COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Testimony of Joel C. White
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Committee on Ways and Means
Hearing on Rising Health Insurance Premiums
Under the Affordable Care Act

July 12, 2016

Chairman Brady, Ranking Member Levin, and Members of the Committee, I appreciate the opportunity to testify today regarding premiums for health insurance plans offered on the Affordable Care Act's (ACA) exchanges. My name is Joel White, and I am the President of the Council for Affordable Health Coverage, also known as CAHC, which is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a broad range of interests—organizations representing patient groups, consumers, small and large employers, insurers, and physician organizations. We run several solutions-oriented campaigns to promote affordability, including efforts to improve health care transparency, reform health markets, and improve patient adherence to medications. All told, our members total more than 75 distinct organizations representing tens of millions of people with an interest in lower health costs and more affordable coverage.

My testimony to the Committee will focus on rate increases for individual market plans offered on ACA's exchanges and their impact on enrollment and other factors.

Introduction

CAHC is concerned health costs are too high and rising too fast. In fact, costs continue to rise faster than the economy, while premiums are increasing about three times faster than wages. As a result, by 2030 the typical family will spend more than 50 percent of their income on health care. [1]

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 on exchange plans both this year and next. The result is an unbalanced and expensive market that is driving away many of the healthy consumers the exchanges need to attract in order to hold coverage costs down over the long term. 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 enacted six years ago. Recent rate filings indicate this trend will continue and may worsen in the years to come. This fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making health care more affordable and accessible for all Americans.

Background on ACA's Requirements and Exchanges

A basic overview of the ACA's exchanges is appropriate as background on how costs and coverage are playing out in the market. The ACA established new insurance exchanges in every state, where consumers can shop for, compare, and purchase private health insurance plans. Consumers can choose between several uniform tiers of health plans, ranked from Bronze to Platinum, that offer different levels of benefits at varying costs. Plans must cover certain "essential health benefits (EHB)," including emergency services, hospitalization, preventive services, and prescription drugs. Certain other reforms apply, including a ban on pre-existing condition exclusions, guaranteed issue and renewability, and minimum medical loss ratios.

[1] "2015 Milliman Medical Index." Milliman, May 2015. http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf

Community and age rating rules limit premium variation to age, family size, geographic location, and tobacco use; premiums are subsidized for lower income consumers. Specifically, the ACA ties federal premium subsidies to income on a sliding scale for people earning up to 400 percent of the federal poverty level (FPL)—$47,520 for an individual and $97,200 for a family of four in 2016. Cost-sharing subsidies are also available for people earning less than 250 percent of the FPL. Rates are subject to review and approval in the small group and individual market. The table below outlines the various applicable requirements by market.

Major Federal Regulations Impacting Premiums

	Large Group		Small Group		
	Fully Insured	**Self-Insured**	**Fully Insured**	**Self-Insured**	**Non-Group**
Individual Mandate	X	X	X	X	X
Employer Mandate	X	X			
Regulations Governing Insurance Benefits					
Essential Health Benefits			X		X
Prohibition on excluding pre-existing conditions	X	X	X	X	X
Minimum Actuarial Value (generally 60 percent)[a]	X	X	X		X
Regulations Governing Insurance Offers and Pricing					
Guaranteed issue and renewability[b]			X		X
Modified community rating[c]			X		X
Rate review required			X		X
Risk Adjustment			X		X
Minimum Medical Loss Ratios	X		X		X

Source: Congressional Budget Office, Affordable Care Act (P.L 111-148)

A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected. A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.

a. Large employers may be penalized under the employer mandate if they offer coverage that has an actuarial value of less than 60 percent.

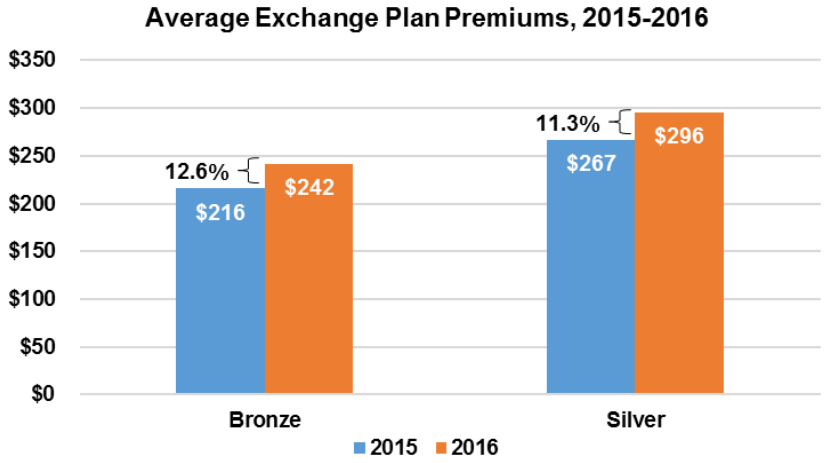
b. For the fully insured large-group market, guaranteed renewability applies; guaranteed issue does not.

c. For large employers and for small ones that self-insure, the total premium or cost per enrollee may vary because of differences in the average health of each firm's enrollees. However, an individual employee's eligibility to enroll in a plan and that employee's required premium payment generally cannot vary on the basis of health.

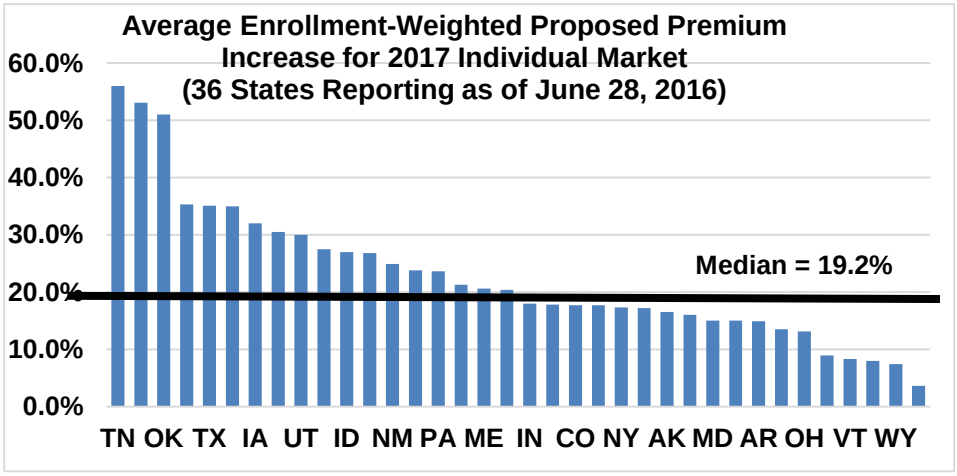
What We Are Seeing Now

Premiums

In 2016, average premiums for both Bronze and Silver plans saw double digit growth.[2] The most significant factors in this growth are the underlying increase in medical costs, the reduction of reinsurance program funds, and the size and changing composition of the risk pool.[3]



Based on rate filings for 2017, consumers can expect another year of double digit increases, on average. The median premium increase for 2017 is 19.2 percent based on average enrollment-weighted proposed rates already filed. [4] Notably, Blue Cross Blue Shield issued a report last March pointing out that participants in its exchange plans cost 19 percent more to insure than expected. This being the case, it was only a matter of time before these higher costs were reflected in the price of policies offered on the exchanges.



[2] "Silver Premiums by State." Robert Wood Johnson Foundation, Dec 2015. http://www.rwjf.org/content/dam/files/rwjf-web-files/Research/2015/Table%201_Silver%20Premiums.pdf

[3] For an in-depth discussion of these issues, please see Drivers of 2016 Health Insurance Premium Changes, American Academy of Actuaries, August 2015 accessed at http://actuary.org/files/Drivers_2016_Premiums_080515.pdf

[4] "Presenting the ACA Signups 2017 Requested Rate Hike Challenge." ACA Signups, 22 Jun 2016. http://acasignups.net/16/05/24/presenting-aca-signups-2017-requested-rate-hike-challenge

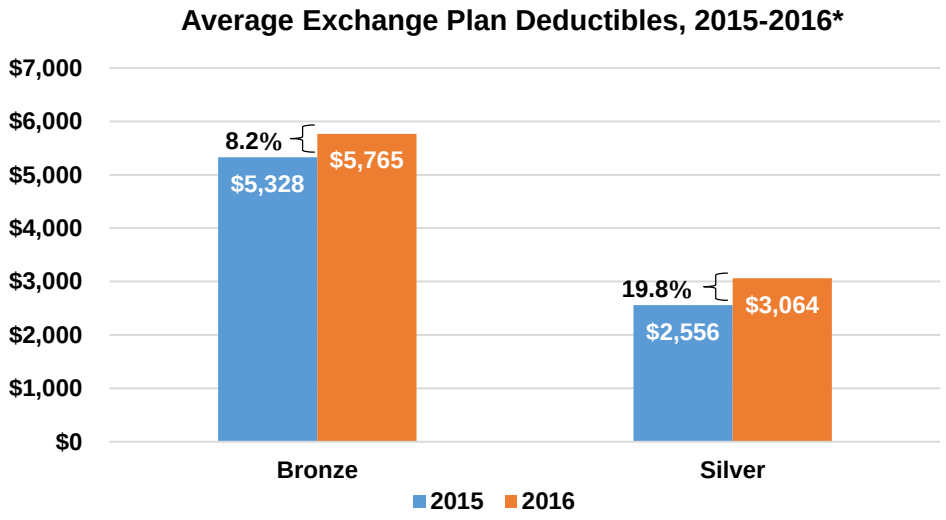
Given that these are applications for increases that are subject to approval, the allowed increases may be less than those shown in the chart (above). Nonetheless consumers should still expect a double digit premium increase in 2017 because of the same factors affecting 2016 rates – rising medical costs, expiration of the reinsurance program, and a risk pool that is older and sicker than originally projected. Statutory changes recently enacted by Congress that will help lower premiums for 2017 include changes to the definition of the small group market and a moratorium on the health insurance tax in 2017.

Future Rates Across Markets

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) recently projected premium rate increases for employment-based plans and non-group insurance and found that premiums for the second lowest cost Silver plan will grow, on average, by 8 percent annually between 2016 and 2018, and by 6 percent annually between 2016 and 2025. By way of comparison, CBO and JCT project employment-based rates to increase by an average of 5 to 6 percent per year during 2016 to 2025.[5]

Cost-Sharing

Cost-sharing, including co-payments, co-insurance, deductibles, and their use on formularies, particularly specialty tiers, is increasing faster than average premiums. For example, in 2016, the average Silver plan had a $3,000+ deductible, reflecting an increase of almost 20 percent over 2015. [6]



Most plans use a mix of pricing strategies involving cost-sharing. For example, most have a combined medical and prescription drug deductible while using both copayments and coinsurance for services and drugs. The Commonwealth Fund examined cost-sharing for exchange plans and found:

[5] Congressional Budget Office, Private Health Insurance Premiums and Federal Policy; February 2016, available at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums_OneCol.pdf

[6] *"Patient Cost-Sharing in Marketplace Plans, 2016." Kaiser Family Foundation, 13 Nov 2015. http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/*

- Average copays, deductibles, and out-of-pocket limits remain considerably higher under Bronze and Silver plans than under employer plans;
- Cost sharing is similar between Gold plans on the exchanges and employer plans; and
- Exchange plans are more likely than employer plans to subject prescription drugs to a deductible, but less likely to do so for primary care provider visits.

For 2016, only one category of cost-sharing decreased on exchange plans. Copays for generic drugs fell by 3 percent. Out-of-pocket limits, general annual deductibles, and copayments for non-preferred brand drugs rose by 7 percent, 10 percent and 14 percent respectively.

A survey from the Kaiser Family Foundation found that families are struggling to meet these obligations. Only about half of households have enough liquid financial assets to meet higher range deductibles ($2,500 for an individual and $5,000 for a family).[7] Higher deductibles and cost-sharing are not necessarily a bad thing, as they can lead to greater awareness of health costs and lead to more judicious use of health services. Congress created a number of mechanisms such as Health Savings Accounts (HSAs) to ensure that consumers enrolled in such plans would continue to have access to needed services. Unfortunately, the majority of high deductible health plans on the exchanges are not coupled with HSAs, including new standardized plans that will be offered next year.

Given historical trends since the enactment of the ACA and absent data that suggests otherwise, CAHC believes these historical trends will continue in 2017 and beyond.

Why are Exchange Premiums and Cost Sharing Increasing?

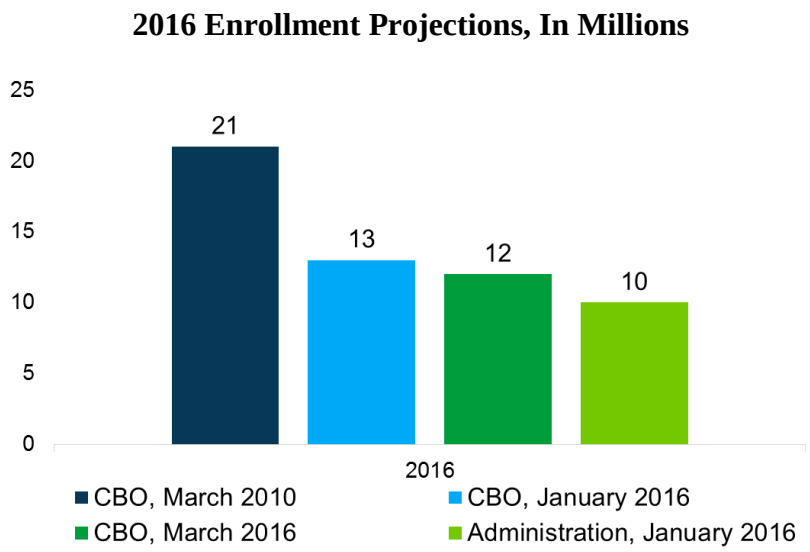
I believe the primary reason premiums and cost-sharing are increasing is that the risk pool is unbalanced and smaller than originally expected; additional reasons include:

1.
2. Rising medical costs, including the impacts of diminished insurer and provider competition;
3. The expiration of premium stabilization programs; and
4. Statutory and regulatory requirements on health plans and employers.

Composition of the Risk Pool

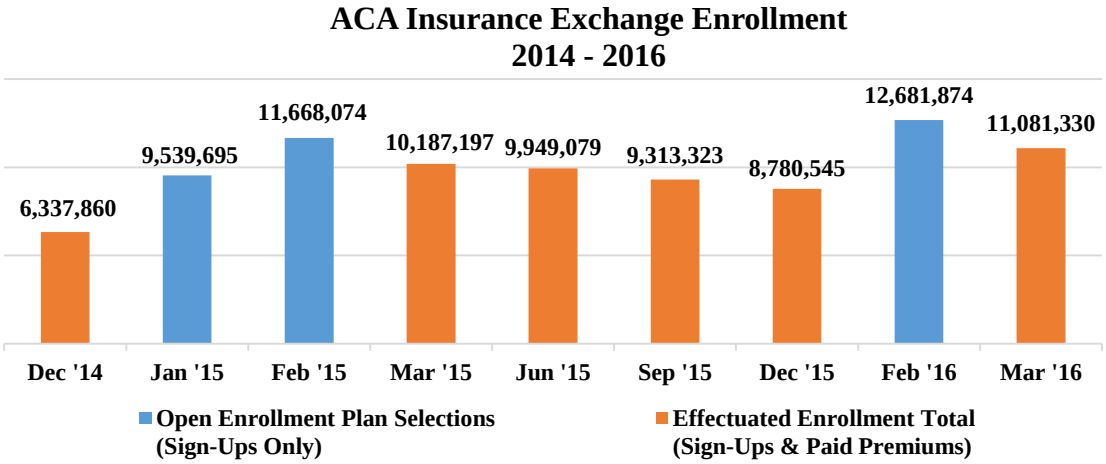
The ACA is widely credited with reducing the number of uninsured to historic lows, but this achievement is mainly the result of the Medicaid expansion, not because products on the exchanges attract the needed number of consumers for a sustainable risk pool.[8] Despite the broad array of available health plans and a tax for being uninsured, many of those who had been expected to sign up for coverage – even those eligible for subsidies – have not done so. In fact, enrollment is only about half of what the CBO projected when the law was first passed. [9]

[7] Claxton, G., Rae, M., and Panchal, N. (2015, March 11). Consumer access and patient cost sharing. Kaiser Family Foundation. Accessed at http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/
[8] "Trends in Health Insurance Enrollment, 2013-2015." RAND Corporation, 6 May 2015. http://www.rand.org/pubs/external_publications/EP50692.html
[9] "Exchange Enrollment: An Opportunity for Reform." Council for Affordable Health Coverage, Avalere Analysis, 7 Jun 2016. http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief_ExchangeEnrollment_061616.pdf



Source: "Exchange Enrollment: An Opportunity for Reform." Council for Affordable Health Coverage, Avalere Analysis, 7 Jun 2016.

CMS reports that as of March 31, 2016 approximately 11.1 million (11,081,330) people had "effectuated coverage" – meaning they paid their premiums and had an active policy as of that date – through the insurance exchanges.[10] It is unclear, however, how many will continue to pay premiums and maintain enrollment through the year. In previous years, non-payment of premiums, failure to provide documentation and transitioning to other coverage (such as Medicaid or an employer plan), led to attrition in the market. The chart below shows exchange enrollment over time.

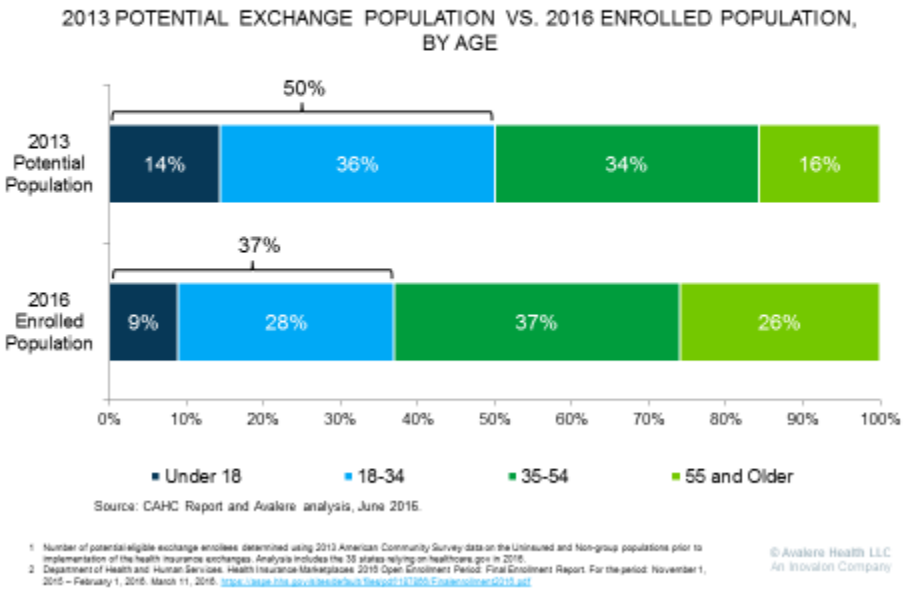


This is problematic because without robust enrollment, the risk pool is unbalanced. In a guaranteed issue market, cost is inversely proportional to enrollment. As more people enroll, average costs decrease, reflecting the relative health status of additional enrollees. The opposite seems to be happening on exchange plans. According to a CAHC analysis of exchange enrollment in 2016, participants tend to be older with greater risk, more females, and more ethnically homogenous than

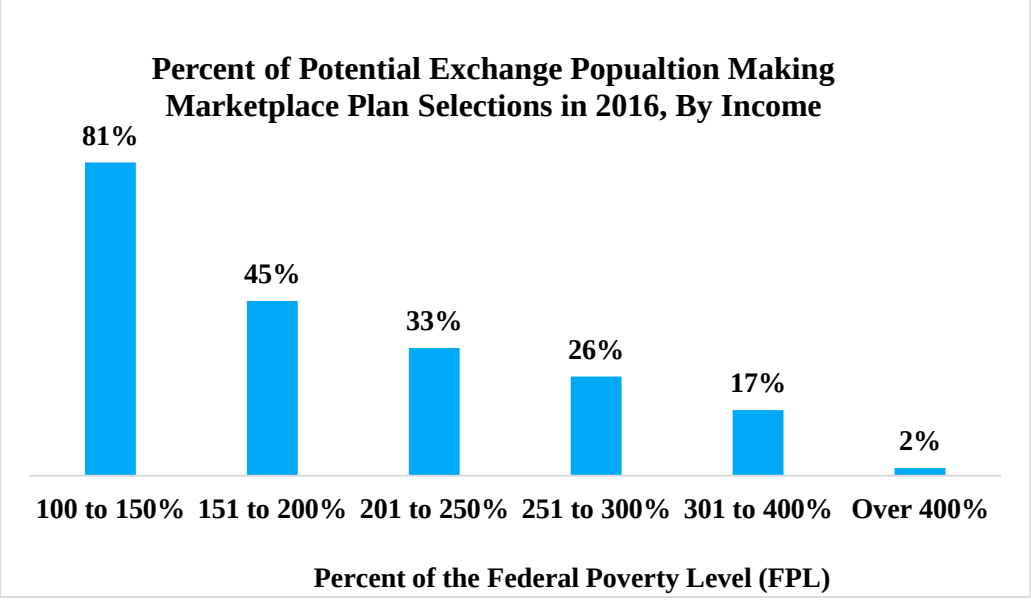
[10] "March 31, 2016 Effectuated Enrollment Snapshot." Centers for Medicare and Medicaid Services, 30 Jun 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html

the eligible population. For example, 50 percent of the potential exchange population was under the age of 35, but less than 40 percent enrollees are actually in that age bracket.

2013 Potential Exchange Population vs. 2016 Enrolled Population, by Age



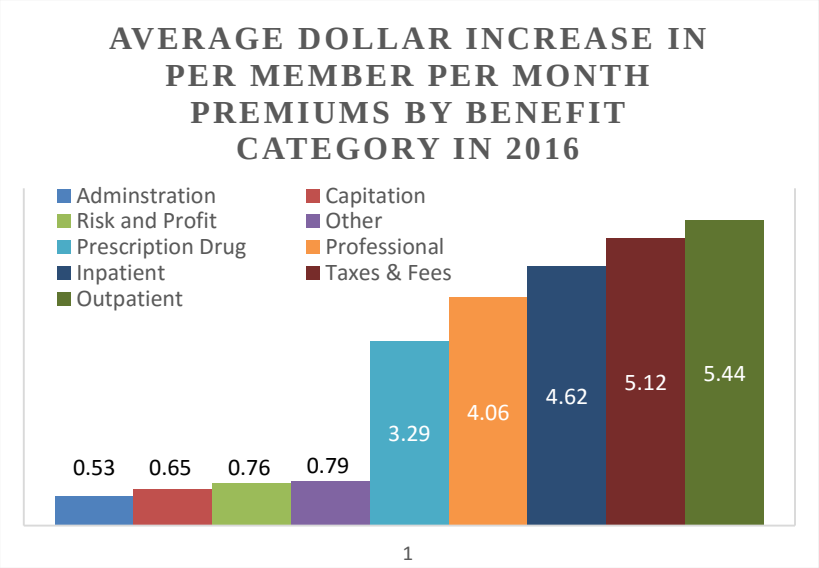
A prominent feature of the market is the extent to which participation rates vary with the generosity of the subsidies; only two percent of the non-subsidy eligible population have enrolled in exchange coverage as of 2016. (These higher income participants may consist disproportionately of individuals with high medical costs).



One of the 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 larger population. What we see on exchanges now is a smaller pool, and the pool itself is riskier. According to actuaries CAHC has consulted, premiums and cost-sharing are greater than expected and are rising more rapidly as a result. The higher rates already filed this year leads us to believe enrollment – and the health of the risk pool – will not improve measurably in 2017, and may in fact worsen. The vast majority of insurers on the exchanges continue to lose money because of this trend. This is evident in the large number of CO-OPs that have folded over the past two years. While some of the larger companies may be able to sustain such losses for a short time, this is not sustainable over the long-term and does not bode well for the future viability of exchange markets.

Rising Medical Costs

All plans sold in the individual and small group market are required to submit actuarially-certified justifications for premium increases, including the portion of the premium increase attributable to each unique benefit category. Avalere conducted an analysis of rate filings and found that the health insurance premium increases in 2016 largely mirror insurer spending on health services and products. The majority of health costs are for hospital services (32 percent), physician and clinical services (20 percent), and prescription drugs (10 percent). This percentage distribution is projected to remain consistent over the next ten years, with hospital services eating up a slightly larger share of the health care dollar over time. PricewaterhouseCoopers' Health Research Institute projects the 2017 medical cost trend to be the same as the current year – a 6.5 percent growth rate.[11] Because hospital (inpatient and outpatient) and physician costs make up roughly two-thirds of each health dollar, premium increases largely track cost increases in those sectors. The chart below outlines the average dollar increase in per-member per-month premiums by benefit category in 2016 in both the individual and small group markets.[12]



[11] PwC Health Research Institute, Medical Cost Trend: Behind the Numbers 2017 accessed at http://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[12] Avalere, Health Insurance Premium Increases Largely Mirror Spending, November 16, 2015, accessed at http://avalere.com/expertise/managed-care/insights/health-insurance-premium-increases-largely-mirror-spending

Importantly, taxes and fees cost more than inpatient spending, illustrating the extent to which government policy is contributing to premium cost increases. This is one area Congress can directly reduce inflationary pressures in the insurance market.

Of course, as insurers and providers vie for business and negotiate the best reimbursement, cost trend and premium rates will be greater or less as a result. About 80 percent of Americans live in highly concentrated medical markets, where too much pricing power limits insurer ability to effectively negotiate rates, which generally leads to higher premiums and cost-sharing for individuals and businesses. This fact, coupled with the problems in the enrolled risk pool, has contributed to plan losses for many insurers participating in exchanges. In fact, several insurers have or plan to exit markets or, indeed, have gone out of business altogether. According to the Kaiser Family Foundation, 664 counties (out of 3,007) may have just one exchange issuer in 2017, up from 225 counties last year.[13]

Sunset of Reinsurance Program

The ACA reinsurance program provides payments to plans for claims within specified dollar limits, partially offsetting the costs of high-cost enrollees and helping to mitigate risk exposure. The Centers for Medicare and Medicaid Services (CMS) has announced it will pay out about 50 cents on the dollar for claims between $90,000 and $250,000 in 2016. Reinsurance payments to insurers end in 2017, and premiums are expected to increase by four to seven percent as a result.[14]

Statutory and Regulatory Changes

While the law largely standardizes plan offerings and seeks to address the real or perceived abuses of the past, mandates and requirements of the law are driving up costs.

- CBO has estimated that the essential health benefits, actuarial value, and guaranteed issue requirements alone drive up costs by 27 to 30 percent.
- Expiration of the reinsurance program will drive up premiums an estimated four to seven percent, while the re-imposition of the health insurance tax may increase premiums by another one to three percent.
- Premium and cost-sharing subsidies and cost-sharing mandates in standardized plans hide costs from consumers and shift costs, but do nothing to actually reduce them, and may even lower consumer cost sensitivity in ways that increase systemic costs and premiums overall.

In implementing the law, regulatory activity related to the ACA that negatively impact costs has been robust. For example, the following list of recent regulations will likely further limit consumer choice and increase costs and premiums now and in the future:

- CMS recently issued a proposed regulation restricting the duration of short-term medical plans to 90 days with an inability to renew such plans. Many consumers enroll in such plans to cover gaps in coverage that last longer than 90 days for a wide variety of reasons.

[13] Kasier Family Foundation. Following some withdrawals, more counties could have one ACA marketplace insurer in 2017. Accessed from http://kff.org/health-reform/slide/following-withdrawals-by-some-marketplace-insurers-more-counties-could-have-one-exchange-insurer-in-2017/

[14] Please see Drivers of 2017 Health Insurance Premium Changes, American Academy of Actuaries, June 2016, http://www.actuary.org/content/drivers-2017-health-insurance-premium-changes-0

Restricting the sale and renewal of these plans could marginally increase enrollment in exchanges, but eliminates an option that some consumers may rely on for continued and consistent coverage.

- The Internal Revenue Service has limited choices for small businesses by defining Health Reimbursement Arrangements (HRAs) as group health plans, subjecting the accounts to all of ACA's market reforms. Businesses that offer these accounts without pairing them with major medical policies will be subject to a $100 per-day, per-employee fine. HRAs can help small employers who cannot afford to provide full health benefits to their employees with assistance in the purchase of qualified health coverage, which could lead to greater enrollment (particularly of non-subsidy eligible) individuals and families on the exchanges. The House recently and overwhelmingly passed legislation sponsored by Congressmen Charles Boustany and Mike Thompson to correct this problem. CAHC applauds you for taking this step.
- Perhaps most troubling is a new policy introduced in the 2017 Notice of Benefit and Payment Parameters, which will introduce standardized plan designs that could lead to reduced plan offerings and higher premiums and cost-sharing for some consumers. The cost-sharing required for some treatments and services would largely make them completely inaccessible and unaffordable for lower income individuals. For example, the standard option design is particularly troublesome for Bronze Plans. Due to the proposed constraints on benefit design for pre-deductible coverage and formulary and network tiering, insurers will be left with few mechanisms to both hold down costs and meet statutory actuarial value requirements. Particularly concerning is the fact that there are only two tiers for formulary drugs – either generic or non-generic – with 50 percent coinsurance for all non-generic drugs, which is highly atypical in today's marketplace. None of the standard benefit options afford consumers the option of using HSAs, even though these plans have extremely high deductibles and cost sharing for many services.

It should be noted that not all changes proposed by CMS are negative. The Agency has committed to restricting the use of Special Enrollment Periods (SEPs), which were supposed to be for life-changing events or special circumstances, but have been used practically to game the system in many instances. CAHC believes that with proper enforcement, this change can improve the risk pool and premiums in the future.

Finally, and despite popular media and party-line narratives from both sides, Congress has enacted 24 changes to the Affordable Care Act since its enactment, most of them in a bipartisan manner. Some of these changes have positively impacted premium rates, including:

- The Protecting Affordable Coverage for Employees Act (on October 7, 2015), which staved off a premium increase of about 18 percent for three million workers in the small group market.
- Congress created flexibility for small businesses by repealing the cap on deductibles for small group plans, saving $1.2 billion over 10 years.
- Last year, Congress enacted a moratorium on collection of the Health Insurance Tax, which will lower premiums by one to three percent in 2017.

These laws were strongly supported by CAHC, but Congress can and should do much more.

Solutions

Fortunately, many of the problems outlined in this testimony are solvable or at least can be remediated, but they will require leadership and, we believe, bipartisanship. CAHC encourages you to enact reforms that will help improve the risk pool, better manage and target care for enrollees, and attract healthier enrollees in both the on- and off-exchange markets. We call on you to introduce and/or move legislation that promotes affordability through reductions in medical cost trend and expanded choices and competition in the marketplace. These include:

- **Improving Consumerism:** Both Republicans and Democrats support the concept of health insurance exchanges. To date, taxpayers have spent about $5 billion on decades old technology that offers only limited views of the information consumers want and need to make smart coverage decisions. CAHC believes this has harmed enrollment both on and off exchanges, which needlessly drives up health premiums. We believe Congress should pass reforms to improve the exchanges and limit taxpayer liabilities. Specifically, Congress should:

    1. Create next generation exchanges that allow for subsidy portability. Consumers would be able to use premium and cost sharing subsidies to purchase plans that comply with federal and state law on both public and private exchanges. The federal and state governments would retain the subsidy eligibility verification and payments to health plans functions. Such a reform would incentivize the private sector to create new and better tools and marketing platforms to reach more consumers annually – including consumers who are currently slipping through the cracks, such as those with higher incomes, individuals under 35, males, and Hispanics.

    2. Enact health care transparency improvements, which could save up to $100 billion annually by empowering consumers to choose efficient and effective providers while giving providers information on costs before treatment. Exchanges must also do better in presenting plan choices to consumers, including covered drugs and their cost sharing, provider directories, and out-of-pocket cost calculators.

    3. Reform SEPs and the grace period for non-payment of premiums. CMS has destabilized the risk pools in its frequent and unnecessary use of special enrollment periods. Open enrollment periods should be meaningful and the government should not encourage, sanction, or turn a blind eye to those who may game the system through non-payment of premiums.

- **Create Additional Flexibility.** As mentioned, the major cost drivers for exchange plans beyond the general costs of health care and risk pools are the mandates surrounding EHB, AV, and rating rules. Flexibility in these areas would create more competition that reduces costs:

    1. Allow AV flexibility, and new metal levels, such as Copper plans as a lower AV option (50 percent) for consumers who could not afford any plan. Congress could allow for the sale of Copper plans and/or expand catastrophic-only policies to those older than 30. Either option would expand enrollment.

2. Provide States with greater control over rating rules. The Energy and Commerce Committee held a hearing on draft legislation to provide plans and states with the flexibility to revert the decision over age rating to states or default to a 5:1 ratio rather than the current 3:1 if no changes are made. This would lower premiums for younger enrollees, which would help improve the risk pool and lower premiums for all consumers in the long-run.

3. Encourage the use of consumer-driven health products, such as Health Savings Accounts (HSA). Currently, CMS does not highlight HSA-compatible plans on Healthcare.gov, despite repeated requests to do so. Additionally, the new standardized benefit plans that will be featured on Healthcare.gov, have high deductibles but are not eligible for HSAs. As we have seen, deductibles and cost-sharing are rising at even higher levels than premiums in the individual market. Consumers should be allowed to avail themselves to current tax code support in paying for high cost sharing found on exchanges.

4. Allow for and incentivize the creation of specialized plans that target and improve care for patients with high-cost conditions such as diabetes, mental health, and other illnesses. Because the exchange population has greater medical needs than the general population, specialized plans can help insurers keep enrollees with higher cost conditions healthier, lowering costs and premiums in a unified risk pool. Current non-discrimination rules may make it difficult for plans to offer such coverage. Additionally, these types of plans are not available to consumers in states such as California that prohibit variation from rigid standardized benefit designs. CAHC is also extremely concerned that CMS' introduction of standardized plans will make it more difficult for enrollees to be aware of and access these innovative plans.

- **Address Medical Cost Trend Drivers.** One of the biggest mistakes of the ACA was to incorrectly assume that the market failures present in the health system and the difficulty many individuals and families had with accessing care was due to insurance design and practice rather than medical cost drivers. Addressing the largest components of medical costs, such as hospital inpatient and outpatient, is key to getting our arms around cost growth. Congress should work to lower cost trend by:

    1. Addressing uncompetitive markets. Consolidation is leading to highly concentrated markets across the country and in every congressional district, which, in turn, dramatically drives up the price of health services and the overall cost of care. This is translating into inflated government spending, higher premiums, and inefficient cost shifting. These factors are creating strong head winds in our labor markets, making retaining and hiring workers more difficult and creating a drag on our economy and household finances. Congress should avoid enacting policies and/or correct those that will likely lead to greater consolidation, particularly in the provider market, which drives

up premiums by preventing effective price negotiations. Congress should also oversee and counteract regulations that have similar effects.

2. Repealing aspects of the law that directly pass through costs to consumers. The medical device, drug, and health insurance taxes should all be repealed because these costs are passed onto the consumer in the form of higher premiums and greater cost sharing.

3. Reforming the laws holding back the proliferation of value-based reimbursements for prescription drugs. We have seen a strong and promising push to move away from a system that pays for volume of medical cost and treatment toward one that pays for value. We believe this should include prescription drugs.

4. Increasing competition in prescription drug markets. With more than 4,000 products awaiting a decision, the Food and Drug Administration's current backlog of generic products is not acceptable. We see time and again when there is expanded competition, there are lower prices.

5. Enacting policies that help patients access and adhere to needed therapies. Policies that improve medication adherence can help patients avoid hospitalizations and emergency room visits, providing $300 billion in potential system-wide savings.

6. Making the Medicare Access and CHIP Reauthorization Act's alternative payment model (APM) pathway more viable for more health care providers. More APMs should have positive spill-over effects into both the individual and group markets.

Conclusion

With the proposed premiums filed for the 2017 market, CAHC is very concerned about diminished affordability and lower enrollment on exchange plans next year. Even with subsidies, many of those enrolled may remain functionally uninsured due to increasing cost sharing. Shopping for different plans will not fix this problem as newly selected plans will likely have lower premiums, but more expensive cost sharing.

Only by addressing the underlying conditions that are producing high and growing premiums and cost sharing obligations will affordability become a reality for most people. Already, the typical family spends 30 percent of their income on health care. If current trends continue, that family will spend more than 50 percent of their income on care within 14 years. Congress can help families avoid this future, but you must be ready and willing to act.

Thank you for the opportunity to testify today, and I am happy to answer any questions.