

**“Health Care: Issues Impacting Cost and Coverage”:** Testimony before the U.S. Senate  
**Committee on Finance**  
**September 12, 2017**

Chairman Hatch, Ranking Member Wyden and members of the Committee. Thank you for the invitation to be back in front of this Committee to discuss an issue of vital importance to millions of American families: improving access to high quality, affordable health care. My name is Andy Slavitt. I currently serve as a Senior Advisor to the Bipartisan Policy Center after having served in an acting capacity as Administrator of the Centers for Medicare and Medicaid Services from 2015 to 2017, which followed a 20-year career in the private sector. While at CMS, I had the honor of working alongside the high caliber men and women of the agency who set out on a daily basis to help the American public get the care they need at all stages of life. CMS serves over 100 million Americans, often at the most vulnerable times in their lives, as they age, have children, change employment and struggle with complex medical conditions and a complex health care system that left on our own few of us could afford.

I am grateful to the Senate Finance Committee for the role you have played through the years in advancing health care for our country and for holding this hearing. I hope that this is part of a new opportunity to discuss and debate bipartisan ideas to support the health care needs of the people in the country. While I had the honor of participating in the implementation, I am not here as an unabashed defender of the Affordable Care Act, but as someone who believes we need to move forward with the best ideas to provide affordable, quality health care. I believe this is best done with an honest accounting of what is working and our challenges and a focus on practical solutions.

I have had the opportunity to see first-hand how the Affordable Care Act has advanced the lives of millions of Americans over its first few years.

- After decades of stagnation, the ACA has provided financial protection and improved access to a regular source of care for millions of Americans, reducing the number of Americans without insurance from 2013 to 2017 from 14% to 8.3% according to the CMS Office of the Actuary,<sup>1</sup> its lowest recorded level.
- The ACA also provided valuable consumer protections to all Americans like prohibiting discrimination against an estimated 130 million people with pre-existing conditions,<sup>2</sup> most of whom currently receive employer-based coverage. The law outlawed annual and lifetime policy limits, and the old insurance practice of often arbitrarily excluding coverage of certain benefits like pharmacy, hospital care, or mental health. Before the Affordable Care Act, if Americans could even qualify for individual coverage, they often did not know what they were getting in a plan. They could be charged more for existing illnesses, or could have limitations in their policies that excluded those illnesses altogether.

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<sup>1</sup> “National Health Expenditure Projections 2016-2017,” Office of the Actuary, Centers for Medicare and Medicaid Services, March 21, 2017. Available at: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected.html>

The actual data referenced is in the “NHE Projections 2016-2025 - Tables [ZIP, 298KB]” file, under “Table 17—Health Insurance Enrollment and Enrollment Growth Rates, Calendar Years 2009-2025”

<sup>2</sup> “Health Insurance Coverage for Americans with Pre-existing Conditions: The Impact of the Affordable Care Act,” Office of the Assistant Secretary for Planning and Evaluation, Department of Health & Human Services, January 5, 2017. Available at: <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf>

- The ACA made health care more affordable for millions more Americans. By providing income-based tax credits to people in the individual market, individual buyers were put roughly on par in terms of tax treatment, for the first time, with people who receive employer sponsored coverage. Along with positively impacting job mobility, this significantly expanded health care affordability. In the last open enrollment, nearly 8 in 10 people who bought coverage on the exchange were able to buy a policy for under \$100/month.<sup>3</sup> Furthermore, according to the Kaiser Family Foundation, the cost of the most popular benchmark plan on the exchange has been virtually unchanged since 2014 when subsidies are accounted for.<sup>4</sup> In fact, in 2018, net premiums will actually be slightly lower than 2017, because the IRS has reduced the percentage of income that people have to pay for the benchmark plan.<sup>5</sup>

These impacts are real. Over and over, when I was at CMS, I met and heard from people who, prior to the ACA, couldn't get insured for a chronic condition, couldn't afford insurance, or couldn't leave their job without fear of being without insurance. Life is immeasurably better for many people as a result of the ACA.

But as with any major legislation, there are areas ripe to address, some of which I will come to as I discuss policy recommendations. Others like the "family glitch", income cliffs, and certain Tribal issues I encourage addressing, but are beyond the time and scope of this hearing.

Nor am I here only with the perspective of a former government official. I understand the potential of the private sector because I have worked for one of the largest participants in the health care private sector. Prior to joining CMS, I had a two-decade private sector health care career. Most of my career has been focused directly on the expansion of coverage, including exchange markets, as well as major initiatives to improve health care affordability for Americans. I have been a health care technology entrepreneur and built a company focusing on online consumer access to health care purchasing for the un- and under-insured as far back as the 1990s. I led an insurance company exclusively serving hard-to-reach rural and farming communities. And I helped build a large and successful private sector health care company which contained among other things, a large actuarial consulting business, a private insurance exchange, and consumer transparency tools.

I have an understanding of how exchanges work and what they need to do in order to be successful from several perspectives—as a regulator, as a market participant, and now as a consumer. If anyone tells you the ACA is failing, doomed, or irreparably broken, I would respectfully disagree and suggest that with the proper management and support, most challenges are addressable. This doesn't mean the ACA doesn't need active management to be as successful as possible. It requires an Administration committed to the goal of getting more people access to coverage, particular as these

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<sup>3</sup> "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace," Office of the Assistant Secretary for Planning and Evaluation, Department of Health & Human Services, October 24, 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>

<sup>4</sup> Kamal, Raba, et al. "An Early Look at 2018 Premium Changes and Insurer Participation on ACA Exchanges." *Henry J. Kaiser Family Foundation*, August 10, 2017. Available at: <http://www.kff.org/health-reform/issue-brief/an-early-look-at-2018-premium-changes-and-insurer-participation-on-aca-exchanges/>

<sup>5</sup> Norris, Louise. "Is the IRS changing how much I'll have to pay for my health insurance next year?" *HealthInsurance.org*, August 15, 2017. Available at: <https://www.healthinsurance.org/faqs/is-the-irs-saying-ill-have-to-pay-more-for-my-health-insurance-next-year/>

are still the early years for the program. And, to be successful, we must continually improve and capitalize on lessons learned from the early years of the exchange.

## Immediate Recommendations

As a starting point, I believe we should be open to any improvements to current law, no matter the origin of the idea. As Americans, we all have a rooting interest in improving health care for our families, and in the communities we live in. Any improvements, however, should meet important criteria. We should support policies which are judged by an impartial body like the Congressional Budget Office to: (1) increase the number of Americans with coverage, (2) improve affordability, (3) maintain or improve the quality of coverage, and (4) do so in a fiscally responsible manner.

Following my recommendations, I will provide a link to a more exhaustive bipartisan set of recommendations from the Bipartisan Policy Center. The best immediate opportunity for Congress is to take steps to improve the affordability of premiums and the size of deductibles without hurting access to coverage.

- As a chorus of bipartisan insurance commissioners, governors, and advocates on all sides have indicated, by simply committing to paying **Cost Sharing Reduction** payments, Congress can take immediate steps to reduce premiums by 20%.<sup>6</sup> This commitment should be made at least through 2019 and has already been accounted for in the federal budget. My experience over many years echoes the sentiment from these bipartisan and non-partisan experts. Uncertainty is not our friend when operating free market exchanges. Predictability and consistency will lead to more competition, lower premiums, and reduced deductibles. Insurance companies begin the 2019 rate filing process as early as the Spring of 2018, and having states and insurance companies and consumers uncertain about the rules for 2019 will limit their participation and increase the cost to consumers.
- Another bipartisan idea that is proven to bring down premiums for consumers is **reinsurance**. Particularly in smaller states, the cost of insurance for everyone covered can be impacted by even a small number of expensive patients with complex medical conditions. Innovative efforts, as we have seen in Alaska, have demonstrated that this approach works. In both Alaska and Minnesota, the estimated impact of a well-structured reinsurance program has been estimated at 20% of premium<sup>7</sup>. Reinsurance is also budget friendly as approximately half of the outlay is recovered by the reduction in premiums and government subsidies.
- **Marketing, outreach and in person enrollment support** is vital to not only bring down the uninsured rate, but to improve the risk pool. This directly reduces premiums for American families and benefits the U.S. taxpayer. No additional funds need to be allocated. Rather HHS should be directed to commit at least the funds that have been recently cut from marketing, outreach and in-person assistance, as well as to provide appropriate levels of call center staffing. Because these funds generally come from user fees paid by insurers,

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<sup>6</sup> "The Effects of Terminating Payments for Cost-Sharing Reductions," Congressional Budget Office, August 15, 2017. Available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>

<sup>7</sup> "Alaska: State Innovation Waiver under section 1332 of the PPACA," Centers for Medicare & Medicaid Services, Department of Health & Human Services, July 22, 2017. Available at: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf>

there would be no budget impact to doing so. Outreach is particularly important with a shortened enrollment period and polls showing much of the public is confused about the status of the ACA and the availability of insurance.

- Due to the foresight of this Committee, we have provisions in the law to allow states to go further and provide local state-based innovations through the **1332 waiver process**. This is a significant opportunity, and one the Committee should consider making easier. Only two waivers have been approved, and I know there are states that are quite concerned about the time it takes to approve a waiver, particularly one that looks a lot like a previous waiver. I would support steps to shorten the timeline for 1332 approvals and other common-sense steps to simplify the waiver process, subject to maintaining the critical guardrails that protect consumers. These guardrails are the same ones I mentioned above - (1) increasing the number of Americans with coverage, (2) improving affordability, (3) maintaining or improving the quality of coverage, and (4) doing so in a fiscally responsible manner - that should be criteria for any health care reform proposals considered.

All-in, while close to 85% of exchange participants don't pay the headline premiums,<sup>8</sup> and as a result have not been subject to the widely reported rate increases, taken together, these recommendations represent an important opportunity for Congress to help reduce premiums for Americans who do not qualify for tax credits. These solutions are not beyond our scope—they are surgical, affordable, and appropriate for where we are at this stage of the exchanges. If the Administration commits to enforcing the existing law and implements these straightforward and budget-friendly proposals, we can be confident of a stable, lower cost, competitive individual market heading into 2019.

### **Cost and Coverage: Medium and Longer-Term Reforms**

We cannot simply focus on how insurance markets work if we want to make health care more affordable, and more accessible, to all Americans. We must address the underlying costs of care, where 85% of a consumer's premium is spent.

We must focus on root cause issues that drive health care costs. Many are well-documented-- poor care coordination, the costs of unmanaged chronic disease, the high administrative burden and complexity of our system, our underinvestment in primary care and the social determinants of health, and the costs of high need patients like those dually eligible for Medicare and Medicaid. Our health care system, in particular, is not well situated to treat people with multiple chronic physical and mental conditions. Ultimately, we need to undergo a major conversion from institutional-based care to keeping people healthy and treating them in comfortable and low-cost settings, where the most successful and satisfying health care is delivered.

To be effective at this, we must also alter how we pay for care if we want to see better, more affordable results. We must commit to moving to a system where we pay for quality outcomes and reward the smart use of resources. This means paying for care in bundles so physicians and other clinicians work as a team to achieve a better outcome. This means paying for prevention like pre-diabetes care and cardiac prevention. And it means we must address the rising costs of prescription

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<sup>8</sup> "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace," Office of the Assistant Secretary for Planning and Evaluation, Department of Health & Human Services, October 24, 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf>

drugs, whose costs put a significant and growing burden on American families and taxpayers. The Medicare Access and CHIP Reauthorization Act Congress passed in 2015 on a bipartisan basis was an important step in the direction of a smarter payment system. Now, in implementing this law, we must listen to patients, caregivers and physicians and other clinicians so the law enables better results for patients-- rather than additional complexity.

We also need to pay special attention to the needs of rural America when it comes to health care. This was one of my priorities when I was at CMS and we began an initiative to focus on the unique competition, access, innovation, and structural health care issues in rural America. I held numerous sessions in rural parts of Oregon, Kansas and other states to understand these issues first hand. The issue of competition in rural counties on the exchanges is one that stems from the limited number of hospitals and contracting options. This dynamic results in higher costs and fewer insurers able to meet the needs of constituents. Special attention should be paid to these uniquely rural issues and to the consideration of creative solutions for consumers who lack access to sufficient choices, including consideration of access to the insurance options like the Federal Employees Health Benefits Plan or a modified version of the state's managed Medicaid plan.

One thing that will not reduce costs is simply reducing what insurance covers or cutting or capping access to vital programs like Medicaid for low-income seniors, children and people with disabilities. We know from experience that when fewer people are covered or have "gotcha" policies, they accrue bills that go unpaid and worse, defer or avoid care until their illnesses are too advanced. This makes health care more expensive for everyone<sup>9</sup>. Vital programs like Medicaid must always be examined and continually reformed. There are bipartisan approaches that move us beyond the current debate on Medicaid. Dr. Gail Wilensky, a former Bush Administration official, and I published a set of bipartisan approaches to reform Medicaid this summer in the *Journal of American Medical Association*<sup>10</sup>.

Ultimately as the title of your hearing indicates, covering more Americans and reducing health care costs are linked. We cannot provide access to the care Americans need without a sustainable system. Likewise, covering fewer people with shoddier insurance only serves to drive costs up.

## Conclusion

The above recommendations are my own. In addition to these recommendations, as a Senior Advisor at the Bipartisan Policy Center, I would also suggest that you look at recent recommendations published by BPC's Future of Health Initiative, in which I took part. Over the last six months, along with other Bipartisan Policy Center leaders, Republicans and Democrats, we have put together a set of recommendations.<sup>11</sup> During this process, I have had the opportunity along with other members of BPC's Future of Health initiative, to meet with hospital and insurer CEOs, Republican and Democratic state health officials, and experts from across the political spectrum to explore the question of what immediate and long-term priorities they have to improve the cost,

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<sup>9</sup> Subramanian, Suhja, "Impact of Medicaid Copayments on Patients with Cancer," *Medical Care*, Vol. 49, No. 9, 842-847, September 2011. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/21577164>

<sup>10</sup> Slavitt, Andy and Gail Wilensky, PhD, "Reforming Medicaid," *JAMA Forum*, July 11, 2017. Available at: <https://newsatjama.jama.com/2017/07/11/jama-forum-reforming-medicaid/>

<sup>11</sup> "Future of Health Care: Bipartisan Policies and Recommendations," Bipartisan Policy Center, August 2017. Available at: <https://bipartisanpolicy.org/library/future-of-health-care-bipartisan-policies-and-recommendations/>

quality and access to care. I have also personally had the opportunity to visit many parts of the country to hear directly from hundreds of ordinary Americans struggling with day-to-day health care concerns. There are, of course, wide ranging views but also common themes.

Two things stand out from all of these conversations. First, everyone asks for additional certainty out of Washington. Uncertain federal policy is not our friend and the only rational response to this uncertainty for many insurers and providers is to increase prices or decide not to participate in our programs entirely.

The second consistent theme from the world outside of Washington is a hope for bipartisanship—a desire that we can all come together to focus on pragmatic solutions when challenges arise. I understand the difficulty of reaching compromise, and I am realistic enough to understand that the politics of health care have grown complex. I know there will be a diverse and substantive set of views presented today. As challenging as it is, in the end it matters because we all have a stake in the same outcome.

With Congress's leadership, I know that I join with many in my commitment to supporting a collaborative path to improving both cost and coverage in America.