Senate Committee on Finance
U.S. Senator Orrin Hatch (R-UT), Ranking Member
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HATCH STATEMENT AT FINANCE COMMITTEE HEARING EXAMINING HEALTH INSURANCE EXCHANGES UNDER THE PRESIDENT'S HEALTH LAW

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing examining the progress of health insurance exchanges established under the President's health law:

Thank you, Chairman Baucus, for holding this hearing. I welcome this opportunity to join you in conducting Congressional oversight on the implementation of the President's health law, and more specifically, on the nature of health care exchanges.

It is no secret that the President promised that his plan to reform the health care system would reduce premiums by $2,500 for individuals.

He made this promise more than once.

At the time I was skeptical. And, as we're seeing now, I had good reason to be.

We are already feeling the impact of the law as the cost of insurance premiums continues to go up.

In 2014, when the law will be fully implemented, premiums will skyrocket further as insurers scramble to meet all of the new mandates that go into effect.

The question is: How high are costs going to go?

We have estimates from an Oliver Wyman study that suggest premiums in the individual market next year will increase an average of 40 percent.

The Society of Actuaries similarly estimates an average increase of 32 percent in premiums in the individual market.

For many communities it gets even worse.

A recent survey of health plans reveals that premiums in the individual market in Phoenix, Arizona could see an average increase of 157 percent. Milwaukee, Wisconsin will see an average increase of 190 percent.

If the point of the health care law was to reduce costs and increase access, these estimates show that it appears to have already failed.

Some of the law's supporters will say that these premium increases will be mitigated by the new health insurance subsidies. However, the Oliver Wyman study that I referred to found that 40 percent of those covered in the individual health insurance market in 2011 would be ineligible for these subsidies in 2014.

It also found that 36 percent of those currently uninsured can expect to pay more out of pocket for single coverage than they would otherwise, even with the availability of premium assistance.

These rate increases will have a significant impact on the ability of individuals to purchase coverage. It was bad policy when we debated it, it was bad policy when the Democrats jammed it through the Senate, and it is still bad policy today. And now consumers are starting to see its impact just as they are about to be able to enroll in the new health exchanges.

Today, we are here to discuss those exchanges.

As most of you know, I have a particular interest in this issue because the state of Utah was one of the first states to establish a market-based state exchange – prior to the passage of the law – that met their unique demographic needs.

The Administration claims that health insurance exchanges will allow plans to compete for business and therefore the cost of health insurance will be reduced.

Unfortunately the exchanges, as designed under the law, will do neither. They will actually increase health care costs.

We know that state-based exchanges are being established in 18 states. Of those states, 13 have published studies providing annual budget estimates for establishing and maintaining state exchanges. Those annual budget estimates range from $6 million to $300 million and will be funded through the establishment of exchange user fees.

Similar to state-based exchanges, the federally-facilitated exchange will be funded through the imposition of onerous user fees. The Administration recently proposed a 3.5 percent fee on each plan offered through the exchange.

This is no small amount and we all know that the cost will be passed down to consumers in the form of higher prices. Those who have doubts about this can ask the Joint Committee on Taxation or the Congressional Budget Office.

We also know that premiums are already increasing as a direct result of the new mandates under the law.

However, a number of questions remain.

For example, how much will user fees increase the cost of premiums and what impact will those increases have on individuals choosing to purchase a plan?

What is the annual budget of the exchange?

How will the federal data hub work?

What is the process for determining eligibility for the premium tax credits?

So, as you can see, many key details remain unanswered. And, in general, the Administration has provided very little detail on what the federally-facilitated exchange might look like even though the law was passed three years ago.

We have nearly 600 pages of regulations for the state-based exchanges, but only 19 pages of guidance on the contours of the federal exchange. Those 19 pages amount to little more than a statement of purpose from the Administration and exactly what the states can expect remains largely unknown.

I guess it is just another example of this Administration's unshakeable faith in the almighty federal government and its continued skepticism of our state governments.

Only 36 percent of the states have opted to establish a state-based exchange. That means more than half of the states have chosen to go with the federal exchange. However, surprisingly, the vast majority of the information provided by the Administration's is directed toward the minority of states that will be creating their own exchanges.

Of course, most of those states have Democratic governors, so perhaps it shouldn't be much of a surprise.

With individuals in states expecting to benefit from the so-called reforms passed in the health care law, it is critical that they have a clear understanding of how the federal exchange will work.

I expected the Administration to withhold details about the exchanges prior to the election, but we are now less than nine months away from open enrollment and the details necessary for the successful implementation of the plan are largely absent.

I think it is likely that the biggest reason these details have not been not provided is because many of them have yet to be agreed upon. If that is true, then I think it's fair to predict that a majority of Americans will not be able to access plans on the exchange come October 1, and a scenario for delay will soon be presented.

We have already seen proposed regulations pushing back the combined eligibility requirement to 2015.

I recommend that the Administration work with us to help us better understand the status of the exchange that will be providing insurance to over 13 million Americans.

With the announcement of nominations and the need to fill critical roles at the Treasury Department and HHS, it would be wise of the Administration to work with us and provide real answers to our questions. Sadly, so far, none of our letters regarding the exchanges have received a substantive response.

Chairman Baucus, since our committee has sole oversight jurisdiction on this important matter, I hope you will join me in asking for a renewed commitment on behalf of the Centers for Medicare and Medicaid Services, to answer our questions in a timely and substantive fashion. Pre-fabricated and boilerplate answers have no room in this important discussion. Ignoring this core responsibility is a huge disservice not only to the members of this committee, but more importantly to our hard working constituents in Utah and Montana who deserve these answers.

I look forward to hearing the testimony of Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight and our witnesses from Rhode Island, Delaware and Arizona.

I thank the Chairman for calling this hearing and look forward to working with him on this important issue.

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