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Stabilizing Premiums and Helping Individuals in the Individual Insurance Market: Health Care Stakeholders

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Introduction

Thank you, Chairman Alexander, Ranking Member Murray, and members of the Committee for the opportunity to testify today. I am Robert Ruiz-Moss, Vice President, Individual Business Segment at Anthem, Inc., and it is my honor to appear before you to share Anthem's ongoing experience in working with stakeholders across the health care spectrum to achieve a functioning, stable individual health insurance market.

Anthem is uniquely positioned to offer our perspective. For more than 75 years, Anthem has been focused on caring for America's health. Today, we serve more than 74 million Americans. As an independent licensee of the Blue Cross and Blue Shield Association, Anthem operates affiliated Blue-health plans in 14 states or state regions across the country. Through our Medicaid presence, we are able to broaden that reach, partnering with 20 states to serve 6.5 million beneficiaries. When combined with our growing Medicare business and diverse portfolio of specialty products and subsidiaries, Anthem plays a pivotal role in the health and well-being of communities across this country and for generations of American families.

I have over 25 years of experience across numerous facets of the health care industry, including serving as an original board member of the Colorado Health Benefits Exchange, appointed by Governor John Hickenlooper. Since joining Anthem in 2009, my primary objective has been refining the company's business model to meet the health care coverage needs of consumers in the reformed individual market.

Anthem remains committed to transforming health care by making it more affordable, higher quality, and more accessible for all. We are grateful for the work that you and your colleagues have done to improve our health care system. However, the uncertainty that continues to surround the individual market has only served to undermine its ability to function effectively, leading to increased costs and limited choices for consumers.

I appreciate this opportunity to speak to you today about some of the challenges we have observed in the individual market – from the opening of the Exchanges in 2014 to today – and to offer our recommendations for ways in which health care stakeholders, lawmakers, and regulators can work together to bring stability to that market in 2018 for the millions of consumers who rely on it.

Fundamentals of a Viable, Functioning Insurance Market

For more than seven decades, Anthem has served consumers in the individual market. Throughout that time, our commitment to providing our members access to affordable, quality health care coverage has been unwavering. As consumers' expectations have shifted, we have evolved to be responsive stewards of the trust they have placed in us to manage their health care benefits. Since the creation of the insurance exchanges through the Affordable Care Act (ACA), we have continued to serve consumers in all of the states where we provide fully-insured individual health plans.

While we are pleased that a number of steps have been taken to address the long-term challenges facing the individual market, the underlying lack of stability and predictability in the structure of the market continues to undermine our ability to map out a sustainable path forward. For Anthem, that has resulted in our having to make difficult decisions regarding our participation in markets across the country next year, which we do not take lightly.

A stable insurance market is dependent upon three fundamental conditions. First, there must be a balanced risk pool. A balanced risk pool is the result of health plans' ability to offer products that create value for consumers through the broad spreading of risk, as well as market dynamics which promote ongoing enrollment by individuals of all risks – healthy and unhealthy. Second, it requires a predictable regulatory environment with a known set of rules and conditions under which rates can be reliably developed. Finally, it requires predictable financing to ensure affordability for consumers. Unfortunately, those three conditions

have failed to fully materialize, which has made the planning and pricing of health plans in the individual market increasingly difficult, leading to a deteriorating and contracting risk pool with higher costs and fewer choices for consumers.

1. **Balanced Risk Pool:** Not enough healthy individuals are enrolling in coverage. This, in combination with the increased prevalence of "buying to use" behavior, in which individuals only purchase coverage in order to receive services before dropping that coverage, has accelerated deterioration of the individual market risk pool. The effects of this behavior are reflected in the average risk score of enrollees in the individual market, which Anthem data shows to be 10 percent higher than that of enrollees in the small group market in 2016, with the gap widening further so far this year. In addition, nearly 20 percent of Anthem individual market members only maintained their coverage for six months or less in 2016.

2. **Predictable Regulatory Environment:** Health plans serving consumers in the individual market are regulated by two, and in some cases three or four, separate governmental entities with varying requirements, mandates and timelines to follow. For example, in states that established a state-based exchange, health plans are subject to regulation from the federal government, state government and state exchange operating entity. In addition, some states have separate regulating entities for HMO and non-HMO plan offerings, which in addition to the federal government and state exchange operating entity, lead to four separate governmental regulating entities. Accordingly, plan participation in the individual market requires the careful orchestration of a multitude of moving parts in order to bring a product to market. For health plans, that means gathering input from clinicians, actuaries, claims departments, pharmaceutical benefits managers, and countless other functions, in the development of a high-quality product that is not only tailored to suit the varied health care needs of today's consumer, but is also affordable. Unfortunately, these efforts are rendered ineffective if the regulatory environment in which these products are developed is unreliable. The rules governing the individual market must be predictable and stable to ensure a balanced and functional operating environment for health plans.

3. **Predictable Financing to Ensure Affordability for Consumers:** It is critical that the individual market provide affordable options for consumers. Any payments from government sources to help achieve that objective must be predictable and reliable to ensure a stable market. There are many low-income individuals who cannot afford to purchase coverage in the individual market without financial assistance. As such, the uncertainty surrounding funding for the cost-sharing reduction (CSR) subsidies, coupled with the looming threat of the reintroduction of the health insurance tax (HIT), have only contributed to the volatile dynamics undermining health plans' ability to responsibly price products tailored to meet consumers' expectations of quality and affordability. These uncertainties have caused health insurance plans, including Anthem, to be cautious about continuing their participation in the individual market.

Recommendations to Stabilize the Individual Market for 2018

With open enrollment scheduled to begin on November 1, 2017, consumers will be looking to make important decisions regarding their health care needs. In order for them to make the best decisions for themselves and their families, they want assurances that lawmakers, regulators, and industry stakeholders are taking the necessary steps to ensure a viable, functioning individual market for the near- and long-term. While the window is closing, and our geographic participation is set, for 2018, there is still time for lawmakers and regulators to improve some of the conditions that have contributed to the instability of the individual market – but only if they act quickly. Drawing on our considerable experience providing health insurance coverage for more than 1.5 million consumers in this market, we believe the following steps must be taken immediately at the federal level to improve the individual market environment for consumers in 2018:

- **Funding certainty for CSRs:** Cost-sharing reduction subsidies play a pivotal role in ensuring access to health care services for very low-income enrollees, helping these individuals better afford their co-pays, deductibles, and other out-of-pocket costs. Currently, 6.4 million consumers are benefiting from CSRs. However, uncertainty over funding for CSRs for the remainder of 2017 and 2018, including threats to cut off this funding, both immediately and in the future, only contributes to the instability undermining the individual market. In its recent analysis[1] of the effects of terminating payments for CSRs, the Congressional Budget Office predicted that premiums for benchmark plans on the exchanges would go up by nearly 20 percent next year. Further, according to analyst projections, eliminating CSR payments would also result in a net increase in federal costs of $2.3 billion[2] for fiscal year 2018 as the result of the increased benchmark premium also increasing the premium subsidies. Independent analysis[3] also lays out the possibility of additional market exits as health plans are forced to decide whether the overall uncertainty of the market, coupled with the possible elimination of CSR funding, is too much risk to bear. Stakeholders[4] across the health care spectrum have found common cause in their shared recognition of the stabilizing role that funding certainty for CSRs play in the individual market.

- **HIT repeal or extension of the moratorium:** The moratorium on the health insurance tax ends at the close of 2017. The reintroduction of the HIT next year would result[5] in premium increases – ranging from three to five percent – across all fully-insured health insurance coverage, resulting in further disruption to the individual market. An extension of the current HIT moratorium – or full repeal of the onerous tax – would help prevent consumers from having to shoulder this burden, while introducing an additional stabilizing element to the individual market.

- **Market stability funding:** For the individual market to find its footing, it is critical that consumers have affordable options. Given the skewed distribution of health care spending – especially in the individual market – policy mechanisms[6] are necessary to help spread the costs associated with covering high-risk individuals.[7] In order to restore confidence in this fragile market, predictable and broadly financed stabilization funding must be made available. One way this can be accomplished is through a federal reinsurance[8] program that reduces risk[9] and enhances coverage options for individuals with costly health needs while lowering premiums for all consumers.

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[1] "The Effects of Terminating Payments for Cost-Sharing Reductions," Congressional Budget Office, August 2017, https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf

[2] Larry Levitt, Cynthia Cox, and Gary Claxton, "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments," The Henry J. Kaiser Family Foundation, 25 April 2017, http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/

[3] Dianna Welch and Kurt Giesa, "Analysis: Potential Impact of Defunding CSR Payments," Oliver Wyman Health, 12 May 2017, http://health.oliverwyman.com/transform-care/2017/05/impact_defunding_CSR_payments.html

[4] "Cost-Sharing Reductions Are Essential for Consumer Affordability, Choice, and Stability," AHIP Issue Brief, April 2017, https://www.ahip.org/wp-content/uploads/2017/04/CostSharingReductions_IssueBrief_4.25.17-1.pdf

[5] Chris Carlson, Glenn Giese, and Steven Armstrong, "Analysis of the Impacts of the ACA's Tax on Health Insurance in 2018 and Beyond," Oliver Wyman, 8 August 2017, http://www.stopthehit.com/wp-content/uploads/2017/08/Oliver-Wyman-2018-HIT-Analysis%E2%80%8E-August-8-2017.pdf

[6] "Steps Toward a More Sustainable Individual Health Insurance Market," American Academy of Actuaries, April 2017, http://www.actuary.org/files/publications/Sustainable_Health_Insurance_Marketplace_042417.pdf

[7] "Using High-Risk Pools to Cover High-Risk Enrollees," American Academy of Actuaries, February 2017, http://www.actuary.org/files/publications/HighRiskPools_021017.pdf

[8] Ashley Ridlon, "Stabilizing the Health Insurance Market: What the Experts Say," Bipartisan Policy Center, 8 June 2017, https://bipartisanpolicy.org/blog/stabilizing-the-health-insurance-market-what-the-experts-say/

[9] Michael Chernew and Christopher Barbey, "Supporting the Individual Health Insurance Market," Health Affairs, Blog, 7 August 2017, http://healthaffairs.org/blog/2017/08/07/supporting-the-individual-health-insurance-market/

- **Continuous coverage provisions:** Consumers purchasing coverage through the individual market should be treated like consumers with coverage through their employer and not be allowed to purchase insurance only when they need services. Health plans are required to take all applicants, regardless of health status. To ensure that the risk pool is functioning as intended, with healthy individuals balancing higher risk participants, broad participation is required. Accordingly, sufficient incentives must be in place to encourage healthy individuals to purchase and maintain coverage. Currently, the individual mandate under the Affordable Care Act is the mechanism in place that is intended to promote continuous coverage. However, the weak enforcement of the individual mandate – since its inception in 2014 – coupled with the organic weakening that has occurred as a result of the widening gap between the cost of 12-months of premiums and the mandate's financial penalty, is a primary driver of growing instability in the individual market. If the individual mandate is repealed, and health plans are still required to take all applicants, there must be an alternative mechanism to incentivize individuals to purchase and maintain health coverage. This can be accomplished through the introduction of rules incentivizing both enrollment and maintenance of continuous coverage. For example, establishing a waiting period to access benefits or assessing a late enrollment charge for someone who has failed to meet the continuous coverage requirement.

- In addition, while we appreciate efforts by both the previous and current Administrations to constrain special enrollment periods (SEPs) by requiring pre-enrollment verification of eligibility, more must be done to discourage "gaming" of the enrollment rules, including:

  - Limiting the number of life events that trigger an SEP to better align with the employer-sponsored market;
  - Requiring State-based exchanges to implement the same pre-enrollment verification rules required for the Federal exchange;
  - Tightening premium payment grace period rules or returning authority to state regulators, to more closely align with pre-ACA grace periods, which were typically shorter than the current 90-day period under federal law, thereby limiting gaming opportunities, while still giving consumers a reasonable time to pay for coverage; and,
  - Requiring that consumers be able to demonstrate continuous coverage to qualify for an SEP.

- **Predictable regulation and implementation:** As previously referenced, health plans serving consumers in the individual market are regulated by two, and in some cases three or four, separate governmental entities with varying requirements, mandates and timelines to follow. Stability and predictability of law and regulation is essential to a company's ability to engage in a market and effectively plan and execute its business operations. Successful partnership between government and business relies upon clear and predictable rules. The implementation of even small regulatory changes in the individual insurance market can be tremendously burdensome, requiring, at a minimum, sufficient lead time to plan and execute under the current rate and product filing requirements. Additionally, issuance of sub-regulatory guidance such as FAQs must be predictable and timely.

With the 2018 open enrollment period scheduled to begin on November 1, 2017, the window for making legislative and regulatory changes to promote a viable market is growing smaller, but it has not closed. While the changes that we are recommending will not change our geographic participation for 2018, they can still be implemented and operationalized for the 2018 plan year to improve the market environment for consumers – but, only if actions to effectuate those changes are taken very quickly. I urge the Committee to act on these recommendations as soon as possible in order to provide a more stable market environment in 2018 that leads to more affordable, quality health coverage options for consumers. While the focus of this hearing is on stabilizing the individual market for 2018, it is important to note that the aforementioned recommendations will also have a lasting, positive effect on the individual market environment in 2019 and beyond.

Recommendations for Long-Term Improvements to the Individual Market

The process for planning products and geographic participation for 2019 will begin in a few months. As such, we encourage the Committee to also devote time and attention to several issues that will help ensure the long-term stability of the individual market, including: Section 1332 waivers under the ACA; long-term stability funding; limiting third-party premium payments; and returning to the states more regulatory authority over the individual and small group markets.

- **Section 1332 Waiver Flexibility:** Section 1332 waivers offer a valuable opportunity for states to implement innovative programs to stabilize and promote long-term sustainability in their markets. Given the length of time that it takes to develop and obtain approval of a waiver, any future changes to the Section 1332 waiver requirements or process may not impact 2018. Such changes, however, could greatly benefit states seeking to make changes to their markets in 2019 and beyond.

  Unfortunately, rigid requirements and a burdensome process have dissuaded states from seeking innovation waivers until recently, when continuing instability prompted a number of states to pursue waivers in an effort to ensure that their residents would have access to affordable coverage in 2018. Waivers for reinsurance programs, in particular, have shown great potential for promoting stability, reducing premiums, and increasing the number of individuals covered in a state. For example:

  - Alaska recently received approval of a waiver to implement a reinsurance program for 2018. Premiums are expected to be 20 percent lower in 2018 than they would have been without the waiver. In addition, Alaska predicts that an additional 1,641 individuals will have health insurance coverage due to the lower cost of health care through stabilization of the individual market.

  - Minnesota and Oklahoma have also submitted applications seeking to implement reinsurance programs in their marketplaces for 2018, while Colorado and Maine are exploring possible waivers of their own.

  We recommend providing states flexibility to make innovative changes tailored to their markets by simplifying and streamlining the process for obtaining Section 1332 waivers and affording them greater flexibility in navigating the guardrails for obtaining a waiver. Specifically, actions should be taken to:

  - Reduce the time period for federal review of waiver applications, expediting the approval of waivers similar to those already approved for other states;

  - Allow states to authorize filing a waiver application via executive order or certification by the Governor and department of insurance, as opposed to requiring legislation; and,

  - Allow states to satisfy the budget neutrality requirements for a waiver over its lifetime, as opposed to year by year.

- **Long-Term Stability Funding:** In addition to the need for market stability funding in the short-term, we recommend establishing predictable and reliable long-term funding, from broadly based revenue, to help spread the costs of high-risk individuals. There are several viable ways to direct such funding, including reinsurance programs and high risk pools.

- **Prohibit Third Party Steerage:** Another recommendation that will improve the long-term stability of the individual market is to prohibit third parties from steering high-cost patients from public programs into the individual market. Health plans set rates based on the assumption that

certain populations, like end-stage renal disease (ESRD) patients, will be covered under Medicare and/or Medicaid. Currently, certain third parties are taking action to seek higher reimbursements from health plans by paying premiums on behalf of Medicare and/or Medicaid-eligible Americans to move them into the individual market. This practice is increasing costs for consumers by driving more high-risk individuals into an already unstable market, while disadvantaging consumers from accessing specialized public programs established for their unique care needs.

- **Reduce Duplicative Regulation while returning authority to states:** Health plans serving consumers in the individual market are regulated by two, and in some cases three or four, separate governmental entities, which leads to duplication of regulation by federal and state entities in some instances. Specifically, the ACA created duplicative federal regulation in several areas where states are better positioned to know what works best for their markets. While increased federal oversight has led to greater uniformity, it has also compounded the regulatory schemes that health plans must comply with, which often increases costs for consumers. We recommend reducing duplicative regulation and returning regulatory authority to the states in the following areas to give health plans greater ability to customize products to meet the local needs of consumers, while maximizing quality and affordability:

    - ***Individual and small group rate and benefit design review:*** The states have a long history of reviewing forms and rate requests for health insurance plans. Fully recognizing and relying on state activity in these areas will ensure that experienced regulators continue to review rates and forms while eliminating a duplicative process that often requires submissions of different forms, through different platforms, on different timelines at the federal level.

    - ***Network adequacy determination and enforcement:*** States are best positioned to evaluate plan networks as they are familiar with consumer needs, provider availability, market dynamics, geographies and patterns of care – all of which are relevant to evaluating the adequacy of a health plan's network.

    - ***Grace periods for nonpayment:*** The ACA contained a provision requiring for a 90-day grace period, meaning consumers could get coverage for the whole year while only paying for 9 months of coverage. Regulation in this area should be governed by state law, which prior to the ACA established grace period standards that were typically shorter than 90 days, limiting gaming opportunities, while still giving consumers a reasonable time to pay for their coverage.

Anthem's Commitment to Transforming Health Care

Anthem values the important role we play in the lives of millions of consumers. Our commitment to transforming health care is built upon the foundational belief that by driving innovation, we can deliver greater value for our members and provider partners, and ultimately, improve the sustainability of the system as a whole. We do this every day by focusing on four strategic areas: provider collaboration, consumer centricity, quality, and cost of care.

- **Provider collaboration**. Stakeholders are increasingly sharing risk. Behind this trend is our health care system's growing emphasis on value-based care. Anthem is working hard to cultivate the kind of close, collaborative models with providers that result in a better holistic health care experience for our members.

- **Consumer centricity**. As consumers' comfort with their health care options has increased, so, too, have their expectations. This fluency has led to an increased demand for a more personalized health care experience. Anthem has responded by investing in new tools that enhance our members' interaction with their benefits, while improving the quality of that care and lowering costs.

- **Quality**. Anthem understands that it is not enough for health care to be affordable and accessible – it must also be high quality. This is why we have made our goal to transform and improve health care a foundational component of who we are as an organization. We see quality as more than just a clinical goal, though, and are actively remaking ourselves, developing the necessary structures and process improvements across every business operation to further enhance our high quality standards.

- **Cost of care**. Our final strategic focus has to do with managing the total cost of care. While bringing stability to the individual market is a short-term imperative, a long-term health care crisis is being overshadowed: The continually rising cost of health care. Cost is the biggest and most pressing challenge facing our health care system. The cost of health care is simply too expensive and continues to rise at an unsustainable rate. Fifty years ago, spending on health care amounted to approximately 5 percent of the country's gross domestic product. By 2015, that number jumped to an alarming 17.8 percent, and is projected to reach 19.9 percent by 2025. Our country cannot simply continue to just spend more money on health care. We must seek solutions to address the underlying causes of cost growth in health care.

  Consumer research tells us that 'affordability' is now the most important factor guiding consumers' health care decisions. It is also a top priority for employers, as well as for our federal and state government partners. Improving affordability requires a focus on the cost of care – at both the individual and population levels. Anthem is doing our part to address the cost of health care. Examples include:

  - ***Value-based care.*** We now pay nearly 60 percent of our reimbursements through value-based care models. Today, more than 64,000 doctors across our family of health plans receive value-based payments and are accountable for the cost and quality of care for more than 5.5 million of Anthem's commercial members. Further, through our partnership with health care analytics firm, Castlight Health, we are able to provide members with the type of price and quality information that empowers them to make better informed choices. Also, Anthem has successfully built reference-based benefits programs with large employers, like the California Public Employee Retiree System (CalPERS)[10], in which set price limits are established for certain services – e.g., hip replacement – so consumers are armed with information about price and quality as they go to select their provider. Reference-based benefits have driven greater consumer engagement, addressing the disparity that often exists in provider costs, without compromising access to quality care. In fact, independent studies estimate savings for CalPERS of over $7.5 million per year on several procedures alone, including colonoscopies and arthroscopies.

  - ***Mitigating escalating drug prices*.** Spending on prescription drugs is now the fastest growing area of health care costs,[11] and is expected to continue rising faster than overall health care spending. Last year, the cost of drugs exceeded the cost of inpatient hospital stays in Anthem's commercial business. This trend is most acutely felt in the area of specialty drugs, where—across the entire health care system—spending on this category rose 13.1 percent in 2014, and is projected to exceed $400 billion by 2020. Closer to home, we project that by next year,

[10] Ann Boynton and James C. Robinson, "Appropriate Use of Reference Pricing Can Increase Value," Health Affairs, Blog, 7 July 2015, http://healthaffairs.org/blog/2015/07/07/appropriate-use-of-reference-pricing-can-increase-value/

[11] Jeff Lagasse, "Prescription Drug Spending Shows Fastest Growth, Overall Spending Outpaces Previous Two Years, Report Shows," Healthcare Finance, 23 November 2016, http://www.healthcarefinancenews.com/news/prescription-drug-spending-shows-fastest-growth-overall-spending-outpaces-previous-two-years

spending on specialty drugs alone will account for approximately half of Anthem's total prescription drug spend – up from about 30 percent currently. Meanwhile, according to expert analysis,[12] just ten breakthrough drugs are projected to cost government programs an estimated $50 billion over the next decade.

Given drug costs' disproportionate impact on the overall health care cost curve, the necessity of finding workable solutions cannot be overstated. With that in mind, Anthem joined forces with biopharmaceutical manufacturer, Eli Lilly & Co., in an attempt to confront the issue. Our partnership was born out of a shared understanding that our health care system needs vested stakeholders to put aside parochial interests in the service of moving towards real, achievable solutions. In keeping with the transition to paying for value that is currently reshaping other areas of the health care sector, similar value-based payment arrangements for pharmaceuticals must also be explored.

Anthem believes that this transition towards a value-based system for prescription drugs will help drive payment innovation. So, together with Lilly, we released two policy proposals aimed at changing federal regulations to help mitigate the challenges ahead in adopting sensible payment reforms for pharmaceuticals: 1) explicitly allowing for communication between health benefits companies and drug manufacturers regarding their products prior to FDA approval; and, 2) changing existing restrictions that hamper efforts to establish value-based contracts for new drug therapies. These two policy proposals are not a panacea for addressing rising drug costs, but they would have a positive real world impact and, more importantly, can help advance the current debate into legislative and regulatory action.

- ***Innovation.*** Anthem believes in the power of innovation to bring about transformational improvements to our health care system. That belief has seen us make considerable investments in technologies, like our LiveHealth Online telehealth platform that allows users to virtually connect to the care they need, when and where it is most convenient to them. Telehealth holds tremendous promise for improving access to health care in the day-to-day lives of consumers and during emergency situations. For example, Anthem is making access to LiveHealth Online free for the people of Texas and Louisiana impacted by Hurricane Harvey.

  Adopting a forward-thinking approach to anticipating consumers' evolving expectations, we have also established an Innovation Studio in Atlanta that brings together industry and technology leaders in a collaborative environment to brainstorm ideas and come up with new solutions that will enhance their experience. One innovation that is being piloted is a mobile bill-paying app that allows our members to pay premiums or medical bills directly from their mobile device. In its first six months of use, we received more than 50,000 transactions via the app.

Separately, as we look to help our members better manage their total cost of care, we interact with them more comprehensively along their entire continuum of care – from prevention to treatment to follow-up. This is made possible by our deep understanding of, and significant investment in, data analytics, which have enabled us to develop clinical programs and quality improvement initiatives that benefit consumers directly. For example, through our Anthem Cancer Care Quality Program – developed with our AIM Specialty Health subsidiary – we are able to make actionable data available to oncologists to help them make better informed treatment decisions. Last year, more than 1.6 million Americans were diagnosed with cancer. While advances in treatment continue to

[12] "The Future Cost of Innovation: An Analysis of the Impact of Breakthrough Therapies on Government Spending," Avalere Health, LLC., June 2015, file:///C:/Users/aa47057/Downloads/1433970206_061015_Avalere_AHIP_WhitePaper_LP_Final_03%20(1).pdf

offer hope, it remains a challenge for patients, their families, and their physicians to select from available therapies when seeking the best treatment options. With treatments costing about $100,000 on average per patient per year, information on health outcomes and cost effectiveness is critical.

These key investments in our health care data analytics capabilities speak to our ongoing effort to unlock greater savings for our members. Last year alone, we processed more than 730 million claims. The sheer enormity of that data translates into 17 petabytes of health information about our members – which is the equivalent of 1,700 times the entire printed collection housed in the Library of Congress.

Conclusion

For all the challenges facing us, we remain optimistic about what lies ahead. Anthem is doing our part, but we cannot do it alone. We must also recognize that given the layers of federal and state regulation over the individual market, federal actions alone will not achieve long-term stability. The level of deterioration and contraction of risk pools vary by state, in some instances due to challenges at the state level in need of attention. However, we are confident that the collective efforts of stakeholders and federal and state legislators and regulators from across the political spectrum, will continue to result in the kinds of improvements that make a difference in the health and well-being of consumers everywhere. We applaud the Committee for advancing a thorough and balanced dialogue aimed at bringing much needed stability to the individual health insurance market.

While a balanced risk pool and a more predictable and stable regulatory environment remain necessary components of a viable, functioning individual health insurance market, we must also turn our attention to the underlying cost of health care. Working in our favor are advances in both science and medicine, technological enhancements, and the mutual goal that affordable, high-quality health care should be accessible to all.

Thank you, again, for inviting me to share Anthem's perspective today and for the opportunity to work with you as we strive to ensure better health care for our nation's consumers.

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