as they compete in the marketplace. We do not take all-comers and if a carrier does not meet these standards, we will turn them away.

After choosing which plans will participate in the exchange, Covered California vigorously negotiates the premiums they can charge. For the 2015 individual market, Covered California negotiated a weighted average change of 4.2 percent. Covered California does not negotiate by table-pounding, but rather by providing good data on the risk mix of who is enrolled and working the health plans to garner maximum enrollment. In 2015, we provided data that proved Covered California enrollees were healthier and presented less risk to insurance companies than anticipated, which helped drive down the cost of health premiums. Covered California enrollees saved an estimated $100 million in premiums because of this innovative use of information.

In 2016, the average weighted change was just 4 percent, but as I noted earlier, consumers could reduce the cost of their existing premium in 2016 by an average of 4.5 percent if they shopped around and switched to the lowest-cost plan in the same metal tier. Again, we used data that proved we had a good risk mix to negotiate a better deal with the health insurance companies and save consumers approximately $200 million in premiums.

Providing data has been an important component to helping health plans “price-right,” but just as important has been the consumer-centric market dynamic, which means health plans know that they will lose enrollment if they price too high and the market discipline of knowing they will lose money if they price too low. We want “Goldilocks pricing” — health plans having the lowest possible price that will support covering all the medical costs that will be incurred by those enrolled in the individual market.

Covered California is currently wrapping up negotiations for its 2017 rates. As we have seen across the nation, and for the reasons listed previously, we expect our rates to be higher than we saw in our first two years. At the end of this week we will finish our negotiations and our health plans will submit their rates to regulators — and then be subject to regulatory review, as is the case across the nation. We will announce these preliminary results next week.

It is important to remember that the rates and benefits Covered California negotiates apply to the coverage our health insurance carriers offer in the off-exchange individual market as well. This means that an estimated 900,000 Californians, who are not in Covered California, receive the benefit of our work to expand the insurance pool, negotiating with health plans and our patient-centered benefit designs.

Our negotiated rates also help the tens of millions of Californians with employer-based coverage in two ways. First, by lowering the number of uninsured — we are reducing the cost shift to employers and their employees from hospitals and other providers

needing to make up their uncompensated care in commercial premiums. Second, all Californians now know that if they lose employer-based coverage, they will have affordable insurance available to them.

Currently we have 12 plans serving the state, including some of the biggest names in the health insurance industry, along with well-known regional entities and carriers that focus on California's Medi-Cal population. Covered California has 19 rating regions across the state and many of those regions are bigger than other states in the country. Currently each region has between three and six plans serving consumers.

- *Patient-Centered Benefit Design*

Covered California also has put consumers first by developing a patient-centered benefit design, which standardizes what our health plans offer to provide comparable set of designs that are all geared around promoting ways for consumers to get the right care at the right time. By working with health plans, clinicians, consumer advocates and others to both design and continually update these plans, California has made it far easier for consumers to compare plans both inside Covered California and in the broader individual and small group markets, without having to navigate incomprehensible variations in designs.

The plans are specifically designed to reduce the number of services that are subject to a deductible, thus increasing a consumer's access to care. For example, every outpatient service in our Silver, Gold and Platinum plans can be accessed without being subject to the consumer's deductible. That includes primary care visits, specialist visits, lab tests, X-rays and imaging. Some of our enhanced, subsidized Silver plans have little or no deductible and very low co-pays, such as a $3 office visit. Even our most affordable plans in the Bronze tier promote care, allows consumers to see their doctor or a specialist three times before being subject to the deductible. With all of the discussion about "high deductibles" — Covered California has sought to turn the attention to look beyond just the size of the deductible, but also to what is or is not subject to the deductible.

By offering standardized products, Covered California is providing consumers better options, even if these options are fewer in number. Looking across the nation, in most areas health plans have decided to offer four different "silver products" and about one-third of the silver products offered nationally in 2016 require consumers to meet their deductible prior to having any doctor visit fully covered. Many of those products with the cheapest premiums mean you do not get any coverage unless you have satisfied a deductible of several thousand dollars. We believe that is a recipe for promoting a bad

risk mix — since many consumers will not see the value of their health insurance and will be more likely to drop coverage.

Other ways Covered Californian seeks to be both innovative and patient-centered can be seen in our coverage of specialty drugs. We are the first health exchange in the country to institute a specialty drug cap to partially protect our enrollees from these rising costs. We wanted to make sure that our consumers have access to the medications they need, including those used to treat HIV, AIDS, Diabetes and Hepatitis C. The vast majority of Covered California consumers have had their specialty drugs capped at $250 per month, per prescription. Overall, the caps will range from $150 to $500, and because of Covered California's patient-centered benefit design, they must be offered by every health plan in the individual market, and in all plans offered by the exchange.

All of these benefits are designed to bring health care within reach and to make sure that a Covered California plan is not just an insurance card, but something that opens the door to health care and helps consumers get the services they need and deserve.

By requiring all carriers to have patient-centered benefit designs for each metal tier, carriers are required to compete with one another based on premium, network, quality, and consumer tools and service. For 2017, the Federally Facilitated Marketplace is encouraging plans it offers to provide at least one common patient-centered design for their consumers. This will help consumers more easily compare plans to make it easier for them to see what services are subject to a deductible and which ones are not.

Getting benefit designs right, however, is not just an issue for state and federal marketplaces and its significance goes beyond "just" encouraging consumers to get care when they need it. Earlier this year I co-authored an article with Dr. Elliott Fisher from Dartmouth College, where we urged state-based marketplaces, the employer-sponsored insurance market and health insurance companies to take action and move towards these patient-centered plan designs as needed complements to payment changes, seeking to promote better care coordination and effective primary care.

Covered California's competitive marketplace and patient-centered design model helped it receive the highest overall grade from the National Health Council in its "State Progress Reports" which examined which exchanges were "beneficial for patients." The report stated Covered California:

> *"Has led other states in its efforts to improve the comparability of exchange plans. Key protections in the state include the standardized benefit designs across all metal levels, including the cost-sharing reduction versions of Silver*

plans that are available to people with limited income. The state does not allow any non-standard plans in the exchange, which is unique among states with standardized plans. These requirements mean that all people enrolled in the same metal level plan in the state encounter the same cost sharing for the same benefits; in effect, it levels the playing field."[11]

- *Expanded Medicaid*

California expanded its version of Medicaid, known as Medi-Cal. This critical decision opened the door to no-cost or low-cost health insurance for millions of low-income Californians.

- *Unified Risk Pool*

Covered California also made the tough decision to eliminate transition plans in our first year. While this move was unpopular in some circles, it was the right thing to do for the majority of our consumers because it unified our pool of consumers and gave our carriers more certainty as we embarked on this new era.

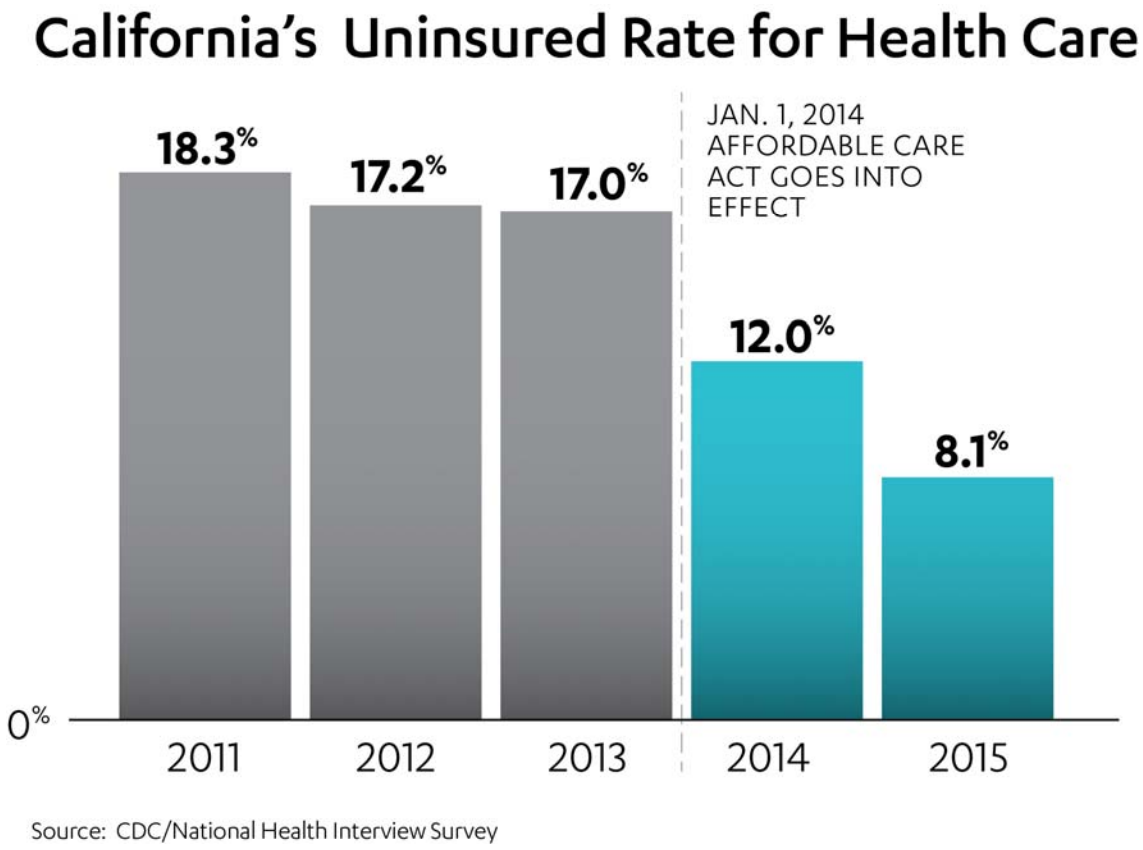
Taken all together, Covered California has created a cycle of sustainability by building a competitive market where consumers have a wide choice of carriers with plans that promote care by removing financial barriers and benefits that attract consumers.

Covered California is Working and Building a Competitive Market

Since we opened our doors in January of 2014 more than 2.5 million people have signed up for health care coverage through Covered California. These are people who either had no health insurance previously because they could not afford the coverage or were refused coverage because of a pre-existing condition, or they may have found themselves without coverage because of a change in their jobs or life conditions.

The latest data from the Centers for Disease Control and Prevention shows that since Covered California began offering coverage in 2014, the uninsured rate in the state for all ages has been cut by more than half, from 17 percent at the end of 2013 to 8.1 percent by the end of 2015. This 52 percent drop puts California's uninsured rate at the lowest level on record.

[11] National Health Council - http://www.nationalhealthcouncil.org/sites/default/files/Enhancing-State-Health-Insurance-Markets.pdf



Covered California Continues to Enroll a Healthy and Diverse Mix of Consumers

Covered California's success is firmly rooted in the hundreds of thousands of consumers we have helped obtain quality and affordable health care coverage, who have enrolled because they understand the benefits of their coverage, who get tax credits that bring health care within reach and are the product of a broad multi-faceted marketing, outreach and education campaigns across California. As of May 2016, Covered California had 1.4 million consumers actively enrolled in a plan participating in our health exchange.

The mix of consumers we have continues to be young, healthy and diverse. During our third open-enrollment period (OE3), from Nov. 1, 2015 to Jan. 31, 2016, more than 439,000 people signed up for coverage and Covered California saw strong enrollment in many key demographics, particularly among Latinos, African-Americans and Asian/Pacific Islander consumers.

The breakdown below shows how Covered California hit nearly all of the marks estimated by the University of California's statistical model (CalSIM 1.91) of California's subsidy-eligible population.

	Open Enrollment 3	CalSIM 1.91
Latino	36%	38%
Caucasian	34%	34%
Asian/Pacific Islander	20%	21%
African-American	4%	5%

Covered California's enrollees also got younger during our third open-enrollment period. The percentage of consumers between the ages of 18 and 34 who signed up for coverage was 29 percent during our first open enrollment period, 34 percent in our second open-enrollment period and 38 percent during our most recent open-enrollment period.

Even more importantly, a new CMS report showed that California had the lowest average risk liability score in the country, 19 percent lower than the national average, which means Covered California's enrollees are among our nation's healthiest. [12]

This healthy risk mix is an essential key to helping keep rate changes moderate. As we noted previously, data on California's healthy risk mix played a significant role in helping Covered California negotiate the best premium rates for its consumers and save a total of more than $300 million dollars in premiums over the past two years.

The healthy risk mix is not an accident. The risk mix and its impact on rates for all Californians is the product of Covered California making significant investments in marketing, outreach, consumer enrollment experiences and customer service over the past four years. We are just now starting our 2016-17 fiscal year which will be the first in which we will not be spending any of the federal establishment funds that were so important to our launch. This coming year, we have a $320 million budget, which includes almost $100 million for marketing and outreach, with additional substantial investments in improving our customer service and our website.

Covered California will continue to conduct extensive marketing, in multiple languages, in all corners of our state, on television, radio, print, and digital platforms to effectively reach potential consumers and support the retention of those consumers. This includes

[12] Centers for Medicare and Medicaid Services - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html

conveying the value of coverage, supporting informed choice, enrollment and education, as well as working with the agent community and consumer groups to promote enrollment and helping consumers use their care once they get covered.

For this year, we will fund our budget from our assessment on health plans and spending a portion of the over $278 million reserve we have built up since 2014. In our next fiscal year, we project to be break-even and to continue operating with a prudent surplus and a strong balance sheet.

Our assessment on health plans is based on 4 percent of premium for “on-exchange enrollment,” which because of the large off-exchange enrollment in our products — at the exact same price — means that the actual increase to premiums is about 2 percent. Based on work done by Price Waterhouse Coopers, we estimate that compared to the cost of acquiring individuals prior to the Affordable Care Act, Covered California has been part of reducing the “load” on premium from about 7.8 percent to about 5.8 percent — a reduction of 2 percent. But as important as this reduction is, even more important is the need to make continued ongoing investments to assure enrollment.

Covered California has surveyed consumers who have left the exchange and the vast majority transitioned to another source of coverage — with the biggest portion moving to employer-based coverage. Our marketplace, along with the federal and other state-based marketplaces, is serving as the glue that helps make the employer-based, individual and public insurance offerings work. This reality, however, means that the need to do robust marketing and enrollment is ongoing. With about half of our enrollees turning over each year to get another form of coverage, continued efforts are critical to maintaining a healthy risk pool and providing that safe and affordable way station for millions of Americans.

Reducing Health Care Costs by Improving the Delivery System

While assuring a good risk mix is an imperative for any marketplace, moving forward, Covered California is also focusing with the plans it contracts with on the underlying issues driving health care premiums that are the cost and use of health care. Premiums are a reflection of what health care costs and how it is delivered.

Right now the U.S. spends more on healthcare per capita than any other nation.[13] Instead of moving forward, insurance providers are cutting back, reducing benefits and increasing the share that consumers and employees must pay.

[13] Organisation for Economic Cooperation and Development - http://www.oecd-ilibrary.org/social-issues-migration-health/total-expenditure-on-health-per-capita-2014-1_hlthxp-cap-table-2014-1-en

The Affordable Care Act provides new tools to meaningfully change our expensive, fragmented and confusing health care system by providing new ways to make our health care system work better for everyone. Increasingly, Medicare and other purchasers are looking at actively promoting changes in how we organize and pay for care to put patients at the center of our healthcare system.

In order to improve how health care is delivered, and ensure that patients receive quality care at a good value, Covered California's Board recently approved significant new changes to its contracts with health insurers. The new contracts, which will cover the years 2017-2019, are specifically designed to achieve the "triple aim" of better quality, healthier consumers and lower costs by rewarding quality over quantity.

Specifically, the new contract includes the following initiatives:

- Plans will ensure all consumers either select or are provisionally assigned a primary care clinician within 60 days of effectuation into their plan, so they have an established source of care that can help them navigate the health care system.
- Covered California will encourage plans to promote enrollment in advanced models of primary care, including patient-centered medical homes and integrated health care models, such as Accountable Care Organizations.
- Plans will exchange data with providers so that physicians can be notified if their patients are hospitalized and can track trends and improve performance on chronic conditions, such as hypertension or diabetes.
- Plans will be required to track health disparities among all their patients receiving care, identify trends in those disparities and reduce the disparities, beginning with four major conditions: diabetes, hypertension, asthma and depression.
- Plans will develop programs to proactively identify and manage at-risk enrollees, with requirements to improve in targeted areas.
- Plans will be required to help consumers be active participants in their health care by providing tools to help consumers better understand their diagnoses and treatment options and understand their share of costs for medical services — based on the contracted costs of their plan.

Covered California is committed to working to reduce the burden on clinicians, while we align our efforts with those of other public and private purchasers to promote improvements in how care is delivered.

Conclusion

In closing, the Affordable Care Act is working and we at Covered California have built a sustainable and competitive marketplace. In addition to our 1.4 million consumers, approximately 900,000 Californians who do not get subsidies, benefit from the lower rates, protections and the more consumer-centric competitive marketplace that we foster.

We are seeing lives changed by the security they now have and the quality care they have received. We are also seeing lives changed by the fact that all Californians know they are no longer a pink-slip away from going without health insurance.

Thank you for having me here this morning. Our job is not done, but in California and across the nation we are seeing the building blocks being put in place that are creating competitive marketplaces and promoting fundamental changes to the health care system as we work to improve the lives of millions of people. We are grateful for your support and I look forward to answering your questions and doing whatever we can at Covered California to help implement this new era of health care in our state and across the country.

United States House of Representatives

Before the House of Representatives
Ways & Means Committee

Peter V. Lee
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July 12, 2016

The Affordable Care Act is Working

Rate Increases for 2017 are a One-Time Adjustment

- The end of the federal reinsurance program
- Adjustment for mispricing
- Rising trend in health care costs (such as cost of specialty drugs)
- Competition matters

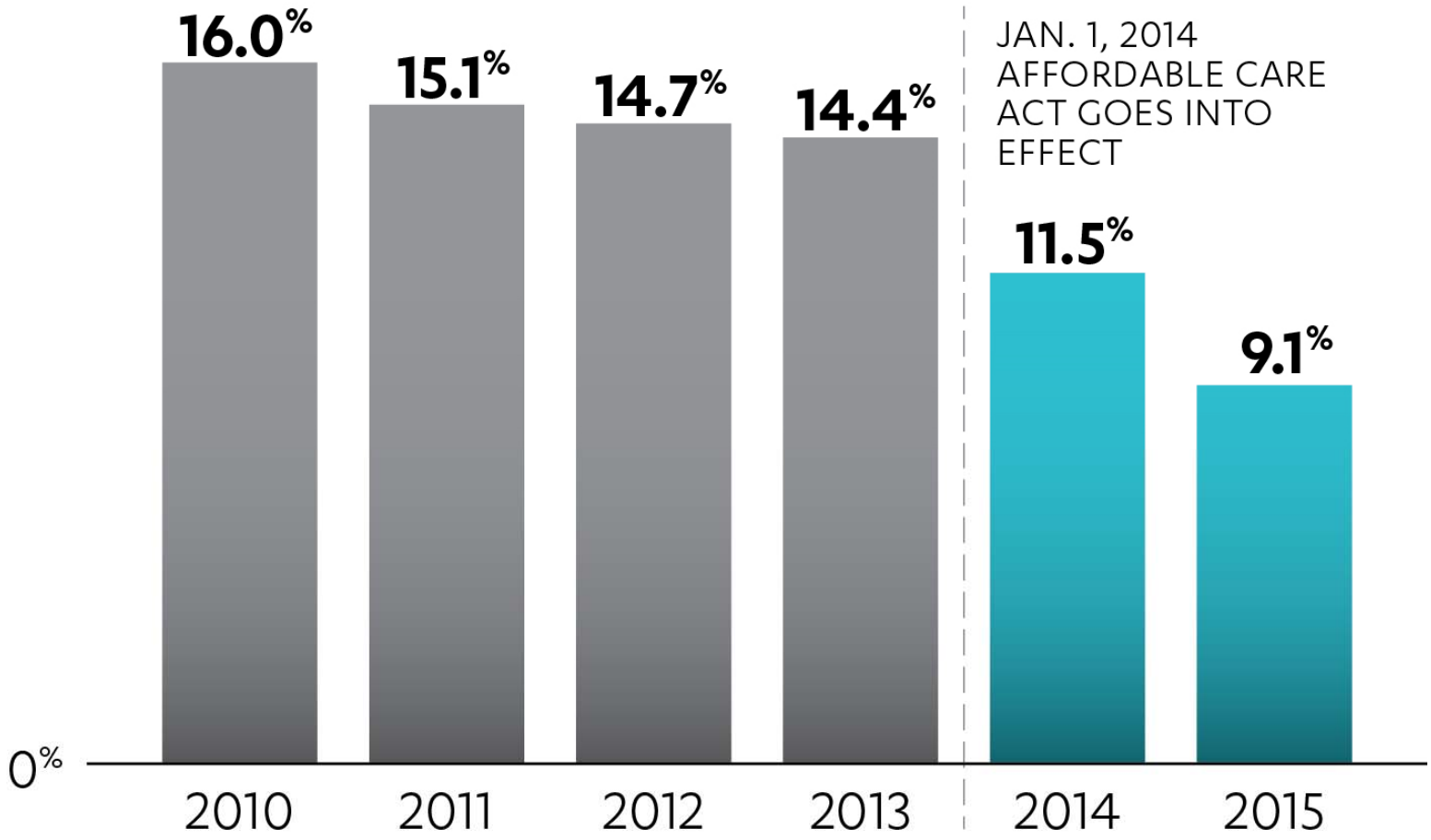
Health Insurance Marketplace Premium Changes for 2015-16 in HealthCare.gov States*

	2015 Avg. Monthly Premium	**2016** Avg. Monthly Premium	Increase in Average Monthly Premium	
Full monthly premium among all plan selections	$356	$386	$30	8%
Net monthly premium among plan selections with premium tax credits	$102	$106	$4	4%

* Source: Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services

Uninsured Rate at Historic Lows — Nationally

National Uninsured Rate for Health Care

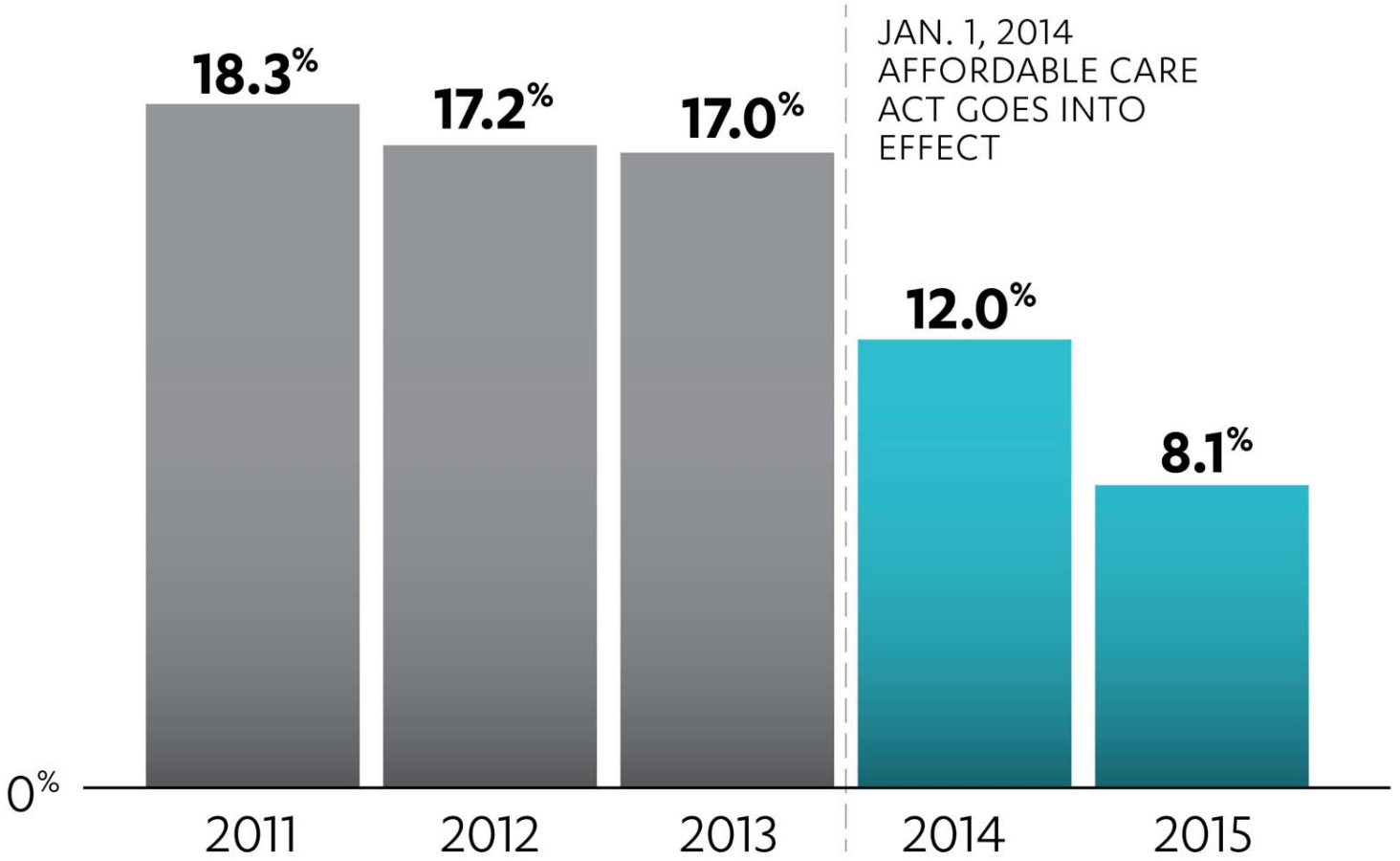


Source: CDC/National Health Interview Survey

Uninsured Rate at Historic Lows in California

Since the Affordable Care Act, uninsured rate has been cut by half

California's Uninsured Rate for Health Care



Source: CDC/National Health Interview Survey

Covered California is Big and Having Big Impacts

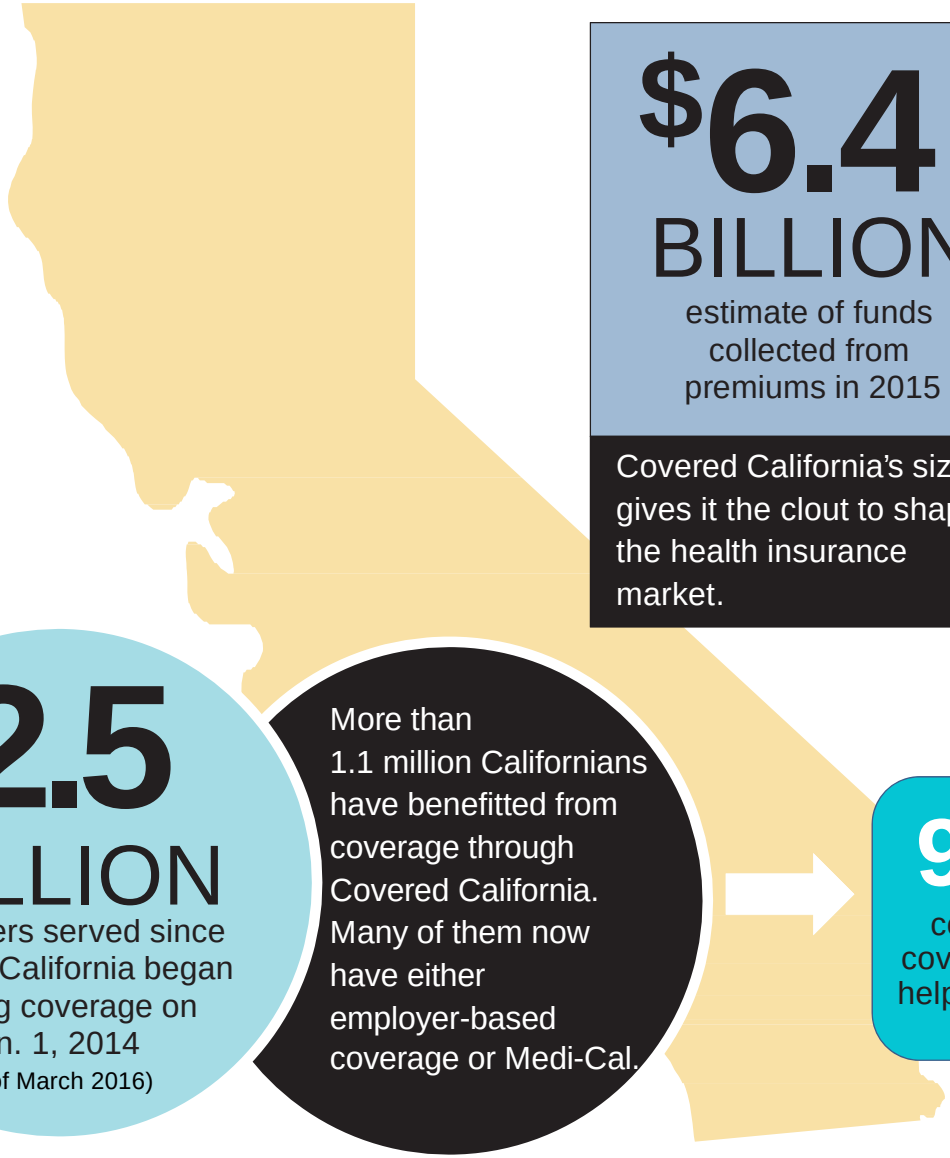
It is now one of the largest purchasers of health insurance in California and the nation.

1.4
MILLION
consumers have active health insurance as of March 2016

Covered California is now the second largest purchaser of health insurance in the state for those under age 65.

$6.4
BILLION
estimate of funds collected from premiums in 2015

Covered California's size gives it the clout to shape the health insurance market.



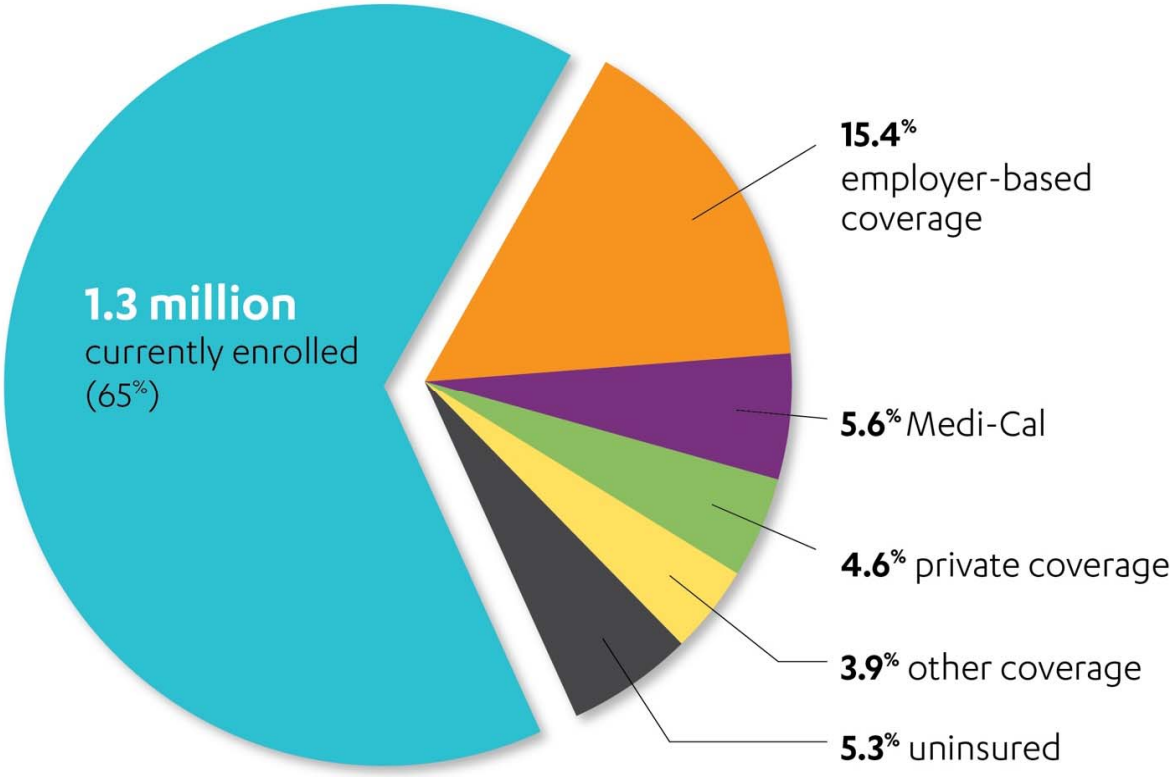
2.5
MILLION
consumers served since Covered California began offering coverage on Jan. 1, 2014
(as of March 2016)

More than 1.1 million Californians have benefitted from coverage through Covered California. Many of them now have either employer-based coverage or Medi-Cal.

9 out of **10**
consumers enrolled in coverage receive financial help to pay their premiums

More Than Two and a Half Million Consumers Served

The majority of those served have continuous coverage and of those who have left Covered California, the vast majority (85 percent) continue to have health insurance.



- Prior to 2014, Covered California forecasted that about one-third of enrollees would leave coverage on an annual basis.
- In the period from January 2014 through September 2015, more than two million Californians have had coverage for some period of time with approximately 700,000 of those no longer active in June 2015.
- As of June 2015, the actual rate of disenrollment is about 33 percent.
- Based on a recently completed Covered California survey of members who left ("disenrolled"), the vast majority (85 percent) left for employer-based, Medi-Cal, Medicare, or other coverage.

Estimated from Covered California enrollment data and 2015 member survey (n=3,373)

Covered California is Creating a Competitive Market

Broad Choice and Many Local Options

PRICING REGION	ANTHEM	BLUE SHIELD	CHINESE COMMUNITY HEALTH PLAN	HEALTH NET	KAISER PERMANENTE	L.A. CARE HEALTH PLAN	MOLINA HEALTHCARE	OSCAR HEALTH PLAN	SHARP HEALTH PLAN	UNITEDHEALTHCARE	VALLEY HEALTH PLAN	WESTERN HEALTH ADVANTAGE
1 Northern counties	●	●		◒	◒					●		
2 North Bay Area	●	●		●	◒							◒
3 Greater Sacramento	●	●		◒	◒							◒
4 San Francisco County	●	●	●	●	●							
5 Contra Costa County	●	●		●	●							
6 Alameda County	●	●			●							
7 Santa Clara County	●	●		◒	◒						●	
8 San Mateo County	●	●	◒	●	●							
9 Santa Cruz, San Benito, Monterey	●	●		◒						●		
10 Central Valley	●	●		◒	◒							
11 Fresno, Kings, Madera counties	●	●		◒	◒					●		
12 Central Coast	●	●			◒					●		
13 Eastern counties	●	●			◒		◒			●		
14 Kern County	●	●		◒	◒							
15 Los Angeles County, partial	●	●		●	◒	◒	◒					
16 Los Angeles County , partial	●	●		●	●	●	◒	◒				
17 Inland Empire	●	●		◒	◒		◒					
18 Orange County	●	●		●	●			◒				
19 San Diego County	●	●		●	◒		◒		◒			

● Full Region

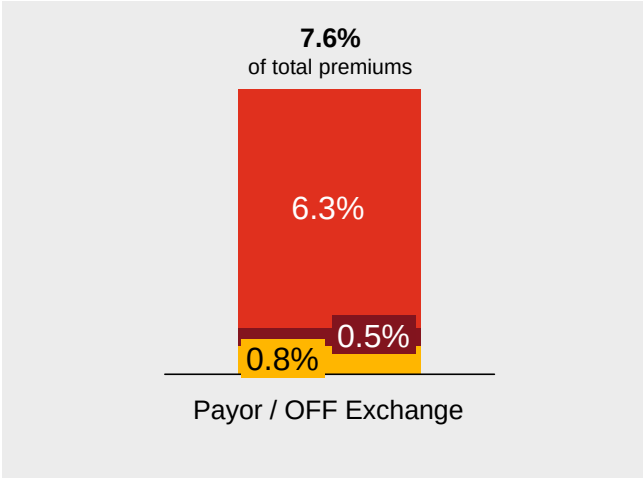
◒ Partial Region

For full details on plans and rates, see Health Insurance Companies and Plan Rates for 2016 http://bit.ly/1L7umLW

In California, Individual Market Acquisition Costs Have Dropped Significantly as a Percent of Total Premiums — Helping Lower Overall Premiums While Driving More Enrollment

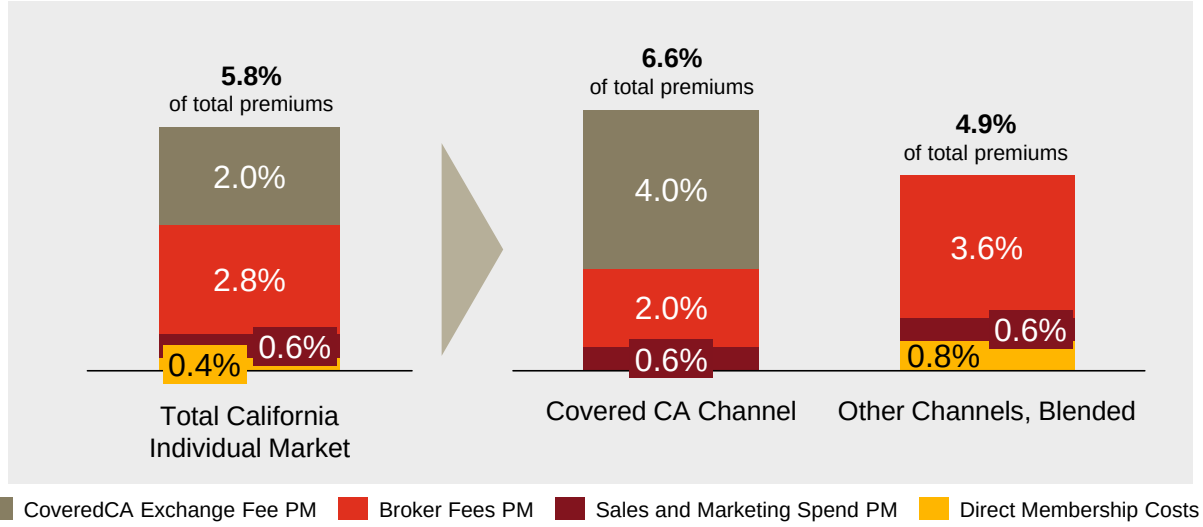
Pre ACA Member Acquisition (National View)

7.6% of Total Premiums Spent on Member Acquisition



Post ACA Member Acquisition (California View)

5.8% of Total Premiums Spent on Member Acquisition



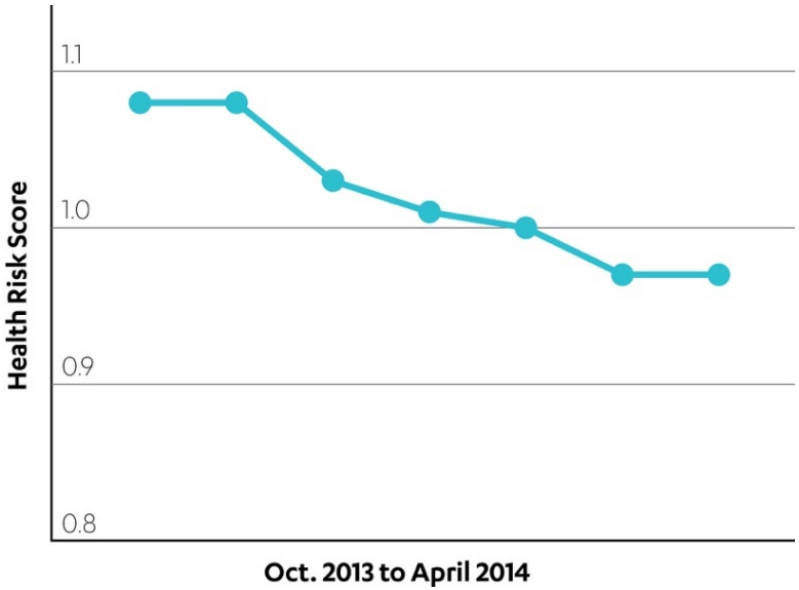
Sources: Kaiser Family Foundation, Covered California, Price Waterhouse Coopers analysis, June, 2016.

Note: Independent of acquisition costs, health plans have had changes to there costs that may be either reduce or increase costs – for instance, eliminating costs related to conducting medical underwriting or adding costs for data exchanges with state or federal marketplaces. Under any circumstance, in the post-Affordable Care Act period health plans total non-health related expenses are limited by the Medical Loss Ratio standards.

Affective Outreach, Partnerships and Policies Create a Healthy Risk Mix that Benefits the Entire Individual Market

Good Risk in California

- In 2015 California had the healthiest risk mix in the nation, about 19% lower than the national average. This is the second year in a row that California had the best risk mix.
- In 2014 health insurance companies in California had consistently strong financial performance, contributing more than half of all risk corridor "excess" profits ($182 million).



The Percent of Enrollment of 18 to 34 Year Olds Continues To Grow

2014	2015	2016
29%	34%	38%

Through our innovative data analysis, we were able to prove to our health insurance companies that the risk scores were decreasing over time, allowing Covered California to negotiate better prices.

Sources: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year, and Health Services Research. "Sorting Out the Health Risk in California's State-Based Marketplace." Andrew B. Bindman, Dennis Hulett, Todd P. Gilmer, and John Bertko.

Covered California 2016 Patient-Centered Benefit Designs

In California, patient-centered benefit designs allow apples-to-apples plan comparisons and seek to **encourage** utilization of the right care at the right time with many services that are not subject to a deductible. ***Benefits below shown in blue are not subject to a deductible.***

MEDICAL COST SHARES BY METAL TIER				
Coverage Category	Bronze	Silver	Gold	Platinum
	Covers **60%** average annual cost	Covers **70%** average annual cost	Covers **80%** average annual cost	Covers **90%** average annual cost
Annual Wellness Exam	$0	$0	$0	$0
Primary Care Visit	$70*	$45	$35	$20
Specialty Care Visit	$90*	$70	$55	$40
Urgent Care Visit	$120*	$90	$60	$40
Emergency Room Facility	Full cost until out-of-pocket maximum is met	$250 once medical deductible is met	$250	$150
Laboratory Tests	$40	$35	$35	$20
X-Ray and Diagnostics	Full cost until out-of-pocket maximum is met	$65	$50	$40
Deductible	Individual: $6,000 medical $500 drug Family: $12,000 medical $1,000 drug	Individual: $2,250 medical $250 drug Family: $4,500 medical $500 drug	N/A	N/A
Annual Out-of-Pocket Maximum	$6,500 individual and $13,000 family	$6,250 individual and $12,500 family	$6,200 individual and $12,400 family	$4,000 individual and $8,000 family

Benefits shown in blue are not subject to a deductible.

**Copay is for any combination of the first three visits. After three visits, they will be at full cost until the out-pocket-maximum is met.*

DRUG COST SHARES — 30 DAY SUPPLY				
Generic Drugs (Tier 1)	up to $500, after deductible is met	$15 or less	$15 or less	$5 or less
Preferred Drugs (Tier 2)	up to $500, after deductible is met	$50 after drug deductible	$50 or less	$15 or less
Non-preferred Drugs (Tier 3)	up to $500, after deductible is met	$70 after drug deductible	$70 or less	$25 or less
Specialty Drugs (Tier 4)	up to $500, after deductible is met	20% up to $250 after drug deductible	20% up to $250	10% up to $250

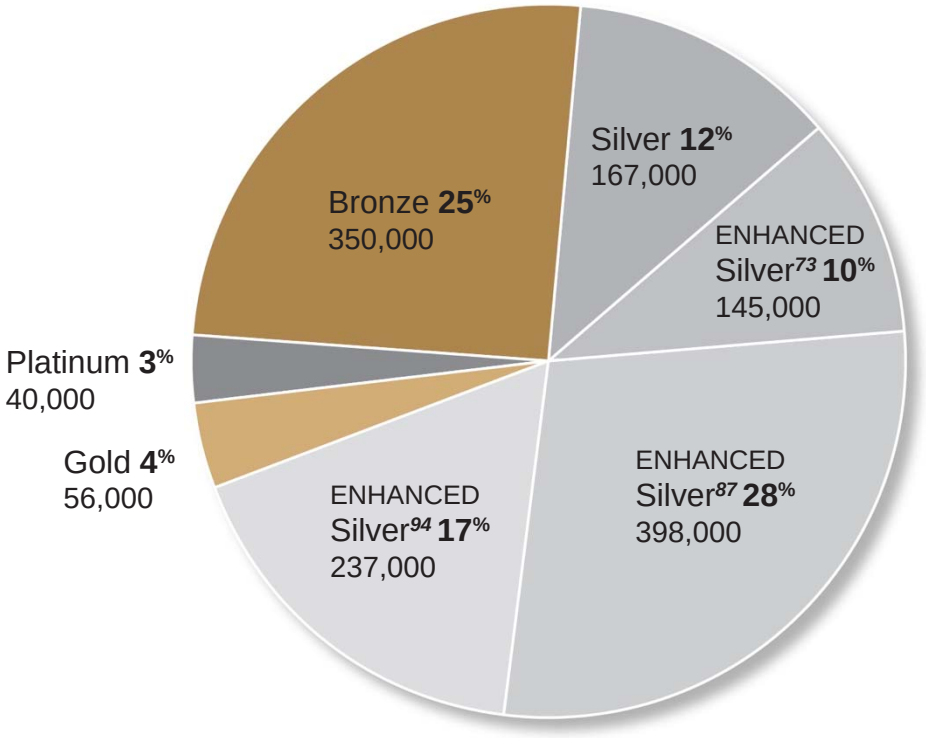
MEDICAL COST SHARES BY INCOME			
Coverage Category	Enhanced Silver 94	Enhanced Silver 87	Enhanced Silver 73
Eligibility Based on Income and Premium Assistance	Covers **94%** average annual cost	Covers **87%** average annual cost	Covers **73%** average annual cost
Single Income Ranges	up to $17,655 (≤150% FPL)	$17,656 to $23,450 (>150% to ≤200% FPL)	$23,451 to $29,425 (>200% to ≤250% FPL)
Annual Wellness Exam	$0	$0	$0
Primary Care Vist	$5	$15	$40
Specialist Visit	$8	$25	$55
Urgent Care Visit	$6	$30	$80
Laboratory Tests	$8	$15	$35
X-Rays and Diagnostics	$8	$25	$50
Imaging	$50	$100	$250
Deductible	Individual: $75 medical Family: $150 medical	Individual: $550 medical $50 drug Family: $1,100 medical $100 drug	Ind.: $1,900 medical $250 drug Family: $3,800 medical $500 drug
Annual Out-of-Pocket Maximum	$2,250 individual and $4,500 family	$2,250 individual and $4,500 family	$5,450 individual and $10,900 family
DRUG COST SHARES — 30 DAY SUPPLY			
Generic Drugs (Tier 1)	$3 or less	$5 or less	$15 or less
Preferred Drugs (Tier 2)	$10 or less	$20 after drug deductible	$45 after drug deductible
Non-preferred Drugs (Tier 3)	$15 or less	$35 after drug deductible	$70 after drug deductible
Specialty Drugs (Tier 4)	10% up to $150	15% up to $150 after drug deductible	20% up to $250 after drug deductible

Benefits shown in blue are not subject to any deductible.

Covered California Enrollees Able to Choose Both Low Premium and Low Out-of-Pocket Designs

More than 68 percent of Covered California subsidy-eligible enrollees selected a Silver plan, which have NO deductibles for any out-patient services and 56 percent of all subsidy-eligible enrollees qualified for an "Enhanced Silver" plan, which means even lower out-of-pocket costs when accessing services.

2016 Subsidized Enrollment
by Metal Tier



A few notes on monthly premium costs:

73 percent pay less than $150 per month per individual.

More than 192,000 enrollees pay less than $25 per month per individual.

For consumers enrolled in an Enhanced Silver 94 plan, more than half pay less than $50.

In addition, these individuals pay only $3 for doctor visits.

Covered California's Patient-Centered Benefit Design:

- Bronze — three office visits and lab work, not subject to deductible.
- Silver, Gold, Platinum — no deductibles on **any** outpatient services.

Source: Covered California enrollment data as of April 1, 2016, including only subsidized enrollees who have paid for coverage.

Enhancing the Patient Centeredness of State Health Insurance Markets — State Progress Reports

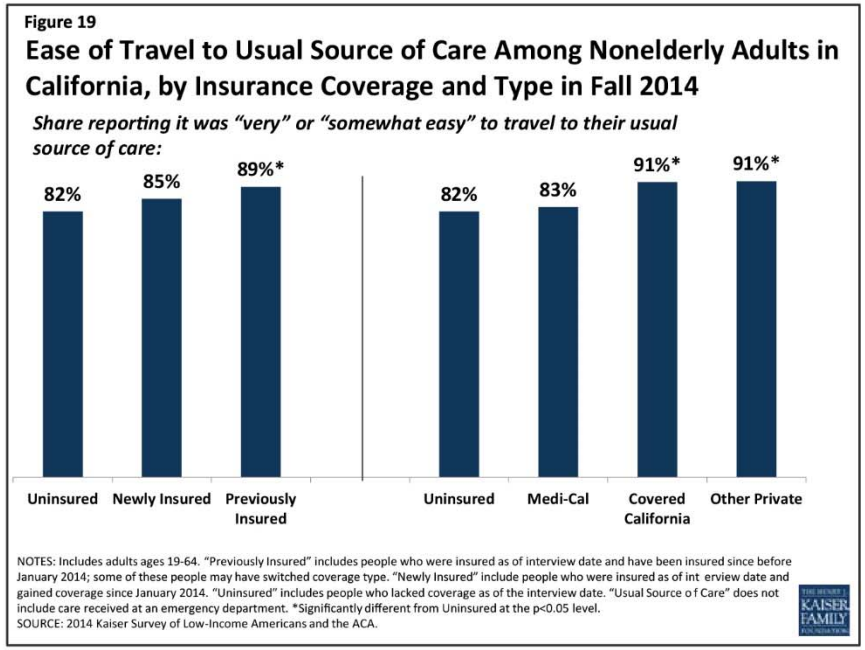
Health Council, July 2015

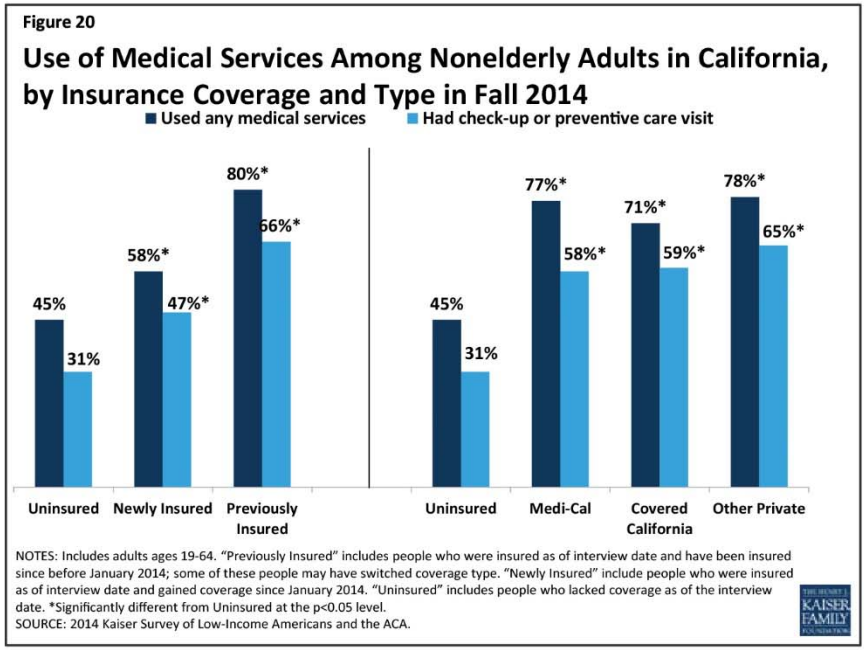
Link to full Report: http://www.nationalhealthcouncil.org/sites/default/files/Enhancing-State-Health-Insurance-Markets.pdf

Health Care Access is Improving Dramatically for both Covered California and Medi-Cal Enrollees

A Kaiser Family Foundation independent survey of consumer released in May 2015 reported on services through the Fall of 2014.

- **91 percent** of Covered California enrollees reported it was “very” or “somewhat easy” to travel to their usual source of care, which matches the Other Private markets (Figure 19).
- **59 percent** of Covered California enrollees had a check-up or preventive care visit by the Fall of 2014, which is nearly twice the rate for preventive visits amongst the uninsured (Figure 20). This is not significantly statistically different from other private market, and if extrapolated over time, this means more than 800,000 preventive visits have been provided through Covered California since Jan. 2014.

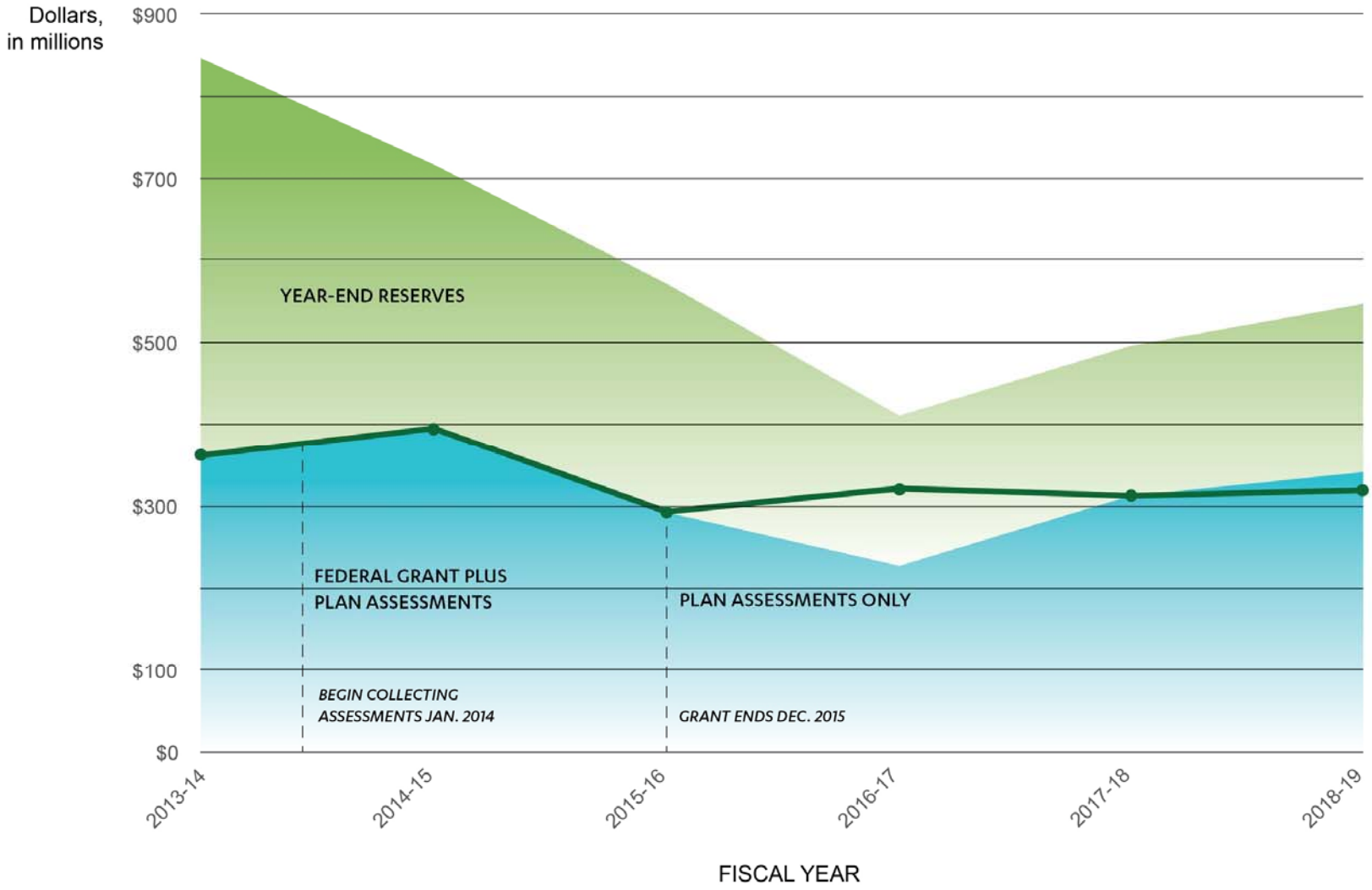




Source: Henry J. Kaiser Family Foundation. 2015. “Coverage Expansions and the Remaining Uninsured: A Look at California During Year One of ACA Implementation”. Menlo Park, CA.

Covered California's Strong Balance Sheet and Financial Management Assures Long-Term Viability

Covered California has a business model that guarantees ongoing support. For fiscal year 2016-17, Covered California's budget includes $320.9 million and unrestricted reserves of more than $278 million.



Promoting Affordability Over the Long Term — Covered California is Pushing Improvements in the Delivery of Care

Covered California contract requirements to promote the triple aim of improving health, delivering better care and lowering costs for all Californians include:

Promoting innovative ways for patients to receive coordinated care, as well as have immediate access to primary care clinicians

- All Covered California enrollees (HMO and PPO) must have a primary care clinician.
- Plans must promote enrollment in patient-centered medical homes and in integrated healthcare models/Accountable Care Organizations.

Reducing health disparities and promoting health equity

- Plans must "track, trend and improve" care across racial/ethnic populations and gender with a specific focus on diabetes, asthma, hypertension and depression.

Changing payment to move from volume to value

- Plans must adopt and expand payment strategies that make a business case for physicians and hospitals.

Assuring high-quality contracted networks

- Covered California requires plans to select networks on cost and quality and in future years, will require exclusion of "high cost" and "low quality" outliers — allowing health insurance companies to keep outlier providers, but detailing plans for improvement.

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to http://hbex.coveredca.com/stakeholders/plan-management/