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EXAMINING THREATS TO WORKERS WITH PREEXISTING CONDITIONS

HEARING

BEFORE THE

COMMITTEE ON EDUCATION
AND LABOR
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

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EXAMINING THREATS TO WORKERS WITH PREEXISTING CONDITIONS

Wednesday, February 6, 2019
House of Representatives
Committee on Education and Labor,
Washington, DC.

The committee met, pursuant to notice, at 10:15 a.m., in room 2175, Rayburn House Office Building. Hon. Robert C. "Bobby" Scott (chairman of the committee) presiding.

Present: Representatives Scott, Davis, Courtney, Sablan, Bonamici, Takano, Adams, Norcross, Jayapal, Morelle, Harder, McBath, Schrier, Underwood, Hayes, Shalala, Levin, Omar, Trone, Stevens, Lee, Trahan, Castro, Foxx, Roe, Thompson, Walberg, Guthrie, Byrne, Grothman, Stefanik, Allen, Smucker, Banks, Walker, Comer, Cline, Fulcher, Taylor, Watkins, Wright, Meuser, Timmons, and Johnson.

Staff present: Tylease Alli, Chief Clerk; Nekea Brown, Deputy Clerk; Ilana Brunner, General Counsel; David Dailey, Senior Counsel; Daniel Foster, Health and Labor Counsel; Mishawn Freeman, Staff Assistant; Alison Hart, Professional Staff; Carrie Hughes, Director of Health and Human Services; Eli Hovland, Staff Assistant; Eunice Ikene, Labor Policy Advisor; Ariel Jona, Staff Assistant; Kimberly Knackstedt, Disability Policy Advisor; Stephanie Lalle, Deputy Communications Director; Andre Lindsay, Staff Assistant; Max Moore, Office Aide; Merrick Nelson, Digital Manager; Udochi Onwubiko, Labor Policy Counsel; Véronique Pluviose, Staff Director; Banyon Vassar, Deputy Director of Information Technology; Joshua Weisz, Communications Director; Cyrus Artz, Minority Parliamentarian; Marty Boughton, Minority Press Secretary; Courtney Butcher, Minority Coalitions and Member Services Coordinator; Rob Green, Minority Director of Workforce Policy; John Martin, Minority Workforce Policy Counsel; Sarah Martin, Minority Professional Staff Member; Hannah Matesic, Minority Legislative Operations Manager; Kelley McNabb, Minority Communications Director; Alexis Murray, Minority Professional Staff Member; Brandon Renz, Minority Staff Director; Ben Ridder, Minority Legislative Assistant; Meredith Schellin, Minority Deputy Press Secretary and Digital Advisor; Heather Wadyka, Minority Staff Assistant; and Lauren Williams, Minority Professional Staff Member.

Chairman SCOTT. The Committee on Education and Labor will come to order, and I want to welcome everyone to the hearing. I note that a quorum is present. The Committee is meeting today to

hear testimony on examining threats to workers with preexisting conditions.

Pursuant to committee rule 7(c) opening statements are limited to the chair and the ranking member. This allows us to hear from our witnesses a lot sooner and provides all members with adequate time to ask questions.

I recognize myself now for the purpose of making an opening Statement.

Today we are here to examine the threats to affordable healthcare for workers with preexisting conditions. I want to welcome our distinguished witnesses for agreeing to be here today and to testify on an issue that affects roughly 133 million Americans across the country.

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act into law. Over the last 9 years, this historic legislation has improved the lives of countless Americans by making insurance more affordable and more accessible, while strengthening the quality of health coverage and enacting lifesaving consumer protections.

The Affordable Care Act's success is even more remarkable in the context of the persistent attempts to repeal and sabotage the law. Since it was passed the House Republicans called more than 70 votes to repeal all or parts of the ACA. Those efforts were punctuated by the American Health Care Act, a bill passed by House Republicans in 2017, which gutted protections for patients with preexisting conditions. According to the CBO, the repeal bill would have resulted in 23 million fewer Americans with health coverage, would have raised premiums by 20 percent the first year while providing less comprehensive benefits, and would have jeopardized many of the consumer protections found in the ACA.

The Trump Administration has taken an equally aggressive approach to undermining the law. For example, the Administration has expanded the use of junk plans that roll back consumer protections, raise the costs for most consumers, and have a troubling record of fraud and abuse.

On June 19, 2018, the Department of Labor finalized a rule to expand association health plans. Under the rule, associations can sell coverage to small businesses and self-employed individuals without meeting certain ACA standards that would otherwise apply, such as: the requirement to cover essential benefits, the prohibition against charging higher premiums based on factors such as gender or occupation, and the age rating limit, which prevents insurers from charging unaffordable premiums to older people.

Extensive research has shown that association health plans create a few winners and a lot of losers. A report published by the Government Accountability Office in 2000 found that they are likely to increase costs for most workers who are not in association plans and make it harder for older, sicker workers to get affordable care. The prevalence of fraud in these plans is equally concerning. A 2004 Congressional Budget Office report identified 144 "unauthorized or bogus" plans from 2000 to 2002. Those plans covered at least 15,000 employers and more than 200,000 policyholders, and left unpaid medical bills over $252 million.

On August 3, 2018, the Departments of Health and Human Services, Labor, and Treasury jointly moved to expand the use of short-term health plans. The Departments issued a final rule to extend the allowable duration of short-term plans from 3 months to up to 12 months, with renewability up to 36 months. Under the rule the short-term plans do not have include Federal consumer protections, including protections for patients with preexisting conditions. Because of the risk of confusion and overall lack of consumer safeguards, not one single group representing patients, physicians, nurses or hospitals voiced support for the rule expanding the use of short-term plans.

The Administration's final and most dangerous attack on the ACA is its unusual decision to side with a group of Republican attorneys general in a lawsuit against the Federal Government seeking to strike the ACA in court. So the Trump Administration is effectively arguing that the ACA's consumer protections should be invalidated, along with the rest of the law.

If this ultimately prevails, as it did in the district court in Texas, the result would be catastrophic. All Americans, whether insured through the ACA marketplace or through their employers, would lose the consumer protections we all take for granted, including elimination of lifetime and annual caps. The prohibition on lifetime and annual coverage limits, which protects workers from incurring unreasonable out-of-pocket expenses. Before the ACA, more than 90 percent of non-group plans had annual or lifetime caps on coverage, and a majority of the employer-provided plans imposed lifetime limits.

Cost-sharing protections, the requirement that plans offer to limit out-of-pocket costs to an affordable percentage of a worker's income, elimination of preexisting health condition exclusions, the requirement that all health plans cover patients with preexisting conditions at the standard rate. Last night I was pleased to hear the President's comment that he wants to protect patients with preexisting conditions and end the spread of AIDS. As I said, the actions of the Administration have jeopardized those protections and people with HIV or AIDS who would be excluded from coverage based on preexisting conditions if those initiatives succeed. Preventive services without cost-sharing, the protection that allows workers and families to access vital preventive care without paying out-of-pocket expenses. That protection would be eliminated.

While I appreciate that my Republican colleagues are now voicing support for many of these protections, their words have not translated into actions. On January 9, Democrats voted on a resolution to empower the House counsel to intervene in the Texas case to defend the ACA and protect people with preexisting conditions. Only three House Republicans voted to support the resolution.

There many different views within the Democratic Party and across the political spectrum regarding the best path forward to further expand affordable care. But we must all commit, both with our words and deeds, to maintaining the lifesaving consumer protections enacted in the ACA and we must refuse to go backward.

Until efforts to repeal and sabotage this historic legislation cease, workers with preexisting conditions will be at risk of losing access to the care they need to live healthy and fulfilling lives.

I now recognize the distinguished ranking member for the purpose of an opening statement.

[The statement of Chairman Scott follows:]

Prepared Statement of Hon. Robert C. "Bobby" Scott, Chairman, Committee on Education and Labor

Today, we are here to examine the threats to affordable health care for workers with pre-existing conditions. I want to welcome and thank our distinguished witnesses for agreeing to be here and testify today on an issue that effects roughly 133 million Americans across this country.

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act into law. Over the past 9 years, this historic legislation has improved the lives of countless Americans by making insurance more affordable and more accessible, while also strengthening the quality of health coverage and enacting lifesaving consumer protections.

Prior to the ACA, Federal law allowed insurers to deny people coverage for certain pre-existing conditions, including recently treated substance use disorder, pregnancy, and cancer. Prior to the ACA, insurers in the individual market could exclude these individuals from coverage, charge higher premiums, or put annual or lifetime caps of health care coverage.

According to a 2007 Commonwealth Fund survey, 36 percent of adults who attempted to purchase coverage in the individual market reported being turned down or charged a higher price because of their medical history. The ACA guaranteed access to affordable care for the roughly 133 million Americans with pre-existing conditions at the standard rate.

By any objective measure, the Affordable Care Act has been a success. The uninsured rate, which was 16.7 percent in 2009, fell to just 8.8 percent in 2017.

The ACA's success is even more remarkable in the context of the persistent attempts to repeal and sabotage the law. Since it was passed, House Republicans have voted more than 70 times to repeal all or parts of the ACA. Those efforts were punctuated by the American Health Care Act, a bill passed by House Republicans in 2017, which gutted protections for patients with pre-existing conditions. According to the CBO, the repeal bill would have resulted in 23 million fewer Americans with health coverage and would have raised premiums by 20 percent in the first year while providing less comprehensive benefits.

The Trump Administration has taken an equally aggressive approach to undermining the law. For example, the Administration has expanded the use of junk health plans that rollback consumer protections, raise costs for all consumers, and have a troubling record of fraud and abuse.

On June 19th, 2018, the Department of Labor finalized a rule to expand association health plans. Under the rule, associations can sell coverage to small businesses and self-employed individuals without meeting certain ACA standards that would otherwise apply, such as: 1) the requirement to cover essential health benefits; 2) the prohibition against charging higher premiums based on factors such as gender or occupation; and 3) the age rating limit, which prevents insurers from charging unaffordable premiums to older people.

Extensive research has shown that association health plans create winners and losers. A report published by the Government Accountability Office in 2000, found that they are likely to increase costs to some workers and make it harder for older, sicker workers to get affordable care. The prevalence of fraud in these plans is equally concerning. A 2004 Congressional Budget Office identified 144 "unauthorized or bogus" plans from 2000 to 2002, covering at least 15,000 employers and more than 200,000 policyholders, leaving $252 million in unpaid medical claims.

On August 3rd, 2018, the Departments of Health and Human Services, Labor, and the Treasury jointly moved to expand the use of short-term health plans. The Departments issued a final rule to extend the allowable duration of short-term health plans from 3 months to up to 12 months, with plans renewable for up to 36 months. Under the rule, short-term plans do not have include Federal consumer protections, including protections for patients with pre-existing conditions.

Because of the risk of confusion and the overall lack of consumer safeguards, not one single group representing patients, physicians, nurses or hospitals voiced support for the rule expanding the use of short-term plans.

The Administration's final and most dangerous attack on the ACA is its unusual decision to side with a group of Republican Attorneys General in a lawsuit against the Federal Government seeking to strike down the law in court. Specifically, the

Trump Administration is arguing that the ACA's consumer protections should be invalidated.

If it ultimately prevails, as it did in a District Court in Texas, the result would be catastrophic. All Americans, whether insured through an ACA marketplace or through their employer, would lose the consumer protections we all take for granted, including:

Elimination of Lifetime and Annual Caps: The prohibition on lifetime and annual coverage limits, which protects workers from incurring unreasonable out-of-pocket expenses. Before the ACA, more than 90 percent of nongroup plans had annual or lifetime caps on coverage, and a majority of employer-provided plans imposed lifetime limits.

Cost-Sharing Protections: The requirement that plans limit out-of-pocket costs to an affordable percentage of a worker's income.

Elimination of Preexisting Health Condition Exclusions: The requirement that all health plans cover patients' pre-existing conditions.

Preventive Services without Cost-sharing: The protection that allows workers and families to access vital preventive care without paying out-of-pocket.

While I appreciate that my Republican colleagues are now voicing support for many of these protections, their words have not translated into actions. On January 9, House Democrats voted on a resolution to empower the House counsel to intervene in the Texas case to defend the ACA and protect people with pre-existing conditions. Only three House Republicans votes to support the resolution.

There many different views both within the Democratic Party and across the political spectrum regarding the best path forward to further expand access to affordable care. But we must all commit both with our words and our actions to maintaining the lifesaving consumer protections enacted in the ACA and refusing to go backward.

Until efforts to repeal and sabotage this historic legislation cease, workers with pre-existing conditions will be at risk of losing access to the care they need to live healthy and fulfilling lives.

Thank you and I now yield to the Ranking Member, Dr. Foxx.

Mrs. FOXX. Thank you, Mr. Chairman. Americans with preexisting conditions need health insurance. This is a fact and a value that Congress and the President have affirmed countless times. It is also the law. Insurance companies are prohibited from denying or not renewing health coverage due to a preexisting condition. Insurance companies are banned from rescinding coverage based on a preexisting condition. Insurance companies are banned from excluding benefits based on a preexisting condition. Insurance companies are prevented from raising premiums on individuals with preexisting conditions who maintain continuous coverage.

So it is perplexing why Committee Democrats are even holding this hearing. And by doing so, they are making it about threats. Instead, this hearing should focus on how the strong economy, with its extraordinary job growth, is increasing the number of workers with employer-sponsored health coverage.

This committee's work on—employer-based health care options dates back to when the cost of health care began to rise several decades ago. The status quo was not sustainable, then and in 2010, the tide took a radical turn for the worse with the Affordable Care Act, which decimated options for employers earnestly seeking to provide competitive benefits packages to recruit and retain workers and sent individual premium costs on an even faster upward trajectory. Workers paid the price, employers paid the price.

But, after 8 years of Republican leadership in the House of Representatives and the election of President Trump, the U.S. economy and job markets are thriving. With consistent wage growth and greater availability of highly competitive jobs, smart employers are continuing to ensure that they offer competitive benefits pack-

ages—including sponsored health care plans—to recruit and retain workers. And their efforts are working.

According to the Kaiser Family Foundation, 152 million Americans—including many who have preexisting conditions—are insured through plans offered by their employer. That is the majority of the American work force and more than the individual market, Medicare, or Medicaid. Since 2013, 7 million more Americans have gained employer-sponsored health care coverage, with 2.6 million gaining coverage since President Trump took office. The plans employers offer are on average higher quality and provide better value than what can be found on the individual market.

In 2017, the average premium for individual and family employer-sponsored coverage increased by a modest 3 and 5 percent respectively. In contrast, the average exchange premium, Obamacare, went up by roughly 30 percent.

So, if we are going to have this hearing at all, we welcome it as an opportunity to talk once more about the importance of making sure American workers have more options, more flexibility, and more freedom.

Last Congress, the Republican-led House of Representatives passed the American Health Care Act. The legislation would restore stability to the health care marketplace and deliver lower costs to consumers. Ensuring protections for individuals with preexisting conditions was a central piece of the bill. It was Section 137 of the legislation stating: "Nothing in this Act shall be construed as permitting health insurance insurers to limit access to health coverage for individuals with preexisting conditions." So, people may have an opinion, but they cannot argue with the facts. The facts are written in this legislation—Section 137.

Republicans on this committee also led the passage of the Small Business Health Fairness Act. That legislation would empower small businesses to band together through association health plans, AHPs, to negotiate for lower health insurance costs on behalf of their employees. And last summer, the Department of Labor finalized a rule expanding access to AHPs.

During the 115th Congress, House Republicans also passed the Competitive Health Insurance Reform Act and the Committee-led Self Insurance Protection Act. What all of these bills have in common is their goal to expand coverage, lower health care costs for all Americans, and again, give freedom to Americans.

Committee Republicans welcome this opportunity once again to assure Americans with preexisting conditions that their coverage is protected.

House Republicans will continue to champion legislative solutions to combat some of the most pressing problems facing our healthcare system, including skyrocketing costs, the high prices of certain drugs, the industry's lack of cost transparency, and the looming threat of a single payer system. These are the factors that pose the real threat to Americans having options to work for them.

I yield back, Mr. Chairman.

[The statement of Mrs. Foxx follows:]

Prepared Statement of Hon. Virginia Foxx, Ranking Member, Committee on Education and Labor

Americans with pre-existing conditions need health insurance. This is a fact, and a value that Congress and the President have affirmed countless times. It's also the law. Insurance companies are prohibited from denying or not renewing health coverage due to a pre-existing condition. Insurance companies are banned from rescinding coverage based on a pre-existing condition. Insurance companies are banned from excluding benefits based on a pre-existing condition. Insurance companies are prevented from raising premiums on individuals with pre-existing conditions who maintain continuous coverage.

So it's perplexing why Committee Democrats are even holding this hearing, and by doing so they are trying to make it about threats. Instead, this hearing should focus on how the strong economy with its extraordinary job growth is increasing the number of workers with employer-sponsored health coverage.

This committee's work on employer-based health care options dates back to when the costs of health care began to rise several decades ago. The status quo was not sustainable then, and in 2010 the tide took a radical turn for the worse with the Affordable Care Act, which decimated options for employers earnestly seeking to provide competitive benefits packages to recruit and retain workers and sent individual premium costs on an even faster upward trajectory.

Workers paid the price. Employers paid the price.

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Health Fairness Act. That legislation would empower small businesses to band together through association health plans (AHPs) to negotiate for lower health insurance costs on behalf of their employees, and last summer, the Department of Labor finalized a rule expanding access to AHPs.

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Chairman SCOTT. Thank you. Without objection, all the members who wish to insert written statements to the record should do so by submitting them to the committee clerk electronically in Microsoft Word format by 5 p.m. February 19, 2019.

I will now introduce our witnesses.

Our first witness will be Sabrina Corlette, a research professor at the Center on Health Insurance Reforms at Georgetown University's McCourt School of Public Policy where she directs research on private health insurance and market research. Prior to joining Georgetown faculty she was the director of health policy programs at the National Partnership for Women and Families where she focused on insurance market reform, benefit design, and the quality and affordability of healthcare. She is a member of the Washington, DC Bar Association.

Chad Riedy is 37 years old, has cystic fibrosis. He lives in Alexandria, Virginia with his wife, Julie, and two sons. In addition to volunteering for the Cystic Fibrosis Foundation he has spent the last 13 year working in the real estate industry.

Grace-Marie Turner is president of Galen Institute, a public policy research organization she founded in 1995 to promote free market ideas for health reform. She has served as a member of the Long-term Care Commission, the Medicaid Commission, the National Advisory Board for the Agency for Healthcare Research and Quality. Prior to founding the Galen Institute she served as executive director for the National Commission on Economic Growth and Tax Reform.

Dr. Rahul Gupta is the senior vice president and chief medical and health officer for the March of Dimes. He is one of the world's leading health experts. In his role Dr. Gupta provides strategic oversight for the March of Dimes' medical and public health efforts to improve healthcare for moms and babies. Prior to joining the March of Dimes he served under two Governors as West Virginia's health commissioner, and as the chief health officer he led the State's opioid crisis response efforts and several public health initiatives.

We appreciate all of the witnesses for being here today and look forward to your testimony. Let me remind the witnesses that we have read your written statements and they will appear in full in the hearing record. Pursuant to committee rule 7(d), the committee, and committee practice, each of you will be asked to limit your oral presentation to a 5-minute summary of your written Statement.

Let me remind the witnesses that pursuant to Title 18 of the U.S. Code Section 1, it is illegal to knowingly and willfully falsify a Statement, representation, writing document, or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony please remember to press the button on your microphone in front of you so that it will be turned on and the members can hear you. As you begin to speak the light in front of you will turn green, after 4 minutes the light will turn yellow to signal you have 1 minute remaining. When the light turns red we ask you to summarize and end your testimony.

We will then let the entire panel make their presentations before we move to member questions. When answering a question please remember once again to turn your microphone on.

I will first recognize Ms. Corlette.

TESTIMONY OF SABRINA CORLETTE, RESEARCH PROFESSOR, CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE

Ms. CORLETTE. Thank you, Mr. Chairman. Ranking Member Foxx, members of this committee, it is really an honor to be here with you today and to discuss the need for affordable, adequate insurance coverage, particularly for those with preexisting conditions.

In my testimony I will focus on some of the challenges faced by people with preexisting conditions before the ACA was enacted and how current threats to the ACA could have disproportionately harmful effects on these individuals and workers.

Before the ACA was enacted roughly 48 million people lacked health insurance and an estimated 22,000 died prematurely each year due to being uninsured. 60 percent of the uninsured reported having problems with medical debt. The high number of uninsured was costing providers an estimated $1,000 per person in uncompensated care costs. The lack of affordable adequate coverage also led to a phenomenon called "job lock", where workers are reluctant to leave the guarantee of subsidized employer-based coverage for the uncertainty of the individual market. And for many people with health issues job-based coverage could also be spotty or include barriers to enrolling.

Prior to the ACA, in most States, people seeking health insurance could be denied a policy or charged more because of their health status, age, or gender, or have the services needed to treat their condition excluded from their benefit package. Indeed, a 2011 GAO study found that insurance companies denied applicants a policy close to 20 percent of the time. Under the ACA these practices are prohibited.

Prior to the ACA coverage also could come with significant gaps, such as for prescription drugs, mental health, and substance use services and maternity care. Under the ACA insurers must cover a basic set of essential benefits.

Extremely high deductibles and annual or lifetime limits on benefits were also common before the ACA. The law protects people from both by capping the annual amount paid out-of-pocket each year and prohibiting insurers from placing arbitrary caps on coverage.

Members of this committee are aware that the ACA is now under threat of being overturned due to pending litigation in Federal court. If the plaintiffs' argument prevails it would be tantamount to repealing the ACA without any public policy to replace it. And this is a scenario that Congress rejected in multiple votes in 2017. Congress rejected it because repealing the ACA without replacing it would result in 32 million Americans losing insurance, double premiums for people in the individual insurance market, leave an estimated three-quarters of the Nation's population in areas without any insurer, cause a significant financial harm for hospitals and other providers due to uncompensated care costs, cause the

loss of an estimated 2.6 million jobs around the country, and importantly for this committee, result in harm to people with job-based covered, including the loss of coverage for preventative service without cost-sharing, such as vaccines, well visits, and contraception, the return to preexisting condition exclusions, young adults no longer allowed to stay on their parents health plans, and insecurity due to crippling out-of-pocket costs for people with high cost conditions.

This Administration has also instituted regulatory changes that have resulted in higher premiums for people in the individual market. These include the decision to cut off a key ACA subsidy, the dramatic reduction in outreach and consumer enrollment assistance, and the introduction of junk insurance policies that are permitted to discriminate against people with preexisting conditions. The zeroing out of the mandate penalty has also increased premiums.

While the bulk of the negative effects of these policies are felt by people in the individual market, these negative effects spill over into the job-based market. The ACA is by no means perfect. Even its most ardent supporters argue that more could be done to expand Medicaid and improve affordability for middle class families. There are a range of policy options that this committee and others can explore to strengthen the law's foundation while also building on its remarkable achievements.

Thank you for providing this forum and I look forward to the discussion.

[The statement of Ms. Corlette follows:]



Georgetown University Health Policy Institute

CENTER ON HEALTH INSURANCE REFORMS

STATEMENT OF
SABRINA CORLETTE, J.D. RESEARCH PROFESSOR
CENTER ON HEALTH INSURANCE REFORMS
MCCOURT SCHOOL OF PUBLIC POLICY
GEORGETOWN UNIVERSITY

LEGISLATIVE HEARING "EXAMINING THREATS TO WORKERS WITH PRE-EXISTING CONDITIONS"
U.S. HOUSE OF REPRESENTATIVES
EDUCATION & LABOR COMMITTEE
FEBRUARY 6, 2019

Good morning, Mr. Chairman, Ranking Member Foxx, members of this committee. I am Sabrina Corlette, a Research Professor at Georgetown University's Center on Health Insurance Reforms (CHIR). I am responsible for directing research and analysis on health insurance, health insurance markets, and implementation of the Patient Protection and Affordable Care Act (ACA). The views I express today are my own and do not reflect those of Georgetown University.

I thank you for the opportunity to testify, and for the leadership of this Committee in addressing the need for affordable job-based coverage, particularly for those with pre-existing conditions. In my testimony I will discuss many of the challenges that people with pre-existing conditions faced in obtaining affordable, adequate insurance before the ACA was enacted, how the ACA was designed to address those challenges, and how current threats to the ACA could have disproportionately harmful effects on individuals and workers with health care needs.

The ACA Corrected Many Problems in a Dysfunctional Insurance Market

The Affordable Care Act was enacted in part to correct serious deficiencies in health insurance markets that left millions uninsured and millions more with inadequate coverage that failed to protect them from serious financial harm if and when they got sick. In order to assess the impact the ACA has had, it is important to understand the problems that Congress was seeking to solve when it enacted the law in 2010.

Prior to implementation of the Affordable Care Act's market reforms, approximately 48 million Americans lacked health insurance.[1] Those without health insurance have a lower life expectancy than those with coverage. Before the ACA was enacted, an estimated 22,000 people per year died prematurely because they lacked insurance.[2] This is likely because the uninsured are more than six times as likely as the insured to delay or forego needed care due to costs. For example, uninsured cancer patients are more than five times more likely than their insured counterparts to forego cancer treatment due to cost.[3]

Being uninsured also results in financial insecurity. In 2010, when the ACA was enacted, sixty percent of the uninsured reported having problems with medical bills or medical debt.[4] Additionally, prior to the ACA, the high and rising uninsured rate led to high and rising uncompensated care costs for providers, in 2009 estimated at $1000 worth of services per

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[1] DeNavas-Walt C, Proctor BD, Smith J. *Income, Poverty, and Health Insurance Coverage in the United States: 2012*, U.S. Census Bureau, Sept. 2013. Available at https://www.census.gov/prod/2013pubs/p60-245.pdf.

[2] Dorn S. *Uninsured and Dying Because of It*, The Urban Institute, Jan. 2008. Available at https://www.urban.org/sites/default/files/publication/31386/411588-Uninsured-and-Dying-Because-of-It.PDF.

[3] *Lives on the Line: The Deadly Consequences of Delaying Health Reform*, Families USA, Feb. 2010. Available at http://familiesusa.org/sites/default/files/product_documents/delaying-reform.pdf.

[4] Cunningham, P. and Sommers, A. *Medical Bill Problems Steady for U.S. Families 2007-2010*, Center for Studying Health System Change, Dec. 2011. Available at http://www.hschange.org/CONTENT/1268/?words=tracking%20report%2028.

uninsured person.[5] Providers ultimately pass those costs onto insured consumers and taxpayers.

Prior to the ACA, for most workers with job-based coverage, leaving their job – to care for a loved one, start their own business, or pursue other work that better fit their skills and talents – meant leaving the guarantee of subsidized health insurance coverage sponsored by the employer for the uncertainty of the individual health insurance marketplace. Economists call this "job lock." Until 2014, the individual health insurance market was an inhospitable place, particularly for anyone in less than perfect health. That's a lot of us - an estimated 133 million Americans have at least one pre-existing condition.[6]

Additionally, although most large employer plans were relatively comprehensive and affordable before the ACA, some plans offered only skimpy coverage or had other barriers to accessing care, leaving individuals—particularly those with costly, chronic health conditions—with big bills and uncovered medical care. For that reason, in addition to reforms for the individual and small-employer insurance markets, the ACA extended several meaningful protections to employees of large businesses.

Problems with Access

Prior to the ACA, in most states, applicants for health insurance could be denied a policy because of their health status, or charged more in premiums based on their health and gender, along with a number of other factors.[7] For many, coverage was often simply not available at any price. One of the many ways insurers maximized revenue was through aggressive underwriting practices resulting in a denial of coverage to individuals posing a potential health risk.[8] A Georgetown University study found that even people with minor health care conditions, such as hay fever, could be turned down for coverage.[9]

A U.S. Government Accountability (GAO) study in 2011 found that average insurer denial rates were 19 percent, but they varied dramatically market-to-market and insurer-to-insurer. For

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[5] Hu, L. et al. *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing*, National Bureau of Economic Research, Feb. 2018. Available at http://www.nber.org/papers/w22170.

[6] Office of the Assistant Secretary for Planning and Evaluation, *Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act*, Issue Brief, Jan. 2017. Available at https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf.

[7] Corlette S, Volk J, Lucia K. *Real Stories, Real Reforms.* Robert Wood Johnson Foundation, Sept. 2013. Available at https://georgetown.app.box.com/file/124506387872.

[8] U.S. Government Printing Office, Senate Hearing 113-663. *A New, Open Marketplace: The Effect of Guaranteed Issue and New Rating Rules*, U.S. Senate Health, Education, Labor & Pension Committee, Apr. 11, 2013. Available at https://www.gpo.gov/fdsys/pkg/CHRG-113shrg95186/html/CHRG-113shrg95186.htm.

[9] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?* Georgetown University and Kaiser Family Foundation, Jun. 2001. Available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/how-accessible-is-individual-health-insurance-for-consumers-in-less-than-perfect-health-executive-summary-june-2001.pdf.

example, across six insurers in one state, denial rates ranged from 6 percent to 40 percent.[10] These underwriting practices were banned by the ACA in 2014.

Additionally, it was not uncommon for insurers to rescind coverage after they had accepted an applicant. If an enrollee had any health care claims within their first year of coverage, the insurer would investigate that person's health history. If they found evidence that their condition was a pre-existing one and not fully disclosed during the initial underwriting process, even if unintentional, the company would deny the relevant claims and rescind or cancel the coverage.[11] The ACA has prohibited this practice except in clear cases of fraud by the policyholder.

Problems with Affordability

Prior to the Affordable Care Act, individual insurance was often unaffordable. Unlike those with employer sponsored coverage or in public programs like Medicare or Medicaid, people with individual insurance had to pay the full cost of their premium. According to one national survey prior to the ACA, 31 percent of individual market respondents spent 10 percent or more of their income on premium costs.[12] And, although those leaving job-based coverage were guaranteed access to an individual policy so long as they maintained continuous coverage, federal rules did not limit how much insurers could charge in premiums based on their age, gender, or health status.

As a result, the cost of premiums caused many individuals to forego coverage completely. A national survey found that nearly three-quarters (73 percent) of people seeking coverage in the individual market did not end up buying a plan, most often because the premium was too high. The coverage was least affordable for those individuals who needed it the most – people with pre-existing conditions.

Prior to the ACA, older and less healthy individuals had to pay more for coverage because health insurers would segment their enrollees into different groups and charge them different prices based on their health or other risk factors. In practice, this meant that people would be charged more because of a pre-existing condition (even if they had been symptom-free for years), because of their age, gender (insurers assume women use more health care services than men), family size, geographic location, the work they do, and even their lifestyle.[13] A

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[10] U.S. Government Accountability Office. *Private Health Insurance: Data on Application and Coverage Denials*, Mar. 2011. Available at https://www.gao.gov/assets/320/316699.pdf.

[11] Girion L. *Health Insurer Tied Bonuses to Dropping Sick Policyholders*, Los Angeles Times, Nov. 9, 2007. Available at http://articles.latimes.com/2007/nov/09/business/fi-insure9.

[12] Collins SR, Robertson R, Garber T, Doty MM. *Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act*, The Commonwealth Fund, Apr. 2013. Available at http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2013/Apr/1681_Collins_insuring_future_biennial_survey_2012_FINAL.pdf.

[13] Buntin MB, Marquis MS, Yegian JM. *The Role Of The Individual Health Insurance Market And Prospects For Change*, Health Affairs, Nov./Dec. 2004. Available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.6.79.

Georgetown University study of insurers' rating practices before the Affordable Care Act found rate variation of more than nine-fold for the same policy based on age and health status.[14]

Under the Affordable Care Act, using health status and gender to set premium rates is prohibited. In addition, the Affordable Care Act provides low- and moderate-income people between 100 and 400 percent of the federal poverty line with subsidies to help defray their premium costs. In 2018, the average monthly premium tax credit was $550, resulting in an average monthly premium for consumers receiving a premium tax credit of $89.[15]

Problems with Coverage Adequacy

Prior to the Affordable Care Act, coverage in the individual market was often inadequate to meet people's health care needs. In addition to paying more in premiums, people in the individual market also spent a larger share of their income on cost-sharing than those with employer-sponsored coverage. A primary reason people buying individual insurance coverage had high out-of-pocket costs was that many individual plans – over half according to one study – did not meet minimum standards for coverage.[16] Coverage in the individual market was inadequate for a number of reasons, including:

- ***Pre-existing condition exclusions***: in many states, insurers in both the individual and employer group markets were permitted to permanently or for a period of time exclude from covered benefits treatments for any health problem that a consumer disclosed on their application. This practice was banned under the Affordable Care Act.
- ***Benefit exclusions***: Insurers in the individual market often sold policies that did not cover basic benefits such as maternity care, prescription drugs, mental health, and substance use treatment services. For example, 20 percent of adults with individual insurance lacked coverage for prescription medicines before the Affordable Care Act.[17] The Affordable Care Act requires insurers in the individual and small employer markets to cover a minimum set of essential health benefits that includes maternity services, prescription drugs, and mental health and substance use treatment. The ACA also requires plans, including employer plans, to cover recommended preventive services without consumer cost-sharing.
- ***High out-of-pocket costs***: Prior to the Affordable Care Act, individual insurance policies often came with high deductibles – $10,000 or more was not uncommon – and high

[14] Pollitz K, Sorian R. *How Accessible is Individual Health Insurance for Consumers in Less-than-perfect Health?*
[15] Kaiser Family Foundation. *Marketplace Average Premiums and Average Advanced Premium Tax Credit (APTC)*, Open Enrollment 2018. Available at https://www.kff.org/health-reform/state-indicator/marketplace-average-premiums-and-average-advanced-premium-tax-credit-aptc/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[16] Gabel JR et al. *More Than Half Of Individual Health Plans Offer Coverage That Falls Short Of What Can Be Sold Through Exchanges As Of 2014*, Health Affairs, Jun. 2012. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2011.1082.
[17] Doty MM, Collins SR, Nicholson JL, Rustgi SG. *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*

cost-sharing.[18] In fact, deductibles were often three times what they were in employer-sponsored plans. As a result, many individual insurance plans were extremely low-value. The ACA requires plans to cover, at minimum, 60 percent of an average enrollee's covered health care costs. The law also helps protect consumers in both individual and employer plans from catastrophic medical costs by capping their annual out-of-pocket spending (for 2019, the annual cap is $7900 per individual).

- ***Lifetime or annual dollar limits on coverage***: Prior to enactment of the ACA, an estimated 102 million people were in plans with a lifetime limit on benefits and about 20,000 people hit those limits every year. An estimated 18 million people were in plans with annual dollar limits on their benefits. For people with serious high cost medical conditions, such as hemophilia, serious cancers, or end-stage renal disease, this can literally be a life or death issue. The ACA ushered in bans on lifetime and annual dollar limits for both individual and employer group plans.

The ACA: Expanding Coverage, Protecting People with Health Care Needs

One of Congress' goals for the ACA was to extend affordable, adequate health insurance coverage to more people and to protect people with pre-existing conditions from common insurance industry practices, described above. Congress tried to achieve these goals through a three-pronged strategy:

- Insurance reforms for the individual and employer group markets to help people with health care needs;
- An individual mandate to encourage healthy people to enroll in the insurance pool and keep premiums stable; and
- Subsidies to help people afford the insurance coverage (with Medicaid expansion available for people under 138 percent of the federal poverty line). The Affordable Care Act also created state-based insurance marketplaces where people can apply for the subsidies and shop for plans.

To a significant degree, the ACA has achieved its goals. It has expanded access to insurance coverage, improved health outcomes, and improved families' financial security. Under the ACA, the percentage of people uninsured declined from 14.5 percent in 2013 to 9.1 percent in 2017. An estimated 20 million people gained insurance coverage because of the ACA, although some recent survey data suggest those gains are now being reversed.[19,20]

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[18] McDevitt R et al. *Group Insurance: A Better Deal For Most People Than Individual Plans*, Health Affairs, Jan. 2010. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2009.0060.

[19] Cohen RA, Zammitti EP, Martinez ME. *Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2017*, Centers for Disease Control and Prevention, National Center for Health Statistics, May 2018. Available at https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201805.pdf.

[20] Gallup News, U.S. Uninsured Rate Rises to Four-Year High, January 23, 2019. Available at https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx.

The goal of expanding coverage is ultimately to improve people's health outcomes and their financial security in the event of an unexpected illness or injury. Although the law is only a few years old, data are beginning to emerge that suggest it is having a significant positive impact.

Since enactment of the ACA, the percentage of Americans reporting that they didn't see a doctor or fill a prescription because they couldn't afford it has declined by more than one-third.[21] Further, more people are reporting that they have a primary care doctor or have had a check-up in the last 12 months.[22]

Research also strongly suggests that expanding access to coverage leads to better health outcomes. For example, studies of the health reforms in Massachusetts, upon which the ACA was modeled, have found that coverage expansion in that state led to reported improvements in physical and mental health, as well as reductions in mortality.[23] A Harvard study found that expanded coverage under the ACA was linked to major improvements in the diagnosis and treatment of chronic diseases such as hypertension, diabetes, and high cholesterol.[24]

In addition to improving access to care, health insurance also provides financial security, particularly in the event of a large, unanticipated medical expense. Survey data show that the number of families who say they are having problems paying medical bills has fallen dramatically since 2013, particularly among low- and moderate-income families.[25]

The ACA has also helped reduce uncompensated care costs borne by providers. For example, hospital-based uncompensated care fell by over 25 percent between 2013 and 2015, and in Medicaid expansion states it has fallen by closer to 50 percent.[26]

Unfortunately, much of the progress under the ACA is at risk due to litigation that threatens to overturn the law, as well as recent federal policy decisions designed to roll back key provisions of the law and bypass consumer protections. Ultimately, some of these decisions are likely to

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[21] McCarthy, J. *U.S. Women More Likely Than Men to Put Off Medical Treatment,* Gallup, Dec. 2017. Available at http://news.gallup.com/poll/223277/women-likely-men-put-off-medical-treatment.aspx.

[22] Karpman, M. et al. *Time for a Checkup: Changes in Health Insurance Coverage, Health Care Access and Affordability, and Plan Satisfaction among Parents and Children between 2013 and 2015,* Urban Institute, Jan. 2016. Available at http://hrms.urban.org/briefs/changes_coverage_access_affordability_parents_children.pdf.

[23] Van Der Wees, PJ, et al. *Improvements In Health Status After Massachusetts Health Care Reform,* National Center for Biotechnology Information, Dec. 2013. Available at https://www.ncbi.nlm.nih.gov/pubmed/24320165.

[24] Hogan DR et al. *Estimating The Potential Impact Of Insurance Expansion On Undiagnosed And Uncontrolled Chronic Conditions*, Health Affairs, Sept. 2015. Available at https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.1435.

[25] Karpman, M and Long, S. *9.4 Million Fewer Families Are Having Problems Paying Medical Bills,* Urban Institute, May 2015. Available at http://hrms.urban.org/briefs/9-4-Million-Fewer-Families-Are-Having-Problems-Paying-Medical-Bills.pdf.

[26] Schubel, J and Broaddus, M. *Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains*, May 2018. Available at https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

result in consumers in the individual market facing higher premiums and fewer plan choices, while putting protections for workers with job-based coverage at risk.

Health System Upheaval and Workers Put at Risk: Consequences of Overturning and Undermining the ACA

Texas v. Azar: ACA "Repeal" without "Replace"

The attorney general of Texas leads a coalition of states seeking to have the ACA enjoined, arguing that the individual mandate is unconstitutional, and the rest of the law is non-severable from the mandate provision. A district court judge has agreed with that view, although he has stayed enjoining the law while his decision is being appealed.[27] Granting Texas' request to enjoin the ACA amounts to an effort to repeal the law without any clear public policy to replace it. Congress explicitly rejected repealing the ACA without a replacement in 2017. This is because uprooting a complex law that has been in place for almost 10 years, touches almost every facet of our health care system, and includes many provisions with widespread bipartisan support (such as allowing young adults to stay on their parents' plans until age 26, closing the Medicare drug benefit "donut hole," and expanding Medicaid) will inevitably result in dramatic negative consequences:

First, an estimated 32 million people will lose their insurance coverage.[28] Second, those remaining in the individual market would see their premiums roughly double.[29]

Third, even a partial repeal of the provisions of the ACA would primarily harm working middle class Americans. The majority of people losing coverage – as many as 82 percent – would be in working families.[30] Fourth, repealing the ACA will have significant negative consequences for public health and safety. For example, researchers from Harvard and New York University found that repealing the ACA would result in 1.25 million Americans with serious mental conditions losing coverage. They further estimate that 2.8 million Americans with a substance use disorder, including roughly 222,000 with an opioid-related disorder, would lose coverage.[31]

Fifth, repealing the ACA will drive insurance companies out of the market. The CBO estimated that legislation repealing the ACA would leave an estimated three-fourths of the nation's

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[27] ***Texas v. Azar...*** https://affordablecareactlitigation.files.wordpress.com/2018/12/Texas-v.-US-partial-summary-judgment-decision.pdf

[28] Congressional Budget Office. ***Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017***, Jul. 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52939-hr1628amendment.pdf.

[29] *Id.*

[30] Blumberg L, Buettgens M, Holahan J. ***Implications of Partial Repeal of the ACA Through Reconciliation***, Urban Institute, Dec. 2016. Available at https://www.urban.org/sites/default/files/publication/86236/2001013-the-implications-of-partial-repeal-of-the-aca-through-reconciliation_1.pdf.

[31] Frank RG, Glied SA. ***Keep Obamacare to Keep Progress on Treating Opioid Disorders and Mental Illnesses***, The Hill, Jan. 2017. Available at http://thehill.com/blogs/pundits-blog/healthcare/313672-keep-obamacare-to-keep-progress-on-treating-opioid-disorders.

population in areas where no insurers are willing to offer nongroup coverage by 2026.[32] These estimates align with my own research at Georgetown, in which colleagues and I conducted interviews with 13 health insurance company executives participating in the individual markets in 28 states. In those interviews, executives told us they would "seriously consider" a market withdrawal if the ACA were repealed.[33]

Sixth, an increase in the uninsured will impose significant financial harm on hospitals and other health care providers. For example, repealing the ACA without a replacement was estimated to cost the nation's public hospitals $54.2 billion in uncompensated care charges between 2018 and 2026.[34]

Seventh, repeal of the ACA would lead to significant negative economic consequences. For example, repealing just the Medicaid expansion and Affordable Care Act tax credits would result in an estimated loss of 2.6 million jobs across the country.[35]

Eighth, and importantly for this committee, overturning the ACA would also harm the estimated 156 million Americans with job-based insurance who will lose critical protections, including:[36]

Preventive Services Without Cost-Sharing

The ACA requires all new health plans, including those sponsored by employers, to cover recommended preventive services without cost-sharing, bringing new benefits to 71 million Americans.[37] That means individuals can get the screenings, immunizations, and annual check-ups that can catch illness early or prevent it altogether without worrying about meeting a costly

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[32] Congressional Budget Office. *Cost Estimate: H.R. 1628, Obamacare Repeal Reconciliation Act of 2017*, Jul. 2017.
[33] Corlette S, Lucia K, Giovannelli J, Palanker D. Uncertain Future for Affordable Care Act Leads Insurers to Rethink Participation, Prices, Georgetown University and Robert Wood Johnson Foundation, Jan. 2017. Available at https://georgetown.app.box.com/file/127781433019.
[34] America's Essential Hospitals. *ACA Replacement Must Protect Vulnerable People, Communities*, Feb. 2017. Available at https://essentialhospitals.org/wp-content/uploads/2017/02/UCC-policy-brief-February-2017-FINAL.pdf.
[35] Ku L, Steinmetz E, Brantley E, Bruen B. *Repealing Federal Health Reform: Economic and Employment Consequences for States*, The Commonwealth Fund, Jan. 2017. Available at http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2017/jan/ku-aca-repeal-job-loss/1924_ku_repealing_federal_hlt_reform_ib.pdf.

[36] Rae M., Claxton G., Levitt L., McDermott D., *Long-Term Trends in Employer-Based Coverage*, Kaiser Family Foundation, January 30, 2019. Available at https://www.healthsystemtracker.org/brief/long-term-trends-in-employer-based-coverage/.

[37] U.S. Department of Health & Human Services, *Assistant Secretary for Planning and Evaluation, Seventy-one Million Additional Americans are Receiving Preventive Services Coverage without Cost-sharing Under the Affordable Care Act*, March 18, 2013. Available at https://aspe.hhs.gov/pdf-report/seventy-one-million-additional-americans-are-receiving-preventive-services-coverage-without-cost-sharing-under-affordable-care-act.

deductible or co-payment. Women employees can also access affordable contraception, making available a wider variety of contraceptive choices and increasing use of long-term contraceptive methods.

Pre-Existing Condition Exclusions

Under the ACA, employers cannot impose a waiting period for coverage of a pre-existing condition. Prior to the ACA, individuals who became eligible for an employer plan—for example, once hired for a new job—might have to wait up to 12 months for the plan to cover pre-existing health conditions. You could "buy down" that waiting period with months of coverage under another plan, so long as it was the right kind of plan and you didn't go without coverage for 63 days or more. But if you lost your job, couldn't afford COBRA, went a few months without coverage and then were lucky enough to get another job with benefits, you might find the care you needed wasn't covered under your plan for an entire year.

Dependent Coverage to Age 26

The ACA requires all health plans, including those sponsored by large employers, to cover dependents up to age 26. Prior to the ACA, one of the fastest growing groups of uninsured was young adults – not because they turned down coverage offered to them, but because they were less likely to have access to employer-based plans or other coverage. The result has been a dramatic increase in the number of insured young adults, particularly among those with employer-sponsored coverage.

Annual Out-Of-Pocket Limit

The ACA requires all new health plans, including those sponsored by employers, to cap the amount individuals can be expected to pay out-of-pocket each year. Prior to the ACA, even those with the security of coverage on the job couldn't count on protection from crippling out-of-pocket costs.

Prohibition On Annual and Lifetime Limits

The ACA prohibits employer plans from having an annual or lifetime dollar limit on benefits. Prior to the ACA, employer plans often included a cap on benefits; when employees hit the cap, the coverage cut off. For individuals who needed costly care, like a baby born prematurely or those with hemophilia or multiple sclerosis, that often meant a desperate scramble to find new coverage options as one after another benefit limit was reached.

External Review

The ACA guarantees individuals the right to an independent review of a health plan's decision to deny benefits or payment for services, regardless of whether the employer plan is insured or self-funded. Prior to the ACA, only workers in insured plans had the right to an independent review of a denied claim. But more than 60 percent of workers are in self-funded plans, and

before the ACA, the only option for those workers to hold their plan accountable was to sue, an expensive and lengthy process.[38]

Administrative Actions to Roll Back ACA Result in Higher Prices for Older, Sicker Americans

In 2016, financial data from insurers demonstrate that the ACA markets were beginning to stabilize and insurers were gaining their footing after a rocky start.[39] Indeed, in 2017 the CBO concluded that the ACA's insurance markets would likely be stable in most places if left unchanged.[40] Consistent with this projection, 2017 appears to have been a profitable year for most individual market insurers.[41]

Unfortunately, my own review of insurers premium rate justifications (referred to as actuarial memoranda) for plan years 2018 and 2019 found that recent policy changes are putting the stability of the individual market at risk.[42] Specifically:

The Trump administration's decision in October of 2017 to cut off reimbursement to insurers for low cost-sharing plans (called cost-sharing reduction or CSR plans) resulted in significant premium increases in 2018. Additionally, the uncertainty about that decision, which the President had been threatening for months, was a contributing factor for some insurers to either exit the marketplaces or reduce their service areas.

Additionally, although Congress did not zero out the individual mandate penalty until 2019, many insurers increased premiums for 2018 coverage on the expectation that the Trump administration would not enforce the individual mandate.

Similarly, insurers increased premiums due to the Trump administration's decision to decrease spending on marketplace advertising and consumer assistance, which are critical for educating and enrolling the healthy uninsured. For example, a Cigna filing for 2018 noted that they

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[38] Kaiser Family Foundation, 2018 Employee Benefit Survey, October 3, 2018. Available at https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-10-plan-funding/.

[39] Banerjee D. *The ACA Individual Market: 2016 Will Be Better Than 2015, But Achieving Target Profitability Will Take Longer*, S&P Global Ratings, Dec. 2016. *See also* Herman B. *How some Blues made the ACA work while others failed*. Modern Healthcare. October 15, 2016. Available at www.modernhealthcare.com/article/20161015/MAGAZINE/310159989.

[40] *H.R. 1628 American Health Care Act of 2017,* Congressional Budget Office, May 2017. Available at https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/hr1628aspassed.pdf.

[41] Cox C, Semanskee A, Levitt L. Individual Insurance Market Performance in 2017, Kaiser Family Foundation, May 2018. Available at http://files.kff.org/attachment/Issue-Brief-Individual-Insurance-Market-Performance-in-2017.

[42] *See* Corlette S. *The Effects of Federal Policy: What Early Premium Rate Filings Can Tell Us About the Future of the Affordable Care Act*, CHIRblog, May 2018. Available at http://chirblog.org/what-early-rate-filings-tell-us-about-future-of-aca/; Corlette S. *We Read Actuarial Memoranda so You Don't Have to: Trends from Early Health Plan Rate Filings*, CHIRblog, Jun. 2017. Available at http://chirblog.org/we-read-actuarial-memoranda-so-you-dont-have-to/; Corlette S. Proposed Premium Rates for 2018: What do Early Insurance Company Filings Tell Us? CHIRblog, May 2017. Available at http://chirblog.org/proposed-premium-rates-for-2018-what-do-early-filings-tell-us/.

expected a smaller and sicker population in their risk pool due to the lower "overall awareness of individual health insurance products."

Going into 2019, insurers predicted that their risk pools would be smaller and sicker due to "potential movement into other markets." These markets include association health plans and short-term health plans, both of which are exempt from many of the Affordable Care Act's consumer protections and are being promoted by the Trump administration as cheaper alternative coverage.

Individuals who are eligible for the ACA's premium tax credits are largely insulated from these premium increases because the tax credit rises, dollar for dollar, with the increase in premiums for silver level health plans. The people who suffer the most from these premium increases are the working middle class: entrepreneurs who run their own businesses, freelancers and consultants, independent contractors, farmers and ranchers, and early retirees who earn too much to qualify for the ACA's premium subsidies.

For people with job-based coverage, the higher prices and uncertainty roiling the individual market inevitably leads to more "job lock," as people stay in jobs that guarantee health benefits, even if their skills and talents are not optimally deployed.

Conclusion

The ACA is by no means perfect, and there remain many people who struggle to find affordable health care coverage. Even the law's most ardent supporters acknowledge that more could be done to encourage states to expand Medicaid, help families who earn too much to qualify for subsidies, reduce excessive deductibles, and improve access for those who are otherwise ineligible for coverage. There are a range of policy options that would strengthen the law's foundation while also building on its remarkable achievements. I applaud this committee for providing a forum for constructive debate on these issues. Thank you, and I look forward to your questions.

Chairman SCOTT. Thank you. Mr. Riedy?

TESTIMONY OF CHAD RIEDY, RESIDENT, ALEXANDRIA, VIRGINIA

Mr. RIEDY. Good morning. Thank you, Chairman Scott, Ranking Member Foxx, and distinguished members of the committee for inviting me to testify today.

I would also like to thank my wife, Julie, and my parents for being here today and for their support.

My name is Chad Riedy and I have cystic fibrosis. I would like to share my story of what living with CF is like and what the protections in the ACA mean to me and millions of other Americans living with chronic health conditions. CF is a rare genetic disease that affects about 30,000 people in the U.S. and causes a thick, sticky mucus to buildup in the airways causing infections. There is no cure for CF.

When I was diagnosed in 1984 at 3 years old, my parents were told that they should not expect me to live to age 12. Today I sit here at 37. I have been married for 12 years and a father of our 2 boys, Liam, who is 8, and Tate, who just turned 7.

Let me tell you what it is like to live with CF. Every day I take 30 pills to help me breathe, digest food, and reduce inflammation in my lungs. I also take inhaled medicines and use a vest that shakes loose mucus in my lungs. Four times a year I go through a lengthy evaluation process with a team of doctors at Johns Hopkins. I do this to keep my lungs well enough to keep me alive. But I will never have the lung capacity of any of you sitting here today.

When I was 26 I got really sick for the first time. My wife and I had just returned from our honeymoon when I started to notice that I was having a hard time breathing performing normal, routine activities, like walking up stairs or talking on the phone. After a visit to my care team I was admitted immediately to the hospital, where I stayed for 7 days receiving intravenous antibiotics, chest physical therapy, and other procedures to stabilize my health. While my healthcare was covered under my employer-based insurance plan, when I returned home I received constant reminders about how close I was to hitting my lifetime and annual caps. Before the ACA banned these practices I would stay awake wondering would I exceed my limits or be denied coverage, then what, how would I pay for these things?

The next time, in 2014, when I got very sick again, over 8 months my lung function, which had been stable for 7 years, declined dramatically. I was so sick that not only was I missing work, I could not walk 10 feet across our living room floor without having to stop and catch my breath. I struggled to carry my kids, who at the time were four and one. Things progressed to the point where we started to have conversations about needing a lung transplant just to stay alive. Thankfully, because the ACA was in place, I could focus on making a strong recovery instead of the financial hardships from all these medical bills.

In January 2018 I started on a drug that has changed my life called SYMDEKO. It treats the underlying cause of my CF, not just the symptoms. It has brought more stability to my lung function, but most importantly it has allowed me to be a better husband, fa-

ther, and friend. I no longer worry when carrying laundry up a couple flights of steps from the basement. And when my boys are tired and want a piggyback ride or need extra love, daddy is there for them.

My treatments and care help me breathe a little easier and stay healthy so that I can work to help provide for my family, but they are expensive. In 2018 the total cost of all my medicines was about $450,000. This does not include my care team, visits to them, or other procedures. While we spend a lot out of pocket, I am thankful that our insurance covers most of these.

This is my story and there are so many more like it across the country. For people battling rare and chronic disease, the policies we are discussing today are a matter of life and death. If the Judge's ruling against the ACA stands and insurance companies are allowed to implement annual and lifetime caps I would reach them in a matter of years and be on the hook for unimaginable financial costs. In addition, the cap on out-of-pocket sharing is vital for someone like me.

I am grateful that I have coverage that allows me to access a great team of doctors and cutting-edge medicines that help me fight this disease. Because of this I have hope, hope for a future where I grow old with my wife, see my kids grow up, graduate college, get married, and start families of their own.

I am not asking for you to take care of me, I do that myself. I also understand that the ACA is not perfect, but the protections it contains are critical to me and millions of other Americans with preexisting conditions.

I thank the committee for giving me the opportunity to share my story and I ask that you are to keep our hope alive as you consider legislation this Congress.

Thank you.

[The statement of Mr. Riedy follows:]

Written Testimony of Chad Riedy

Adult with Cystic Fibrosis

"Examining Threats to Workers with Preexisting Conditions"

House Education and Labor Committee

February 6, 2019

Washington, DC

Statement to the House Education and Labor Committee
Chad Riedy
February 6, 2019

Good morning. Thank you Chairman Scott, Ranking Member Foxx, and distinguished members of the House Education and Labor Committee for inviting me to testify before you today. My name is Chad Riedy and I have cystic fibrosis (cf). I am pleased to be part of this Committee's discussion about how to uphold the critical protections in the current law that workers with pre-existing conditions like myself rely on. Through this important hearing, you are contributing to a pathway of hope for myself, the CF community, and millions of other Americans living with chronic health care conditions.

I'd like to tell you more about my pre-existing condition. Cf is a rare genetic disease that affects roughly 30,000 people in the United States and about 70,000 worldwide. Cf is a degenerative disease that primarily affects the lungs by producing a thick sticky mucus that builds up in the airways, trapping bacteria and causing inflammation and infection. The damage this causes ultimately leads to either death or the need for a life-prolonging lung transplant. In addition to the lungs, cf also affects, the pancreas, liver, bones, and other organs. There is no cure for cf.

I was diagnosed with cystic fibrosis in 1984 at three years old. Upon my diagnosis, my parents were told that they should not expect me to live to see my twelfth birthday. Today, I sit here at the age of 37. I've been married to my wife, Julie, for over 11 years and am a father to our two boys, Liam, who is eight and a half, and Tate, who just turned five. Up through my early twenties I was relatively healthy, playing sports, working, and for the most part living a 'normal' life.

I'd like to share with you what a 'normal' life looks like for someone with cf. Staying healthy means undertaking a daily treatment regimen that includes taking roughly between twenty and thirty pills a day or between 7,300 pills and 10,950 pills a year, that help aid in digestion, fight off infection, reduce inflammation, open up airways and correct the underlying cause of cf. In addition to the pills there are three to four hours of treatments, one and half to two hours in the morning and then again in the evening. These twice-daily treatments start with an inhaled steroid to open up the airways in my lungs; next I have two nebulized treatments, the first is a highly concentrated saline solution to add moisture into the airways and loosen the mucus, the second help to thin the mucus so that it can be coughed up. After my nebulizers, I then hook up to my vest. The vest is worn so that it covers the lungs and is connected to a machine, roughly the size of a 'boom box,' by two tubes. When turned on, the vest inflates to a selected pressure and then starts to pulsate at a set frequency. This is done in five-minute intervals for thirty minutes with the frequency increasing at each interval. In between each interval, there are special breathing techniques used to move the mucus from the small airways to the larger ones and then out through coughing. Once time on the vest is complete, I follow this

up with an inhaled antibiotic through a nebulizer to fight any bacteria I have grown or may be growing in my lungs. This is the routine when healthy, if I have an exacerbation, treatments could increase to three or four a day and visits to my care team also increase.

Currently, I have four annual visits with my care team at Johns Hopkins University. At these visits, I see a pulmonologist, nurse, dietician, respiratory therapist, physician, and social worker that along with my family, and me work together to coordinate my care. At every visit, I take a breathing test called a pulmonary function test that measures my percentage of lungpower. Advanced disease is characterized by rapid decline in lung function and when you drop below 50 percent lung function, it's advised you start considering a lung transplant.

Up through my early twenties, my daily treatment regimen looked slightly different than it does today, primarily because we did not have the targeted treatments we have now. During this time my main course of treatment consisted of my parents preforming physical chest therapy where they would pound on my chest, back, shoulders and sides with their hands to help shake up and break loose the mucus in my lungs. It wasn't until high school that we started adding a nebulized treatment to the chest physical therapy. In addition to the daily treatment regimen I had occasional hospital stays to receive a "tune up," which usually meant intravenous antibiotics, a bronchoscopy and sinus surgery to remove polyps (another complication of cf). These "tune ups" only happened 3 or 4 times through college while I was on my father's employer-based coverage. Looking back, I'm grateful I was able to stay on my parents' health insurance as a young adult.

When I was 26 years old, I got really sick for the first time. My wife and I had just married and returned from our honeymoon when I started to notice that I was having a harder time breathing while performing routine tasks like walking upstairs or talking on the phone. After a visit to my care team and finding out that my lung function had fallen from around 45 percent to the low 30's, I was admitted immediately to the hospital where I stayed for seven days receiving intravenous antibiotics, chest physical therapy, and other procedures to get rid of an infection and stabilize my lungs. Because of the highly specialized care that my care team provides, thankfully, after seven days I was improving and was allowed to go home where I continued the IV antibiotics for an additional two weeks. While my lung function slowly recovered and crept back up to the low 40's, it required more antibiotics and therapies to stay healthy which came with greater cost.

My health care was covered under my employer-based insurance plan but it was the first time I realized the true impact that annual and lifetime caps could have on my life. I remember receiving constant reminders from the insurance company about how much they had covered and just how much I had left until they would no longer cover the medicine, procedures and doctors that I need to simply breathe and stay alive. I worried about what would happen if I got sick again and had to stay in the hospital for an extended period of time or if things got so bad that I needed a lung

transplant to stay alive. Would I exceed my limits or be denied coverage? Then what? How would I pay for these things? These were all questions that I used think about on a regular basis before the ban on annual and lifetime limits was passed into law as part of the ACA.

The next time I would get very sick would be in 2014, when the ACA was in place. Over the course of roughly eight months starting in August 2014, my lung function fell from the low 40's where it had been for about 7 years to the low 20's. During this time, I was seeing my care team almost weekly and on IV antibiotics for extended periods of time. I underwent numerous procedures to both track my lung function and determine what was causing the rapid and sustained decline in my lungs. Things progressed to the point where we started to have conversations about the possibility of needing a lung transplant for me to stay alive. I was so sick that not only was I occasionally missing work, I could not walk 10 feet across our living room floor without having to stop to catch my breath. I struggled carrying my kids, who at the time were ages four and one.

Thankfully, due to the protections afforded by the ACA and having coverage through my wife's employer, we did not have the additional worries of the cost of these procedures and medicines, being denied coverage for my cf, or being kicked off our plan. Instead we were able to focus on our family and my care and doing whatever we needed for me to stay alive so that I could be there for my wife and to see my children grow up. Because of these protections I was able to access the highly specialized care I needed to eventually stabilize my lung function and bring it up to the upper 20's and low 30's where it resides.

Today, I am more hopeful than ever because of the advancements that have been made to treat the underlying cause of cf and the significant progress towards a cure. In January of 2018, I started on a drug that has changed my life. The medicine, Symdeko, represents a major scientific advance and is a relatively new type of treatment that treats the underlying cause of my cf – not just the symptoms of the disease. It has brought more stability to my lung function over the past year, decreased the amount of respiratory symptoms that cause damage to my lungs, and most importantly allowed me to be a better husband, father and friend. My treatment regimen has allowed my lungs to open up and lessened the amount of panic and anxiety attacks that I used to have performing routine tasks. I no longer worry when carrying the laundry up a couple flights of stairs from the basement. When my boys are tired and want a piggy back ride upstairs to bed or are hurt and need some extra love, they know daddy is there for them.

My treatments and care help me breathe a little easier and stay healthy so that I can work to help provide for my family. At the same time, cf treatments and care are expensive. In 2018, the cost of my treatments was just under $450,000 and this does not include the cost for the visits with my care team and the associated procedures to monitor and maintain my health. While we still spend a lot on out-of-pocket costs, I am thankful that our insurance covers the majority of them for us.

This is my story. And there are so many more like it across the country. For people battling rare and chronic diseases, the policies we are here to discuss have a real impact on their ability to stay healthy and ultimately, stay alive.

I am deeply worried about the decision in the Texas v US court case. If the judge's ruling against the ACA is allowed to stand and insurance companies are allowed to implement annual and lifetime caps, I would reach them in a matter of years. In addition, the cap on out-of-pocket cost sharing is another vital protection for someone with high healthcare costs such as myself. If all of these and other 'pre ACA rules" came back, I would then be faced with serious financial tradeoffs in order to continue on the medicines that are extending my life or face the possibility of dying.

I also rely on the pre-existing conditions protections in the law. Knowing I can't be denied coverage, charged more for my coverage, or have services related to my cf excluded from coverage is a critical protection in the ACA. And finally, it is so important that young adults with cf are allowed to stay on their parents' health insurance plan until age 26. For someone with a lifelong chronic condition, this protection provides an enormous amount of security during the early adult years.

I am here today with hope for the future; a future where I grow old with my wife, see my kids grow up, graduate college, get married and start families of their own. This is all because of the access that I have had to adequate and affordable health care and the protections that the ACA has provided. I am not asking you to take care of me as I am already doing that every day, and I understand that the law is not perfect, but the protections it contains are critical to me and millions of other Americans with pre-existing conditions.

I thank the Committee for giving me the opportunity to share my story, and I ask that you will work to keep our hope alive as you consider legislation this Congress.

Chairman SCOTT. Thank you, Mr. Riedy. Ms. Turner?

TESTIMONY OF GRACE-MARIE TURNER, PRESIDENT, GALEN INSTITUTE

Ms. TURNER. Thank you, Chairman Scott, Ranking Member Foxx, and members of the Committee for inviting me to testify today.

At the Galen Institute we focus on ways to ensure affordable health coverage to all Americans, particularly protection for the most vulnerable. I am really pleased to be on the panel with Mr. Riedy, and thank you for so bravely sharing your story. I am thankful for the health care system that supports your care and for continued innovations so new treatments can be available.

Today in my testimony I am going to discuss the centralrole that the employer health insurance market plays in our health sector, new opportunities to reduce costs and expand access to coverage, and bipartisan support for preexisting condition protections, and the need for further improvements.

Nine out of ten workers are employed in the U.S. by companies that offer health insurance. These benefits are tax free, both to workers and companies, a generous benefit but one that leverages nearly $3 in private employer spending for every $1 in Federal tax revenue losses. Employers and employees want the best value for their health care dollar and often work very hard to balance cost and quality.

Long before the ACA, employers offered preventative services because they know that addressing health issues before they become a crisis can lead to better outcomes and minimize costs. These employers also play a vital role in supporting our health sector. Physicians and hospitals are paid much less under Medicare and Medicaid than under employer plans, and because private insurance pays more, they provide the margins that allow many hospitals and providers to stay in business. Leading proposals to expand Medicare coverage to all Americans would extend these public disbursement rates universally, diminishing quality and access to care.

The Trump administration is offering several options through its regulatory authority to help individuals and employees with more affordable coverage. The Chairman mentioned one of them, including association health plans. They allow small firms to group together to get some of the same benefits that large employers have. A Washington Post story just reported on a new study showing that AHP benefits are comparable to most workplace plans and plans are not discriminating on patients with preexisting conditions. They also have new flexibility under Section 1332 of the ACA to lower costs through risk mitigation programs. They separately subsidize patients with the highest cost, lowering premiums for others, and leading to increased enrollment. In Alaska, premiums for the lowest-cost bronze plan fell by 39 percent in 2018 and Maryland is seeing an even larger drop this year.

Putting the sickest people in the same pool with others means that their premiums are higher. Virginia Senator Bryce Reeves talked with one of his constituents recently who said he makes a good living, provides for his family, but he said his health insurance premiums are $4,000 a month. And he said that is more than

my mortgage, and really pleading for help. Unfortunately, many healthy people are dropping out of the market because costs are so high.

There is strong bipartisan support for preexisting condition protections. The ACA assures people cannot be turned down or have their policies canceled because of their health status, and these protections are still in place. Legislation passed by the House of Representatives maintained preexisting condition protection. But they do not work for everyone. Janet—did not use her last name—reported that she was diagnosed in 1999 with Hepatitis C. She lives in Colorado and applied for coverage in the State's high-risk pool. Her premiums in 2010 were $275 a month. Then her liver failed. She needed a transplant. The $600,000 bill was covered 100 percent with only $2,500 out-of-pocket. Colorado's high-risk pools closed when the ACA started in 2014. Her premiums rose to $450. By 2018 they were $1,100 a month. The deductible was $6,300. But her anti-rejection medications were not covered. She said almost everything I needed was denied, which threw me into a world of having to appeal to get the care I needed. She said those of us who are self-employed and are not eligible for tax credits wind up footing way too much of the bill. She said her costs are $19,000 a year before insurance pays and she has to pay extras for her medication. She keeps her insurance because if something else happened, and her liver failed and she needed another transplant, she said it would bankrupt my family.

I hope to work with you to achieve the goals of better access to more affordable coverage and better protection with those with preexisting conditions.

Thank you for the opportunity to testify today.

[The statement of Ms. Turner follows:]



A not-for-profit health and tax policy research organization

Examining Threats to Workers with Preexisting Conditions

Committee on Education and Labor
2175 Rayburn House Office Building
February 6, 2019

Chairman Bobby Scott

Ranking Member Virginia Foxx

Testimony by Grace-Marie Turner
President
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Examining Threats to Workers with Preexisting Conditions

Committee on Education and Labor. Bobby Scott, Chairman

Testimony by Grace-Marie Turner, President, Galen Institute

February 6, 2019

Chairman Scott, Ranking Member Foxx, and members of the committee, thank you for the opportunity to testify today on "Examining Threats to Workers with Preexisting Conditions."

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I also have served as an appointee to the Medicaid Commission, as a member of the Advisory Board of the Agency for Healthcare Research and Quality, and as a congressional appointee to the Long Term Care Commission.

Today, I will discuss the central role that the employer-sponsored health insurance market plays in our health sector and economy, the value that employees place on their employer-sponsored insurance, bipartisan support for pre-existing condition protections, and new opportunities to reduce costs and expand access to coverage.

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Employer-sponsored health insurance: My colleague at the Galen Institute Doug Badger provides a detailed history of how the employer-based health insurance system evolved in the United States and how central it is to the network of programs in our health sector today.[1] He explains that "The vast majority of workers—89 percent according to the Kaiser survey[2]—worked for companies that sponsored health insurance coverage in 2016, and an estimated 79 percent of those employees were eligible to enroll in their firm's plan. In all, 62 percent of those working for employers that sponsor coverage enrolled in that coverage in 2016."[3]

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[1] Doug Badger, "Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers," Galen Institute, December 2018. https://galen.org/assets/Replacing-Empl-Spons-Insur-112618.pdf

[2] Kaiser Family Foundation/Health Research & Education Trust 2016 Employer Health Benefits Survey. Sep 14, 2016. https://www.kff.org/report-section/ehbs-2016-summary-of-findings/

[3] Badger explains that some may have chosen to remain uninsured despite exposure to tax penalties on the uninsured. Others may have had other sources of coverage—through a working spouse, for example, a parent (in the case of those under 26), or through another public program such as Medicaid or Medicare.

In 2016, an estimated 173 million Americans received health coverage through the workplace, either as an employee or as a dependent.

Badger describes the cost in terms of tax preference for employer-sponsored health insurance (ESI) and how that is leveraged to produce a nearly 3-1 ratio in value to tax expenditures:

> ESI offers considerable benefits to the government. Premiums for those with ESI totaled nearly $991.3 billion in 2016.[4] Of that amount, 73 percent was contributed by employers and 27 percent by workers.[5] Government does not tax health benefits. If it treated ESI the same as it does wages, federal income and payroll tax revenues would increase.[6] The Treasury Department estimates that, absent the tax exclusion, federal revenues would have been $348 billion higher in fiscal year 2016.[7]
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> By not taxing ESI, the government leveraged nearly $1 trillion in private health insurance spending at a net cost to the federal budget of less than $350 billion.[8] To finance that sum through payroll taxes in 2016 would have required raising the OASDI [Old-Age, Survivors, and Disability Insurance] tax by 9.6 percentage points, from 12.4 percent to 22.0 percent of taxable payroll.[9]
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> ... Instead of taxing workers and corporations and directly financing their medical

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[4] CMS, National Health Expenditures, Table 24.

[5] CMS, National Health Expenditures, Table 24. It is generally accepted that the employer contribution is, in fact, a form of compensation or, to put it somewhat differently, a labor cost.

[6] Firms do, of course, deduct their contribution to ESI from their corporate taxes but they also deduct the wages they pay. The difference between wage and non-wage compensation is the latter's exclusion from federal income and payroll taxes.

[7] Department of Treasury, "Tax Expenditures," Table 1, line 128 and footnote 12. Line 128 estimates the FY 2016 federal income tax loss at $216.1 billion. Footnote 12 estimates lost payroll tax revenue of $131.6 billion.

[8] This paper is concerned largely with federal expenditures and consequently makes no effort to estimate the effects of the exclusion on state tax revenues. A very rough estimate of the benefit to the government in 2016 can be derived by subtracting the amount of federal revenue lost to the exclusion ($348 billion) from the total amount of ESI premiums ($991.3 billion), yielding $643.3 billion. That is a rough estimate of the net cost of supplanting ESI with direct government financing in 2016.

[9] Wages subject to OASDI taxes totaled $6.7 trillion in 2016. 2017 SSA Trustees Report, Table VI.G6, p. 216. This is not to suggest that the government would finance health care through an increase in the OASDI payroll tax, but merely to provide perspective on the amount of private health spending government leverages through the exclusion.

care, the U.S. government exempts ESI from taxation, leveraging $2.85 in health insurance spending for every $1 in federal revenue losses.[10]

ESI Supports Public Programs: Badger also points out the important role that employer-sponsored health insurance plays by paying doctors and hospitals more than Medicare and Medicaid do, providing the margins many providers need to maintain quality and even keep their doors open.

It can be argued that the employer-sponsored health insurance system is a vital part of the reimbursement matrix supporting the U.S. health sector.

Reimbursement rates to physicians and hospitals are generally substantially less under Medicare and Medicaid than under private employer plans. Leading proposals to extend Medicare coverage to all Americans would extend these public reimbursement rates universally, with a detrimental effect on quality and access to medical care.

The number of employers offering health coverage has remained steady over the last five years at 55 percent, even as firms are struggling to provide this valued benefit despite steadily rising health costs.[11] But that number still is down from the 65 percent of firms that offered coverage in 2001.

Employers know that high quality health coverage leads to better health outcomes and a healthier workforce. Long before the ACA mandate, they offered preventive and wellness services because they know that addressing health issues before they become a crisis can minimize costs and lead to better outcomes.

Employers and employees both have a vested interest in getting the best value for their health care dollars to obtain the highest quality care and coverage at the lowest cost. But costs remain a major concern.

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[10] Others have arrived at a higher ratio. The American Benefits Institute has estimated that employers paid $4.45 to finance health benefits for every $1.00 in foregone federal revenue. (See *American Benefits Legacy: The Unique Value of Employer Sponsorship,* American Benefits Institute, October 2018, p. 31. https://www.americanbenefitscouncil.org/pub/?id=b949f447-f1ca-4dd0-817a-a7e96d8e3bfc .) There are several reasons for the difference between this ratio and the one used in this paper. First, the American Benefits Institute (ABI) paper derives its employer payments for group health insurance from the Commerce Department's National Income and Products Accounts. This paper uses National Health Expenditures data compiled by the CMS Actuary. Second, ABI uses tax expenditure data compiled by the Joint Committee on Taxation. This paper uses Treasury Department data. Most importantly, this paper takes into account both foregone income and payroll taxes that result from the tax treatment of ESI. That yields a denominator of $348 billion in this paper, compared with $155.3 billion in the ABI report.

[11] Badger argues that the employer mandate instituted by the ACA appears to have had very little effect on the percentage of workers enrolled in ESI. In general, it appears that larger firms, which are subject to the mandate, sponsored health insurance before the government required them to do so, while a fairly substantial percentage of smaller firms, which are generally exempt from the mandate, did not offer coverage to their employees.

Costs and Coverage: Annual premiums for employer-sponsored family health coverage reached $19,616 in 2018, up 5 percent from the previous year, with workers on average paying $5,547 toward the cost of their coverage, according to a Kaiser Family Foundation survey.[12]

The Trump administration is offering several options through its regulatory authority to help employers and employees get and keep more affordable coverage.

Association Health Plans: First, the administration has created new options for smaller and medium-sized firms through its new Association Health Plans rule.

The Washington Post reported last week that: "Chambers of commerce and trade associations have launched more than two dozen of these 'association health plans' in 13 states in the seven months since the Labor Department finalized new rules making it easier for small businesses to band together to buy health coverage in the same way large employers do. And there are initial signs the plans are offering generous benefits and premiums lower than can be found in the Obamacare marketplaces."[13]

There have been some criticisms that these plans might not be offering the same protections as ACA-compliant plans. But a new study shows that they are offering benefits comparable to most workplace plans, and they haven't tried to discriminate against patients with preexisting conditions, according to an analysis by Kev Coleman, a former analyst at the insurance information website HealthPocket.[14] "We're not seeing skinny plans," he said.

Health Reimbursement Arrangements: The administration's proposed rule is an enhancement of Health Reimbursement Arrangements (HRAs), originally created by the Bush administration to give employers more flexibility in their benefit offerings. Under those rules, HRAs, which are tax-preferred, notional accounts, can be integrated with group health coverage sponsored by the employer. They cannot be integrated with individual health insurance coverage. As I mentioned, many workers who are offered

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[12] Kaiser Family Foundation/Health Research & Education Trust 2018 Employer Health Benefits Survey. Sep 2018. http://files.kff.org/attachment/Summary-of-Findings-Employer-Health-Benefits-2018

[13] Paige Winfield Cunningham, "The Health 202: Association health plans expanded under Trump look promising so far," January 30, 2019, *The Washington Post.* https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/01/30/the-health-202-association-health-plans-expanded-under-trump-look-promising-so-far/5c50ba751b326b29c3778d05/?noredirect=on&utm_term=.6435676a70d4

[14] Kev Coleman, "First Phase of New Association Health Plans Reveal Promising Trends," Association Health Plan News, January 2019. https://www.associationhealthplans.com/reports/new-ahp-study/

health coverage at work do not participate in their employer plans, often because of costs, and therefore are more likely to be uninsured.

In a 2017 executive order, President Trump directed administration officials to "increase the usability of HRAs, to expand employers' ability to offer HRAs to their employees, and to allow HRAs to be used in conjunction with nongroup coverage."[15]

The proposed rule would allow HRAs to be integrated with individual health coverage. This would allow workers to use their accounts to fund both premiums and out-of-pocket costs associated with individual health insurance coverage.[16]

The Galen Institute has submitted public comments encouraging the administration to take it one step further by allowing spouses to integrate HRA funds to obtain a family plan.[17] We argue that current law would allow the integration of HRAs with group health plans sponsored by the employer of a spouse.[18]

As an example, consider that one spouse is offered health insurance at work. The employer may allow the plan to be extended to cover the family but only if the employee pays the full extra costs, which may be prohibitive for this lower-income worker.

If the other spouse's employer offers an HRA contribution, that employee could use the funds to buy into the first spouse's plan. This working couple could benefit from the ability to combine the HRA funds and obtain a family health insurance plan.

We believe the administration has the authority to include this change when it publishes the final rule. This would provide a new funding option and could expand insurance coverage, especially for those currently shut out of the market.

New Section 1332 Guidelines: States have new flexibility offered under Section 1332 of the Affordable Care Act to lower costs and increase access to health insurance choices by using existing resources to better tailor coverage to the needs of their states.

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[15] Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States, The White House, October 12, 2017. https://www.whitehouse.gov/presidential-actions/presidential-executive-order-promoting-healthcare-choice-competition-across-united-states/

[16] https://www.federalregister.gov/documents/2018/10/29/2018-23183/health-reimbursement-arrangements-and-other-account-based-group-health-plans

[17] https://galen.org/2019/increasing-access-to-health-insurance-for-working-families/

[18] Doug Badger and Grace-Marie Turner, "Give Working Families A Break," *RealClearHealth*, January 7, 2019. https://www.realclearhealth.com/articles/2019/01/07/give_working_families_a_break_110856.html

The Centers for Medicare and Medicaid services issued in October new guidance for state innovation authority in the ACA.[19] It would allow states more flexibility to create their own programs to help improve their individual and small group markets.

I would welcome the opportunity to work with you in developing additional ways to help lower the costs of health coverage, providing employers and employees and those in the individual market with more choices of affordable health coverage while maintaining quality and consumer protections.

The current system is far from perfect, and many people fear the financial impact of losing coverage.

Protection for the vulnerable. There is strong bi-partisan support for pre-existing condition protections.[20] A number of provisions were included in the Affordable Care Act (ACA) to ensure that coverage is available and affordable to those with pre-existing conditions.[21] The law stipulates that people cannot be turned down or have their policies cancelled because of pre-existing conditions and that they are able to purchase policies without facing huge spikes in premium costs because of their health status. These protections are still in place.

Legislation passed by the House of Representatives in 2017 would have preserved pre-existing condition protections, and other legislative and policy proposals offered since then to improve the private health insurance market also provide pre-existing condition protections.

A group of policy experts—the Health Policy Consensus Group[22]—has developed a plan[23] to help the millions of people who are struggling to afford health insurance, particularly in the small group and individual markets, to have access to more choices of

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[19] https://www.cms.gov/newsroom/press-releases/trump-administration-announces-state-relief-and-empowerment-waivers-give-states-flexibility-lower

[20] Morning Consult+POLITICO, National Tracking Poll, Sept. 6-9, 2018. https://morningconsult.com/wp-content/uploads/2018/09/180919_crosstabs_POLITICO_v1_DK.pdf

[21] Karen Pollitz, Testimony before the House Committee on Ways and Means on pre-existing conditions and health insurance, January 29, 2019. http://files.kff.org/attachment/Testimony-of-Karen-Pollitz-Committee-on-Ways%20and-Means-Pre-existing-Conditions-and-Health-Insurance

[22] The Health Policy Consensus Group is comprised of state health policy experts, national think tank leaders, and members and leaders of grassroots organizations across the country. Participants are committed to market-based policy recommendations that give people access to the health plans and doctors they choose at a price they can afford so that they can get the care they need, with strong protections for the most vulnerable.

[23] www.healthcarechoices2020.org

more affordable insurance while protecting the poor and the sick, including those with pre-existing conditions.

It is based upon formula grants to the states, using existing Obamacare resources, but with guidelines that incentivize states to provide people with more choices of more affordable coverage (and even provide an option for some people on Medicaid and CHIP to obtain private coverage, if that is their choice). It provides generous resources for those needing help in purchasing coverage and important protections for those with expensive and chronic illnesses.

Unlike the ACA, the Health Care Choices plan has money dedicated to creating guaranteed protection programs. Rather than forcing those participating in the ACA insurance pools to pay extra to support people with high medical expenses, we would stipulate that dedicated resources be devoted to providing extra financial support for their care.

By putting the sickest people in the same pool with others, premiums are higher, often much higher, for those not eligible for subsidized exchange coverage. Virginia State Sen. Bryce Reeves read in a recent speech [24] an email he received from one of his constituents in Fredericksburg. The constituent wrote he made a good living and tried to provide for his family. But his insurance premiums cost $4,000 a month! "That's more than my mortgage," he told Sen. Reeves. There is only one carrier offering coverage in his area. "What am I supposed to do?"

An analysis by the Center for Health and Economy has shown the Health Care Choices Plan would reduce premiums by one third while keeping coverage numbers level.[25] By encouraging healthy people to remain covered, insurance pools are healthier, and resources can be directed to help those with greater health needs.

State Solutions: States that have used early waiver authority to create risk-mitigation programs have seen in many cases dramatic results with no new federal spending.

Doug Badger and Heritage scholar Ed Haislmaier explain how early targeted waivers granted to states are helping them to better manage patients with chronic and pre-existing conditions.[26] "Several states have successfully used a waiver to change market

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[24] Grace-Marie Turner, "Health Care Choices Proposal: A New Generation of Health Reform," *Forbes*, June 22, 2018. https://www.forbes.com/sites/gracemarieturner/2018/06/22/health-care-choices-proposal-a-new-generation-of-health-reform/#1106ce6664f1

[25] http://healthandeconomy.org/the-health-care-choices-proposal/

[26] Doug Badger, Ed Haislmaier, "State Innovation: The Key to Affordable Health Care Choices," The Heritage Foundation, September 27, 2018. https://www.heritage.org/health-care-reform/report/state-innovation-the-key-affordable-health-care-coverage-choices

conditions sufficiently that premiums fell for individual health insurance while still protecting the ability of people with high health care costs to access care," they write.

After the waiver reform in Alaska, premiums for the lowest-cost Bronze plans fell by 39 percent in 2018, they report. Oregon showed similar results in 2018, with premiums for the lowest-cost Bronze plans falling by 5 percent. Premiums for the highest-cost Bronze plans plunged by 20 percent. In Minnesota, the third state with an approved waiver, premiums dropped in both 2018 and 2019. Average premium for ACA coverage in 2019 will be lower for every Minnesota insurer than they were in 2017. Four other states have had waivers approved for 2019: Maryland, Maine, New Jersey, and Wisconsin.[27]

According to the paper, "States repurpose a portion of federal money that would otherwise have been paid to insurers as premium subsidies, supplement this federal money with non-federal sources, and then use the resulting pool of money to pay medical claims for policyholders who incur high medical bills. Since this process would reduce premiums, it also would reduce federal premium subsidies, making it budget neutral to the federal government."

States are employing various risk mitigation strategies to finance coverage for those with high health costs, repurposing federal money to pay medical bills for residents in poor health. By separately subsidizing those with the highest health costs, they can lower premiums for individual health insurance, and the lower premiums also mean increased enrollment.

Guaranteed protection programs are key for policymakers to protect those with pre-existing conditions and also to ensure access to affordable coverage for those who need insurance to guard against future health risks.

A woman with serious health problems provided a testimonial about why the ACA protections aren't working for her:[28]

"In 1999, I was diagnosed with Hepatitis C, which made me ineligible for insurance (denied for pre-existing conditions). I live in Colorado, and they had a high-risk pool that covered people like me. I applied for that and was accepted," she said.

"My premiums in 2010 were $275/month with a total out of pocket of $2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved

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[27] Grace-Marie Turner, Doug Badger, "Several States Have Found Ways To Mitigate Obamacare's Damage To Their Health Insurance Markets," *Forbes*, October 3, 2018. https://www.forbes.com/sites/gracemarieturner/2018/10/03/several-states-have-found-ways-to-mitigate-obamacares-damage-to-their-health-insurance-markets/#56d1b71730da

[28] From HealthCareChoices2020.org testimonials: https://www.healthcarereform2018.org/testimonial/janets-story-high-medical-costs-worse-coverage/

without a question. My $600,000 transplant was covered 100% with a $2,500 out of pocket maximum!"

When Obamacare went into effect, Colorado's high-risk pool was closed. "I was forced into the regular marketplace that everyone was telling me was a good thing because I couldn't get denied. I think my first year on that policy, my premiums were in the $450 range—which I thought wasn't too terrible, but still more than I had been paying.

"The thing I noticed from the start was that instead of full coverage, almost everything I needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the basic care I needed.

"Since then, my premiums skyrocketed. In 2017, I paid $735 a month with total out-of-pocket costs of $5,500. In 2018, my premiums went up to $1,100 a month with a deductible of $6,300. Once I hit that mark, I'm covered 80%.

"Further, none of my anti-rejection meds are on the formulary of my insurance. If I could not afford them, my body would most certainly reject my liver, causing another liver transplant that would not be covered 100%.

"I don't get any credits from the government to reduce my premiums. Those of us who are self employed but make more than the threshold for tax credits wind up footing the whole bill ourselves. I have to spend $19,500 before my insurance pays anything, and it doesn't cover all my prescription costs. My old plan was almost a third of what I have to pay now.

"I have many friends and work associates in the same boat as me. Many of them are doing without insurance and are betting that they won't need more than what they can afford to pay out of pocket. I cannot do that, because if something happened and I needed another transplant, it would bankrupt my family."

Janet has coverage for pre-existing conditions, but her access to care is inferior to the state high-risk pool coverage she had before, and the cost of her coverage is much higher.

Thank you for the opportunity to testify today. I look forward to your questions and would welcome the opportunity to work to with you to achieve the goals of better access to more affordable coverage and better protection for those with pre-existing conditions.

Chairman SCOTT. Thank you. Dr. Gupta, before you start I think I need to give full disclosure. I have been an active member of the—volunteer for the March of Dimes for several decades. So I appreciate your testimony.

TESTIMONY OF RAHUL GUPTA, SENIOR VICE PRESIDENT AND CHIEF MEDICAL AND HEALTH OFFICER, MARCH OF DIMES

Dr. GUPTA. Thank you for being an active member, Mr. Chairman, and thank you, along with Ranking Member Foxx and members of the committee, for the opportunity to testify today.

My name is Rahul Gupta, I am the senior vice president and chief medical and health officer at the March of Dimes. In addition to my role representing the March of Dimes I also bring perspective from my experience as a practicing physician and as a former State health commissioner and a local health officer.

As a primary care physician, it was not uncommon for me to treat women who were struggling with high costs of employer-based health insurance or priced out of coverage altogether due to their preexisting conditions. These women were in the impossible condition of having to make choices between getting the care they needed and affording their families' basic necessities, such as food and prescription medications. Preexisting conditions are common among Americans. Six in every ten American adults in the U.S. has a chronic disease, and four in ten have two or more.

Chronic conditions, such as high blood pressure, diabetes, heart disease, and obesity can have tragic consequences for women during pregnancy. Each day in the United States more than two women die of pregnancy-related causes, and more than 50,000 have severe pregnancy complications. More American women are dying of pregnancy-related complications than any other developed country in the world, and it is not getting any better.

As pregnancy or childbirth are also widely considered preexisting conditions the prevalence of at least one preexisting condition in this population is almost universal. If conditions like preterm birth, birth defects, or neonatal abstinence syndrome, are considered tens of millions of children could be subject to insurance discrimination throughout their lives. The Affordable Care Act contains a range of provisions to help ensure comprehensive, meaningful, and affordable coverage for women, children, and their families. Amongst its most important popular provisions is the requirement that health plans cover all individuals regardless of preexisting conditions. The law ensures that all American can obtain coverage without worrying that they will be subject to discrimination, whether outright denial of coverage, or carve-outs of the benefits they need the most.

It is difficult for me to overstate the importance of ACA's requirements that all plans cover the 10 essential health benefits, including maternity care.

The ACA has also addressed a range of issues related to affordability of coverage. Cost has historically been and remains one of the greatest barriers to care. If people are unable to afford coverage, healthcare becomes all but inaccessible. Under the ACA, policies sold on the individual and small group markets are prohibited from charging women high premiums. Health plans can no longer impose annual or lifetime caps. In the case of maternal and

childbirth and child health, these caps could be financially devastating.

A woman, for example, with a high-risk pregnancy and delivery could easily exceed an annual cap, leaving her unable to obtain needed care for the rest of the year. Worse, a baby born extremely preterm, who needs months of care in the neonatal ICU, could exhaust a lifetime cap before even coming home.

This triad of preexisting condition protections, essential health benefits, and affordability provisions represent a three-legged stool that supports access to comprehensive quality and affordable coverage for all Americans. All three of these legs must be maintained to protect and promote our Nation's health, especially the health of women, children, and families.

March of Dimes is deeply troubled by Texas v. U.S. This lawsuit appears to have been undertaken as a legal exercise divorced from any real appreciation of its ramification for millions of Americans and their health and wellbeing. With the recent decision of the Federal court judge to declare ACA unconstitutional in its entirety, the plaintiffs appear to be in a classic situation of the dog that caught the car. They were caught off guard by their own victory and now are unsure how to explain that they have argued for an action that will cost millions of Americans their health coverage and potentially even their lives.

In addition, we are deeply concerned about efforts by the Administration to promote access to short-term, limited duration insurance plans. These plans are not required to cover essential health benefits, including maternity care, mental health, and substance use treatment, and could again exclude or charge patients more based on their preexisting conditions. Whatever changes may be undertaken to our Nation's health laws and systems, they must be made with the express goal of improving access to coverage and care that is accessible, comprehensive, and affordable.

In essence, this concept is no different than when I am seeing a patient in my office. I endeavor to provide her with the highest quality care in a compassionate manner, keeping in mind that she should not have to sacrifice her next trip to the grocery store in exchange. I sincerely hope that we can provide the same guarantee to all Americans.

Thank you for holding this meeting, and I look forward to any questions.

[The statement of Dr. Gupta follows:]

TESTIMONY OF

RAHUL GUPTA, MD, MPH, MBA

SENIOR VICE PRESIDENT AND CHIEF MEDICAL AND HEALTH OFFICER,

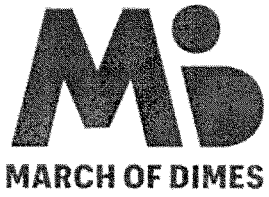
MARCH OF DIMES

BEFORE THE EDUCATION AND LABOR COMMITTEE HEARING

"EXAMINING THREATS TO WORKERS WITH PREEXISTING CONDITIONS"

U.S. HOUSE OF REPRESENTATIVES

FEBRUARY 6, 2019



Thank you, Mr. Chairman, for this opportunity to testify today before the Education and Labor Committee at this hearing, "Examining Threats to Workers with Preexisting Conditions." I am Dr. Rahul Gupta, Senior Vice President and Chief Medical and Health Officer at March of Dimes.

March of Dimes, a non-profit, non-partisan organization, fights for the health of all moms and babies. We educate the public about best practices, support lifesaving research, provide comfort and support to families in neonatal intensive care units, and advocate for the health of all moms and babies. March of Dimes promotes the health of women, children and families across the life course, from birth through adolescence and the childbearing years, with an emphasis on preconception, prenatal, interconception and infant health. Ensuring that women, children and families have access to timely, affordable, and high-quality health care is essential to achieving our goals.

In addition to representing March of Dimes, I bring my perspective from my experience working on the ground as a practicing physician in West Virginia, Alabama, Tennessee and Illinois and as a former state public health commissioner and local health officer. In each of these roles, I saw first-hand the negative impact a lack of access to affordable and comprehensive health insurance can have. This is especially true for our nation's most vulnerable, particularly people with pre-existing health conditions, including many pregnant women, new mothers, and their infants. As a past president of state medical association, I also have had the opportunity to represent my colleagues and the challenges they face as physicians practicing on the ground every single day.

Access to affordable health care coverage is a problem faced in their everyday lives by too many Americans with pre-existing conditions. As a primary care physician, it was not uncommon for me to treat women who were struggling with the high costs of employer-based health insurance or priced out of their employer's coverage altogether due to their pre-existing conditions. These women were in the impossible position of having to make choices between

getting the care they needed and affording their families' basic necessities, such as food or prescription medication.

Pre-existing Conditions Are Common Among Women of Childbearing Age

Pre-existing conditions are common among Americans. Six in every 10 adults in the U.S. have a chronic disease, and 4 in 10 have two or more.[1] Chronic conditions, such as high blood pressure, diabetes, heart disease, and obesity put women at higher risk of pregnancy complications. According to recent CDC studies, nearly half of women are overweight or obese before they become pregnant, which is associated with a higher risk of pregnancy complications.[2] One in 4 pregnancy-related deaths are related to heart conditions.[3] From 2005-2014, the prevalence of chronic conditions increased across all segments of the childbearing population, especially among women from rural and low-income communities and those with deliveries funded by Medicaid.[4] From 2008-2014, there was an increase in mental health conditions, including a 4.4-percentage point increase in anxiety disorders.[5]

For women in their childbearing years, reproductive health is a key concern. Each year in the U.S., over 3 million women deliver about 4 million babies.[6] About 12% of women aged 15-44 in the U.S. have difficulty getting pregnant or carrying a pregnancy to term.[7] Forty-five percent of all pregnancies in the U.S. are unintended, a figure that rises to 75% among teenagers.[8] About 1 in 7 women experience postpartum depression in the year after giving birth.[9] Millions of American women depend on access to contraception; 16% of all women of childbearing age use birth control pills, 8% are using an intrauterine device or implant, and over 14% are using female sterilization.[10]

The opioid epidemic has highlighted our nation's shortcomings in preventing and treating substance use disorder and its consequences, especially among pregnant women. Among 28 states studied during 1999–2013, the overall incidence of neonatal abstinence syndrome quadrupled from 1.5 per 1,000 hospital births in 1999, to 6.0 per 1,000 hospital births in 2013.[11]



In West Virginia, our overall incidence rate of NAS in 2017 was 50.6 cases per 1,000 live births (5.06%).[12] Three percent of pregnant women report binge drinking during pregnancy.[13] By 2014-2015, amphetamine use was identified among approximately 1% of deliveries in some parts of the U.S.; these deliveries were associated with higher incidence of preeclampsia, preterm delivery, and severe maternal morbidity and mortality.[14] Across our nation, women who are of childbearing age or pregnant are faced with a dire shortage of options for treatment and coverage.

Moreover, striking disparities exist among the health of mothers and babies of different racial and ethnic backgrounds. Black children face the highest child mortality rate among racial/ethnic groups – more than 2 times higher than the rate for Asian children and 1.5 times higher than the rate for white children.[15] There are dramatic variations in key measures like well-visits for women and infants among different racial and ethnic groups as well as geographic areas.

These chronic conditions can have tragic consequences, especially during pregnancy. Each year in the United States, about 700 women die of pregnancy-related causes, and more than 50,000 have severe pregnancy complications.[16] Despite the fact that many countries around the world have successfully reduced their maternal mortality rates since the 1990s, the U.S. rate is still higher than most other high-income countries,[17] and the U.S. maternal mortality rate has doubled in the past 25 years.[18] A significant racial and ethnic disparity in maternal mortality exists in the U.S., with black women being three to four times more likely to die from pregnancy-related causes compared to white women.[19,20]

The data clearly show that pre-existing conditions are common among women of childbearing age. As pregnancy or childbirth are also widely considered pre-existing conditions, the prevalence of at least one pre-existing condition in this population is almost universal. If conditions like preterm birth, birth defects or neonatal abstinence syndrome are considered to be pre-existing conditions, tens of millions of children could be subject to insurance discrimination throughout their lives.

The Affordable Care Act Instituted Important Protections for People with Pre-Existing Conditions

The Patient Protection and Affordable Care Act 2010 (ACA) contains a range of provisions to help ensure comprehensive, meaningful, and affordable coverage for women, children and families. Among its most important and popular provisions is the fact that the ACA requires health plans to cover all individuals regardless of pre-existing conditions. The law ensures that all Americans can obtain coverage without worrying that they will be subject to discrimination, whether outright denial of all coverage or carve outs related to the benefits they are most likely to need.

These pre-existing condition provisions are vital to the health and wellbeing of millions of Americans and their families. These provisions have not only ensured access to care for individuals with serious and chronic conditions, but have protected entire families who may otherwise have been unable to obtain coverage. Based on an analysis of the Commonwealth Fund Biennial Health Insurance Surveys, covering 2001–2016, the number of U.S. working-age women lacking health insurance has fallen by nearly half since 2010, when the ACA was enacted.[21] In 2018, approximately 10 million Americans were enrolled in health plans through the ACA marketplaces[22]. In 2017, 17 million individuals received coverage through the Medicaid expansion.[23]

I have personally treated many of these individuals, and I can say without a doubt that many of these so-called 'working poor' patients are able to continue to work because of this coverage and would otherwise be not only uninsured but unemployed. Without health insurance, they would not be able to afford treatment, which means they would have ended up in the emergency rooms in my community. Their expenses would be absorbed by the hospitals as uncompensated care, resulting in higher health care costs for everyone. Without regular access

to health care, they would be unable to remain healthy enough to continue working. Health insurance is vital to not only their health but their economic wellbeing.

It is important to note that the landscape of coverage for women of childbearing age was very different prior to passage of the ACA. According to one survey prior to passage of the ACA, 47% of people who tried to purchase insurance on the individual market were denied coverage, charged more, or had a condition excluded from their coverage.[24] An analysis from the U.S. Department of Health and Human Services found that between 2010 and 2014, when the ACA's major health insurance reforms first took effect, the share of Americans with pre-existing conditions who went uninsured all year fell by 22 percent, meaning 3.6 million *fewer* people went uninsured.[25]

A study funded by March of Dimes in 2015[26] showed that between summer 2013 and winter 2014–15, the uninsurance rate among women of childbearing age decreased from 19.6 percent to 13.3 percent as 5.5 million women gained coverage. At the same time, affordability of care improved, particularly for low-income women in Medicaid expansion states, who reported a 10.4 percentage-point decrease in unmet need for care because of cost. Together, these advances in coverage meant millions of women had access to health care to help them get healthy before they got pregnant, and to protect their health during and after pregnancy and childbirth.

Pre-Existing Conditions Protections Alone Are Not Enough

The ACA included a variety of provisions which aim to expand access to care, its quality, and its affordability. As described above, health plans may not base premiums on health status or deny coverage based on pre-existing conditions, such as being born with a birth defect or being pregnant. However, the requirement that all plans cover individuals with pre-existing conditions is not enough on its own to ensure people have access to the care they need. The ACA also addressed the availability of ten categories of Essential Health Benefits (EHBs) and



protected consumers against high premiums and out-of-pocket costs. Together, this package of provisions guarantee access, quality and affordability of coverage for women and their families.

The ACA's requirement that all plans cover 10 categories of EHBs was a critical step toward ensuring that Americans have access to the services and benefits they need. This provision prevents plans from excluding certain types of services, such as maternity care. Plans must also cover other types of services vital to maternal and child health, including well-woman and well-child preventive care, prescription drugs, and mental health services.

It is difficult to overstate the importance of these essential health benefits. Experience prior to passage of the ACA demonstrated abundantly that people with pre-existing conditions were often subject to benefits carve outs that targeted the services they were mostly likely to need. For example, prior to the ACA only 13% of plans in the individual market offered maternity care.[27] Only 11 states had passed mandates requiring individual plans to cover maternity benefits. As a result, too many families faced untenable choices between having a child and preserving their financial wellbeing.

In addition to EHBs, the ACA addressed a range of issues related to the affordability of coverage. Cost has been historically and remains one of the greatest barriers to care; if people are unable to afford insurance coverage, health care becomes all but inaccessible. When that relates to a pregnant woman or a woman attempting to become pregnant, it is simply unacceptable. According to a 2017 Kaiser Family Foundation study, half of uninsured women went without or delayed care because of costs. Almost as many postponed preventive services (47%) and skipped a recommended medical test or treatment (42%). [28] In October 2018, March of Dimes issued *Nowhere to Go: Maternity Care Deserts Across the U.S.*, a report showing that over 5 million women currently live in a maternity care desert.[29] One-third of this country's counties lack hospitals with services for pregnant women. About 150,000 babies are born in maternity care deserts every year. We need to increase, not decrease, access to these services in these areas.



Under the ACA, policies sold on the individual and small-group markets are prohibited from charging women higher premiums. This practice, known as gender rating, had been used by 92% of individual market plans.[30] Elimination of gender rating removes a significant penalty imposed on women simply because they are women. In other words, thanks to the ACA, being a woman is no longer a pre-existing condition.

In addition, health plans can no longer impose annual or lifetime caps. These caps imposed a dollar amount limit on coverage beyond which a policyholder was responsible for all costs. In the case of maternal and child health, these caps could be financially devastating for families. A woman with a high-risk pregnancy and delivery could easily exceed an annual cap if she experienced a complicated labor, leaving her unable to obtain needed care for the rest of the year. A baby born extremely pre-term who needed months of care in the neonatal intensive care unit could exhaust a lifetime cap before her first birthday.

In order to promote preventive health, the ACA required that certain preventive services be covered without cost-sharing. Among the important maternal and child health services that fall into this category are prenatal care, well-child visits, well-woman visits, screening for gestational diabetes, domestic violence screening, breastfeeding supplies such as breast pumps, and contraceptive services. As a result of these protections, a key barrier to services was removed for millions of women and families.

Finally, the ACA included a range of other tools to control the cost of premiums and cost-sharing, such as advance premium tax credits to subsidize premiums, limits on annual cost-sharing, medical loss ratio provisions, premium increase reviews, and more.

The triad of pre-existing conditions protections, essential health benefits, and affordability provisions represent a three-legged stool that supports access to comprehensive, quality, affordable coverage for all Americans. If any one of these supports is removed, the others are



inadequate to achieve those goals. All three must be maintained to protect and promote our nation's health, and especially the health of women, children and families.

Without all these protections, a single complicated pregnancy or birth could result in a lifelong inability to gain insurance or coverage that is affordable. March of Dimes urges policymakers to make sure that these important consumer protections remain in place so that all women and infants can access the affordable, quality health care and services they need.

Any Changes to the Law Should Ensure Greater Access to Comprehensive, Affordable Care

March of Dimes believes that any changes to the Affordable Care Act or other laws must be undertaken with the goal of providing Americans with greater options for comprehensive, quality, affordable health care. Each of these issues is equally important and inter-connected: comprehensiveness, quality and affordability. It is useless to provide access to cheaper coverage if it fails to cover the services women and families need. Comprehensive, quality health care is out of reach if coverage is not affordable. And affordable coverage with full benefits is not enough if entire categories of people are excluded based on their health status, gender or other factors.

March of Dimes is deeply troubled by the filing and arguments in the case *Texas v. United States*. This lawsuit, filed by a group of state attorneys general and governors, appears to have been undertaken as a legal exercise divorced from any real appreciation of its ramifications for millions of Americans, their health and their wellbeing. With the recent decision of a federal court judge to declare the ACA unconstitutional in its entirety, the plaintiffs appear to be in a classic situation of "the dog that caught the car." They were caught off-guard by their own victory and now are unsure how to explain that they have argued for an action that will cost millions of Americans their health insurance coverage and potentially even their lives. March of Dimes joined 37 other major patient groups in expressing our opposition to this decision and calling on the Supreme Court to reject it.[31]

Beyond *Texas v. United States,* March of Dimes is deeply concerned about efforts by the Administration to promote access to short-term, limited duration insurance plans that would not have to comply with many of the protections under the ACA.[32] We are especially concerned that these plans are not required to cover essential health benefits, including maternity care, mental health, and substance use treatment, and could again exclude or charge patients more based on their pre-existing health conditions. Since these slimmed-down plans offer far fewer benefits, they can be offered at lower premiums.[33] In some cases, however, consumers will be lured in by low premiums only to find that their plan fails to cover the services they need. March of Dimes supports efforts like those in California, New Jersey and New York, where state legislatures have voted to limit the ability of non-compliant short-term plans to be sold, and we encourage other states to do the same.

Given that almost half of all pregnancies in the U.S. are unintended, a lack of coverage for preventive care like contraception as well as prenatal, maternity and newborn care could be disastrous for women who carry such limited policies. And while recent reports indicate that many of the plans now being offered do cover maternity and newborn care,[34] there is no protection available for women and families if they choose not to do so in the future.

A host of other proposals from the Administration are also causing deep concern because they undermine the ACA's goals of providing access to affordable, comprehensive and quality health care. The newly-released Notice of Benefits and Payment Parameters contains provisions that will make coverage more expensive for families by reducing the value of their tax subsidies. It would also increase the annual out-of-pocket limit on medical expenses. Proposals like these take money out of the pockets of hard-working families and put it directly into the pockets of insurance companies. March of Dimes looks forward to completing our analysis of this proposal rule, offering comments expressing our dismay with these proposals, and recommending alternative actions. Efforts like those currently being pursued by the Administration to lower

drug costs are laudable, but they will be of little use if Americans are burdened by skyrocketing premiums and cost-sharing or unable to obtain affordable health coverage at all.

Conclusion

Whatever changes may be undertaken to our nation's health laws and systems, they must be made with the express and central goal of improving access to coverage and care that is accessible, comprehensive and affordable. None of these three goals can be sacrificed; they must work together to provide all women, children and families with meaningful access to the health care they need and deserve. This concept is no different than when I'm seeing a patient in my office. I endeavor to provide her with the highest quality care in a compassionate manner, keeping in mind that she shouldn't have to sacrifice her next trip to the grocery store in exchange. I sincerely hope that we can provide this guarantee to all Americans.

Thank you, Mr. Chairman and members of the committee, for holding today's hearing. March of Dimes looks forward to working with you on a bipartisan basis to continue the progress we have made in expanding access to health coverage for people with pre-existing conditions.

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Chairman SCOTT. Thank you, thank you. And now we will have our members ask questions. First, I am going to defer on my side, and the gentleman from Connecticut, Mr. Courtney.

Mr. COURTNEY. Thank you, Mr. Chairman. And, again, I want to applaud the fact that we are holding this hearing in this committee. Back in 2009 and 2010, when the Affordable Care Act was crafted with three different committees, it was our committee which led the way in terms of preexisting conditions and all the patient protections, because we have jurisdiction over ERISA. So, again, we actually were the place where the law was written that was, in my opinion, you know, one of the great steps forward of our Nation in terms of social and civil rights.

You know, again, Ms. Corlette talked about what the landscape looked like back in 2009 and 2010. I brought along a flyer that was being sold to a lot of businesses, which again, brings back the bad old days. Again, it is a health plan where it is touted as great news for people who buy their own health insurance, a flexible health plan, affordable. However, if you flip to the back, it had sort of in the smaller print the fact that they may not be able to cover people who have ever had treatment for the following, AIDS, alcohol or drug dependence, cancer, COPD, connective tissue disorder, Crohn's disease, diabetes, emphysema, heart attack or stroke, hepatitis, inpatient emotional or mental illness, organ or tissue transplant, or colitis. So if you are like an episode of survivor and you are not in that category, however, you are still not out of the woods yet because it also says that other individuals who are obese, underweight, have undergone diagnostic tests for a whole variety of different illnesses, as well as expectant parents or children less than 2 months old are also not going not be able to take advantage of that policy. And, last, it says this list is not all inclusive. Other conditions may apply.

So, I mean that is what health insurance looked like until President Obama signed the Affordable Care Act in March 2010, which once and for all abolished this whole type of medical underwriting practice. And, again, it was also architecture that was built around it to make that meaningful, such as essential health benefits, the lifetime caps, which Mr. Riedy so powerfully testified to, adjusted community rating so that older people can't be charged more than three times a younger individual.

So, again, regarding the Texas case, as Dr. Gupta said, I mean there is absolutely no question that the Justice Department, which participated with the plaintiffs and did not defend the Department of Health and Human Services, if that ruling were to stand, again, that would just take a wrecking ball to the whole architecture, again, that was built. Is that correct, Ms. Corlette?

Ms. CORLETTE. That is correct. For the plaintiff States, if their position prevails the entire law would be invalidated.

Mr. COURTNEY. And in terms of some of the other changes that they have made through the regulatory process, the association health plans, which, again, on surface sounds great, that small businesses can team together in different sectors and go out and buy collectively. By the way, that was totally legal prior to the Trump Administration's ruling and there were about 600 association health plans across the country. What the ruling really did

was it basically allowed those plans to avoid, again, a lot of these patient protections, such as essential health benefits, which were painstakingly designed with the Institute of Medicine in terms of what is healthcare and what should health insurance be, and lifetime caps, et cetera.

So, again, I just wonder if you could sort of focus on that point, that the Administration, again, is in fact undermining preexisting conditions and preexisting condition protections with those types of regulatory actions.

Ms. CORLETTE. That is absolutely correct. Groups of employers have always been able to join an association and offer benefits if they choose to do so. What the Administration is encouraging is arrangements that essentially are allowed to cherry pick the healthiest and youngest employer groups out of the regulated market and thereby gain a pricing advantage.

Mr. COURTNEY. And the short-term plans, Dr. Gupta, you mentioned, again, it is the same story, that it is really a device to avoid again the protections that were built into the Affordable Care Act.

Dr. GUPTA. That is very true. And along with that, the other part of this is the medical loss ratio that was built into the ACA and that is not subject to in the short-term plans. So they can have as much as 50 percent medical loss ratio and actually profit disproportionately out of—

Mr. COURTNEY. And the short-terms plans are really not that short. Again, when the prior Administration allowed for a very short, short-term plan, these now almost are basically going to be sold for an entire year. Isn't that correct?

Dr. GUPTA. Correct. They could be sold for about 364 days and then renewable afterwards.

Mr. COURTNEY. So, I mean it is basically a whole new product. And, again, we would see the bad old days in terms of, you know, this type of laundry list of fine print where people are going to have a rude awakening when they thought they had insurance and in fact it was totally useless and meaningless.

I yield back.

Chairman SCOTT. Dr. Foxx.

Mrs. FOXX. Thank you, Mr. Chairman. Ms. Turner, people living with preexisting conditions, such as cancer, diabetes, or other illnesses face an incredibly difficult battle each and every day. And, in particular, I commend Mr. Riedy for his strength and courage to share his story with us today. People should not worry about having their coverage denied because of a medical condition when they should be focused on getting well and managing their quality of life. That is why congressional Republicans have voted time and time again to protect preexisting condition protections.

Ms. Turner, are these protections under current law sufficient to protect access to coverage for the most vulnerable healthcare consumers, and do you agree that these protections should be maintained?

Ms. TURNER. The protections absolutely should be maintained. But I do believe that we do have to address the issue of cost because many people who need coverage are not able to afford it and then are completely, completely exposed. So I believe that the preexisting conditions that are in law today and that the House of

Representatives supported in the American Health Care Act were important, will continue to be important. I see the strong support, both in Congress and with the American people, to maintain those protections.

Mrs. FOXX. Thank you, Ms. Turner. Because of policies enacted by the previous House Republican majority and regulatory actions taken the by Trump administration our economy is thriving. As I mentioned, the economy added 304,000 jobs last month, almost double what economists were expecting. As a result, the number of individuals with employer sponsored coverage has grown by nearly 7 million since 2013, with 2.6 million gaining coverage since President Trump took office. How does strong economic growth contribute to more workers gaining health insurance from their employers?

Ms. TURNER. Virtually all employers want to offer health insurance to their employees, but many smaller businesses, in particular, just can't afford it, both because of the regulatory burdens as well as the cost. The Trump administration is giving them some new options, both with association health plans and with health reimbursement arrangements. For those that have employer coverage, it is such a valued benefit and employers and employees work together to balance cost and quality and comprehensiveness of benefits. And as a result, employer-sponsored health insurance is certainly the most popular benefit offered by employers. And I am pleased to say that is not only continuing but being enhanced by the strong economy.

Mrs. FOXX. Thank you. Ms. Turner, when I travel around my district in North Carolina, I hear stories from so many people who struggle with the high and sometimes unpredictable costs that they face when taking care of themselves and their families. Out-of-control drug prices, surprise medical bills are two topics that President Trump has recently identified as places for reform and areas where I believe we can find bipartisan agreement.

In addition to these issues, what other areas do you think that Republicans and Democrats can move forward and work on together to find a solution that benefits patients, workers, and families?

Ms. TURNER. I do work with a number of people in the policy community and it is surprising to see how much agreement there is on really trying to help people. I think we need to strengthen the system for the most vulnerable. I was on a panel yesterday—on Monday at the Academy of Health with several people from center-left and we talked about the importance of thinking of the whole person, of comprehensiveness of care, of allowing people to not only have coverage for health care, but housing support and food support and transportation support. Thinking of the whole person I think is really crucial and devolving more power and authority to the States and localities that have the understanding of their markets and resources I think is really crucial. But I also think addressing the cost of health coverage is so important.

Between 2017 and 2018 we lost 2 million people in the individual health insurance market. They dropped out because of cost. So we have got to address the cost for people who want health insurance, who currently are healthy, but know they need protection. And we

need to make sure that we are strengthening the system for the most vulnerable.

Mrs. FOXX. Thank you, Ms. Turner. I yield back, Mr. Chairman.

Chairman SCOTT. Thank you. The gentlelady from Oregon, Ms. Bonamici.

Ms. BONAMICI. Thank you, Mr. Chairman, and thank you to all of our witnesses.

Last week there was a hearing in the Ways and Means Committee here in the House about preexisting conditions and one of the witnesses was the insurance commissioner from my home State of Oregon, Andrew Stolfi. And he talked about how in Oregon since the ACA we now have more than 3.7 million Oregonians, which is about 94 percent of our population, with health insurance coverage. And since the ACA that has been a significant improvement, significantly reducing the number of people without insurance. And before the ACA insurers had offered limited coverage or excluded so many people who applied. In fact, before the ACA the denial rate was about 30 percent, 30 percent of people who applied were denied. And in Commissioner Stolfi's words, he said the ACA has helped change all of this, pregnant mothers know they can get the care they need and their babies need, children with developmental disabilities can get all of the essential physician-recommended physical, occupational, and behavioral therapy they need to grow to their fullest potential.

So, the ACA is now protecting millions of people in Oregon who have preexisting medical conditions. Lisa from Beaverton is 26 years old, she received a diagnosis when she was 23, stage 4 lymphoma. I am happy to report that her cancer is now in remission and she is pursuing a master's degree, but she is pretty worried, frankly, when she hears all the conversations about repealing the ACA, this Texas lawsuit. She said "I have hopefully a lot of life ahead of me and it frustrates me that my history of cancer could limit my access to healthcare."

Mr. Riedy, thank you so much for sharing your story. I have an advocate in the district I represent, Ella, a young woman with CF, and she comes to the Capitol when she can to advocate for more research and funding. And her family shares your concern about lifetime caps.

How is the last couple of years—how have you personally felt when you hear all these conversations about repealing the Affordable Care Act? And when you hear about this lawsuit that might repeal the Act?

Mr. RIEDY. Thank you. It is scary to think, especially like I testified earlier, with the cost of my care currently, having caps or potentially being able to be denied coverage is a scary thought. Knowing that there is access to drugs that are changing my life and that there is more medicine coming down the pike that will ultimately, I fully believe, one day cure cystic fibrosis. But that will come at a cost. And it is hard to think or sort of comprehend that those treatments may be there and because of a lifetime cap or because of being denied access, that I will not be able to get those medicines, or your constituent's daughter would not be able to get those medicines that could potentially save or prolong her life.

Ms. BONAMICI. Thank you so much. And you made an excellent point, that access does not mean affordability. And if there is not the prohibition against discrimination for people with preexisting conditions, if the companies are saying well, we offer insurance to people with preexisting conditions, it just costs a fortune, it is not meaningful access.

I have another question to Dr. Corlette. I have another constituent, Diane, who is a small business owner and for a long time she—she has a son with autism and a small business—for a long time she could not afford insurance before the ACA. She almost lost her home and business during the financial collapse. She went several years without coverage and she was uninsurable because she had preexisting conditions.

So, she was not able to manage her arthritis, made it difficult for her to work. So, under the ACA she was able to get coverage, she could see a doctor, she eventually had hip replacement surgery, she is now able to work, has rebuilt her business. So, a really positive story largely because of that access to marketplace coverage.

So, Professor Corlette, if the ACA protections we have discussed are undermined, what might that mean for Diane and other small business owners who do look to provide coverage for themselves, their families, and their employees?

Ms. CORLETTE. Sure. So, if the ACA is invalidated in a Texas court it will wipe away some of the protections that your constituent has benefited from. So, for example, in the group market, if she is buying as a small business owner she could—her employees could face what are called preexisting condition exclusions where the insurance company excludes from your benefit package those services that would actually treat your condition, for which you actually need services, for up to a year. The insurance company would not be required to cover essential health benefits, which is a list of benefits that the Institute of Medicine and others have said should be in a basic benefit package, it could impose lifetime annual limits, there may not be a cap on the annual amount that she or her employees would pay out-of-pocket. So, there are a number of critical protections that people in job-based coverage would lose.

Ms. BONAMICI. Thank you very much and I see my time has expired. I yield back. Thank you, Mr. Chairman.

Chairman SCOTT. Thank you. Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman. And, Mr. Riedy, I want to start with you.

First of all, the easiest vote I have made here in the U.S. Congress was for the 21st Century Cures Act. To Dr. Collins, Francis Collins, the director of the NIH, it is very easy for me to vote to increase his budget to $39 billion. When I was a medical student, the first pediatric rotation I had in Memphis was St. Jude's Children's Hospital. Eighty percent of those children died in 1969 when I rotated there, today 80 percent of them live. If you have a rare condition, it is 100 percent for you. So I think there is a cure out there in the way and I think your future is very optimistic. And thank you for being here today.

Look, we could all agree that we want to increase coverage and access and lower costs. That is exactly what we wanted to do with

the ACA. Everyone can agree to that. And we agreed that we wanted to discuss preexisting conditions. And I want to go over very quickly, so everybody understands, that if you have health-based insurance, which I provide in my office for my employees, everyone—you cannot discriminate based on a preexisting condition. No. 2, if you have Medicaid or Medicare, you cannot discriminate versus on a preexisting condition. It is only in the small group and individual market where this occurred. And people feared if they lost their job and they ended up in the small group or individual market that they couldn't do that.

I have a bill that I am dropping today, a very simple bill. It has one paragraph, it is three pages long, that essentially provides ERISA coverage to the small group and individual market. It treats them—me—as an individual—and I have been on the individual market—exactly like a large corporation. And that solves the problem and everyone in here—no matter what the Court does—if the Court rules whatever they rule. If they rule and it takes apart this, we have covered everybody and treated each individual exactly the same as a big company. This should be simple to do, it is one paragraph.

And let me also say, Dr. Gupta, to you, let me share some experiences in Tennessee. We were promised the costs were going to go down. Our costs went up 175 percent and we lowered the number of plans out there that we could have. In my district, where I live, three-fourths as many people paid the penalty as actually get a subsidy. And what is happening in the real world is with these out-of-pockets and co-pays, if the hospital were our practice for 30 years, over 60 percent of the uncollectible debt are people with the insurance, not without insurance, but with insurance. And what happens is a patient will come to my office and if they had a condition, one of the 10 essential health benefits, they got their screening procedure done, that was fine, that was "free". If I found anything wrong with them and I had to send them down to the hospital for a test, they then have to meet their out-of-pocket and co-pay, which can be $3–4–5,000—and my family is $10,000. And so what happens, the hospitals, the providers, end up eating that. That is what his happening in the real world. Or people don't get the second test that they need, and that is what we have to look at.

I also want to say to you all that I have a preexisting condition. I was treated 17–18 months ago for proState cancer. So I am in that pool of preexisting conditions and I don't want to be excluded either, nor do I want my patients excluded. And that is why I think we should all support this bill right here.

And, Miss Turner, if you would, I would like for you to comment a little bit about my suggestion, about just applying these ERISA rules to me or to any individual out there.

Ms. TURNER. As we said, employers so highly value their employer coverage, and one of the reasons is because someone is negotiating on their behalf for a quality health plan. And health plans in the workplace are basically community rated. You may have different plan options, but everybody is basically paying the same amount for premiums. And HIPAA, of course, protections say that if you have group coverage through an employer and you move

from one employer to another, that next employer must cover you at the same rate. So you can't then be basically underwritten. So there are a lot of existing protections in law.

And I am very intrigued with your very creative legislation to basically extend those protections. I think it is important to note that if the Supreme Court—and I don't know anyone who knows what the Supreme Court is going to do—were to strike down the law, Congress is absolutely determined to fix it and to maybe improve the ACA in the process.

Dr. ROE. I agree. And one of the things that I think is out there in the group market, in the self insured market—and we did this when I was on the City Commission in my hometown—is you can have disease management—Dr. Gupta knows this very well. And I have seen those cases where I have a friend of mine who has a large company with 15,000 employees, had a 1 percent increase in their premium per year for the last 5 years. And we can do that in the small group and individual market if we work together.

Mr. Chairman, thank you. I yield back.

Chairman SCOTT. Thank you. Gentleman from California, Mr. Takano.

Mr. TAKANO. Thank you, Mr. Chairman. Let me begin by saying that my home district in Riverside, California, we cut—the Affordable Care Act enabled us to cut our uninsured rate by more than half because of expanded Medicaid and because of Covered California, which is the name of our exchange. I have personally spoken to older people in my district who have not reached Medicare age, but at an age when if there were no ACA they would not get any cost-sharing subsidies and they could not have afforded the insurance. They were very grateful that they got the cost-sharing subsidies so that they could reduce their exposure to a major medical incident.

So, the majority offers these really false solutions of association plans and short-terms plans. Ms. Corlette, could you—you know, I think these plans are really evasions around minimum benefits. Is that correct?

Ms. CORLETTE. That is right. So short-term plans are exempt from all of the Affordable Care Act rules, so they don't have to enroll people who have health issues, they don't have to cover the essential health benefits, and quite commonly with these plans, if you do get diagnosed with something after you enroll, they will do what is called post-claims underwriting and drop you from the plan to avoid paying your medical bills. So, if you do have an unexpected medical event or diagnosis, you might find yourself uncovered.

The concern is that they will siphon away healthy people from the Affordable Care Act marketplaces and result in higher premiums for those who are not perfectly healthy and have to buy one of these ACA plans.

Mr. TAKANO. So, the same for association plans, which were available, but the way the Administration has structured them, a similar sort of result.

Ms. CORLETTE. Association health plans are similar but not exactly the same. They do have to comply with some of the ACA rules, but not all. And so they can use essentially the rating advantage they have, because they can charge higher rates based on age

and other factors to cherry pick healthier employer groups from the ACA market.

Mr. TAKANO. And there goes, you know, any affordability gain by the ACA. So, these are really ways to undermine the ACA and to undermine by extension protections for people with preexisting conditions, is that right?

Ms. CORLETTE. That is right. If you have a preexisting condition or you simply want comprehensive coverage, like maternity care or other things that you feel are important, you would be buying in the ACA market, and if healthy people are siphoned away the ACA market risk pool will be smaller and it will be sicker, and insurers will price higher as a result.

Mr. TAKANO. So, I would say that attempts to undermine the pools, undermine enrollment periods—so if we look at slashing funding for outreach and enrollment activities, that means less people enroll and makes these insurance pools less viable. That is also hurting people with preexisting conditions.

Ms. CORLETTE. That is right. There is no question that research shows that advertising, marketing, outreach, education, consumer assistance, those all work to get healthy people into the pool.

Mr. TAKANO. And this Administration has, you know, really refused to spend the outreach to get people to sign up for insurance, which then creates the premium dollar pool to make insurance viable and actually keep the cost down.

Ms. CORLETTE. That is right. This Administration has slashed outreach and marketing by about 80 percent. So it is hard to bring healthy people in if they are not aware that the coverage opportunity exists.

Mr. TAKANO. It was hard for me to square this President wanting to protect people with preexisting conditions knowing that his Administration intentionally did that.

So also shortening the enrollment period, making it less—giving people less time to enroll into these insurance plans also has the same result.

Ms. CORLETTE. That is right. And a number of the State-based marketplaces that can choose their own open enrollment periods have extended them to give people more time to enroll, and that has been a successful strategy.

Mr. TAKANO. Well, and the Administration has also engaged in undermining the stability of the markets through ending the cost-sharing reduction payments for lower-income consumers. Would prevent people from being able to buy insurance because they don't have these subsidies.

Ms. CORLETTE. It is absolutely the case that the decision by this Administration to cut the cost-sharing reduction subsidy led to an increase in premiums in the individual market significantly. I think 20 percent.

Mr. TAKANO. Well, this intentional undermining in at least the three ways that I have spoken about, I mean certainly reduces the viability of these healthcare exchanges and also really makes meaningless any statement that this President wants to protect people with preexisting conditions and their ability to get insurance.

I yield back, Mr. Chairman.

Chairman SCOTT. Thank you. Gentleman from Pennsylvania, Mr. Thompson.

Mr. THOMPSON. Chairman, thank you for hosting this hearing. Incredibly important topic. As someone who practiced healthcare for 28 years as a therapist, rehabilitation services manager, licensed nursing home administrator, I mean this is an important topic and preexisting conditions is a serious issue, an incredibly important issue. I have been disappointed over the past couple of years where, you know, with preexisting conditions individuals living with preexisting conditions obviously need confidence in their lives that they are going to be able to purchase insurance that they need to cover that condition, for treatment, rehabilitation. But quite frankly, what I have been disappointed in is how—there are people with preexisting conditions—need that health care professionals who are compassionate and dedicated, they want to provide those service, they want to access—they want those patients to be able to access those services. Well, we have got a lot of politicians that have been weaponizing preexisting conditions for political purposes. And whenever we do that, you know, my experience—I have only been here—this is my 11th year. I was here in 2009–2010. It doesn't serve anyone well.

And so also my background, I used to get very frustrated advocating for my patients, whether it was in a nursing home, comprehensive inpatient, rehab, acute care, you know, going to battle with insurance companies. The people with some of the more chronic conditions are the ones that are facing those lifetime benefits. So I certainly support those improvements.

But that said, let us—you know, I really want to clarify here, Ms. Turner, you know, protections for individuals with preexisting conditions has been a consistent area of agreement for both Republicans and Democrats. You Stated that protections for people with preexisting conditions are currently the law of the land and under the American Health Care Act, passed by the House last Congress, would the current law's legal protections for individuals with preexisting conditions be retained?

Ms. TURNER. If the Supreme Court were to invalidate the ACA and find the individual mandate unconstitutional and non-severable, which I think is unlikely, but if it would, it would certainly give several years of transition time before it went into effect to give Congress ample time to figure out how to back up these protections. And as you said, the Congress at the—whoever has been in control of the Congress has been a strong support of protection for preexisting conditions. Even if people don't have them now, they think they could get them in the future and they know someone has chronic conditions. So those protections need to be in place, but they need to be in a place in a way that actually allows the market to continue to work and doesn't drive out the healthy people because the costs are so high.

Mr. THOMPSON. I mean there are a lot of things that impact. I think people getting into the pool, so to speak, that was mentioned by my friend from California, but the folks that have gotten out of the pool, I think there is a significant number who have gotten out because of post ACA, the cost, the escalating cost. And people with preexisting conditions that have—that were pleased that they could

get it, the insurance but their costs have escalated. So we can't be complacent with the law as it is now, whether—we have to take measures.

One final question for you, Ms. Turner. We constantly hear about the challenges that small employers face when dealing with costs and compliance burdens in providing health insurance coverage to their employees. While some small businesses are able to offer health coverage, many simply can't afford to do so. And one option, among others, which was passed by this committee, is for the small employers to band together to provide economies of scale for purchasing health insurance through association health plans.

Now, what are other alternatives that encourage and enable employers, both small and large, to preserve and expand quality health coverage for their employees?

Ms. TURNER. Well, I do think it is important to focus on association health plans because this recent study by a very well respected analyst, Kev Coleman, said that he did not see that the plans that these new association health plans, which are offered in 13 States, just in the 7-months since the rule was finalized, and offering more than two dozen plans, that they really do provide an option for employers.

I have been in seminars with H.R. directors of Fortune 500 companies and talked with innumerable small businesses. They want to negotiate benefits that their employees want and they listen to their employees. And they are as comprehensive of benefits as they can afford and offer that coverage. So I think that it is important to give respect to the people purchasing these policies, that they will find a way to make sure people have coverage that is as good as they can afford, rather than no coverage at all, which is where too many people are without these options.

Mr. THOMPSON. Thank you, Ms. Turner. Thank you, Chairman.

Chairman SCOTT. Thank you. The gentlelady from Washington, Ms. Jayapal.

Ms. JAYAPAL. Thank you, Mr. Chairman. On October 31 of last year, conveniently just a few days before the midterm election, President Trump tweeted, and I quote, "Republicans will protect people with preexisting conditions far better than Democrats." That was a pretty big flip-flop given that the President and Republicans in Congress, including many on this very committee, spent most of last Congress voting to try to kill the Affordable Care Act and its protections for individuals with preexisting conditions. In fact, I think I am right about this, the only Republican members of this committee who did not vote for the horrible Trump Care bill last Congress were the eight new members who had not yet been elected.

Now, this Administration is backing a lawsuit that could strip coverage for more than 133 million Americans with preexisting conditions with absolutely no plan to replace that coverage. And if this ruling takes effect more than 17 million people would lose coverage in the first year alone.

So, to my Republican colleagues, which one is it? Do the American people deserve coverage for preexisting conditions or don't they?

Let me also point out that overturning preexisting conditions protections would disproportionately harm racial and ethnic minorities. And, Mr. Chairman, I seek unanimous consent to enter a written Statement from the Asian and Pacific Islander American Health Forum into the record.

Chairman SCOTT. Without objection. And I want to remind our colleagues that pursuant to committee practice, materials must be submitted to the committee clerk within 14 days following the last day of the hearing, preferably in a Microsoft Word format. The materials submitted must address the subject matter of the hearing. And only a member of the committee or an invited witness may submit the materials for inclusion in the record.

Documents are limited to 50 pages. Documents longer than 50 pages will be incorporated into the record by way of an internet link, so that you must provide the committee clerk with that in the timeframe, but recognize that years from now that link may no longer work.

And I will give you a couple of seconds at the end.

Thank you.

Ms. JAYAPAL. Thank you, Mr. Chairman. And noted for the future.

So let me start with my first question for Ms. Corlette. Thank you for your testimony. In your professional opinion as a research professor at the Center on Health Insurance Reforms, let us go back a little bit, why did it take an act of Congress to require insurance companies to insure people with preexisting conditions?

Ms. CORLETTE. Well, before the ACA insurance companies, in order to make money, the business strategy was to enroll as many healthy people as you could, bring in their premiums, and pay out as little as possible in claims. So, to do that they engaged in what was called medical underwriting, which required people when they applied for coverage to submit health forms. They had lists of up to 400 different conditions that would cause you to be excluded from coverage. But, essentially that was the business strategy.

What the ACA tried to do was change the business strategy away from risk avoidance to risk management.

Ms. JAYAPAL. Thank you. So, just to be frank, insurance companies wouldn't cover people with preexisting conditions because they are too expensive, correct?

Ms. CORLETTE. Yes.

Ms. JAYAPAL. OK. So, Ms. Corlette, you also said in your testimony that the Affordable Care Act was enacted in part to correct serious deficiencies in health insurance markets that left millions uninsured and millions more with inadequate coverage. The reality is that the profit-seeking motives of insurance companies and big pharma are at odds with providing comprehensive care for everyone in this country. Do you believe that government should play a role in insuring that corporate greed doesn't allow insurance companies to deny coverage to people with preexisting conditions?

Ms. CORLETTE. I think absolutely government needs to play a role, both in terms of financing, and I think it is important—you know, this committee is as aware as anybody else that employer-sponsored coverage is the source of the biggest subsidy in the Federal tax code. So critical role in terms of financing, but also to set

the rules of the road. So, to the extent that we have private market actors on the provider side or the payer side, that there are clear rules of the road to protect people who need help, which is individuals, consumers, small businesses.

Ms. JAYAPAL. So, thank you. In 2017—this is again a question for you—Aetena's CEO was paid nearly $59 million, Cigna's CEO took home almost $44 million, UnitedHealthcare's CEO $27 million. So, our healthcare system is underwritten by greed and health insurance companies and big pharma are profiting off of sick Americans. Without the protections ensured by the ACA, do you believe that insurance companies would continue to guarantee coverage for people with preexisting conditions?

Ms. CORLETTE. No, I think they would go back to the business practices they were engaged in before the ACA was passed.

Ms. JAYAPAL. Thank you. The Urban Institute estimates that 17 million people will lose coverage in the first year alone if the Republican lawsuit stripping the ACA goes through. We have waited long enough for corporate executives to do the right thing, in my opinion. They simply aren't going to do so without government intervention. And that is why we passed the ACA.

And, Mr. Chairman, that is why we must go further. Ultimately, I believe we need to take the pure profit-seeking motives out of our healthcare system and ensure that the No. 1 thing we do is protect every American's right to have healthcare. And so today we are united as Democrats in protecting the ACA, making it clear that we stand with millions of Americans who are at risk of losing coverage. But I am also determined to put forward a bold new vision for Medicare for all, something that the majority of all Americans support. As Members of Congress, we are ready to listen to them and put people over profits.

Thank you, Mr. Chairman, I yield back.

Chairman SCOTT. Thank you. Gentleman from Michigan, Mr. Walberg.

Mr. WALBERG. Thank you, Mr. Chairman. Protections for individuals with preexisting conditions has been a consistent area of agreement for both Republicans and Democrats. We have to keep reiterating that.

I strongly believe that these protections need to remain in place and I voted and co-sponsored legislation to safeguard them and give peace of mind to patients, and that is a matter of record.

I am disheartened with my friends on the other side of the aisle's continued misinformation on our record on this issue. There was no Trumpcare, nothing got to his desk. There was the Affordable Health Care Act that dealt with all of the issues of concern that the ACA brought up because it didn't work for many people who did have a health care plan that they paid for, but when they went to use it, so many of them, so many of them did not have health care. So I hope that changes at some point in time, the rhetoric that continues on.

This committee has jurisdiction over employer-sponsored health insurance. I know there are some that believe we need to move beyond the employer-sponsored coverage, however, the employer sponsored system currently provides health insurance for over 181 million Americans. So instead of forcing Americans off their plans

that they like, or in the cases of union employees, forcing them to give up health plans that they worked hard for and made salary sacrifices to negotiate, we should explore ways to strengthen our employer sponsored system, reduce costs, so more businesses can offer these good benefits to their employees.

I constantly hear from small employers in Michigan who are dealing with the cost and compliance burdens of providing health insurance coverage to their employees. While some small businesses are able to offer health coverage, many simply cannot afford to do so. One option among others, which was passed by this committee, is for small employers to band together to provide economies of scale for purchasing health insurance through an association health plan.

Ms. Turner, thank you for being here. As you know, in August the Department of Labor issued a final rule to expand access to AHPs. In your opinion, when finalized, will DOL's rule help or hinder efforts to increase coverage for small employers and their employees?

Ms. TURNER. It absolutely will provide them an important new option to negotiate benefits on behalf of their employees. Talking with another H.R. director who has a work force of primarily medium and lower income workers, he said what happens is that as healthcare costs go up it eats up their wage increases. So employees see their wages as flat, but part of their compensation because too much of their compensation package is going to health benefits.

Some employers are very creative, helping to provide coordinated care for people that they have identified that have the greatest healthcare needs. So I think employers play an important role and I think association health plans also play an important role, as well as the new health reimbursement arrangement rule, which would allow employers who cannot afford and do not have the resources to actually provide coverage to give their employees a stipend to be able to purchase health insurance on their own. We recommended they be able to combine salaries from two spouses, for example. One spouse may be offered health insurance at work, the other one can get a stipend to help make that a family plan rather than just an individual plan.

Mr. WALBERG. The beauty of more flexibility, creativity, and options that go on.

Ms. TURNER. Yes. And also to recognize the competition out there.

Mr. WALBERG. Right.

Ms. TURNER. Plans are competing, companies are competing, everybody is trying to do the best job to get the best value.

Mr. WALBERG. You mentioned in your testimony a study by Kev Coleman, a former analyst at the insurance information website HealthPocket. In his study, what type of plans did Mr. Coleman find that AHPs were offering? And let me ask this as well, are essential benefits covered in the plans that he discussed?

Ms. TURNER. The study by Kev Coleman showed that these AHP plans are offering benefits comparable to the largest employers that have negotiated these benefits for years and that they are not discriminating against patients with preexisting conditions. Many

of these employers may have someone on their staff, maybe even a family member, that has a preexisting condition.

Mr. WALBERG. Or themselves.

Ms. TURNER. Yes. And so they want those benefits and they are really pressing the market to figure out how do you do that in a price that they can afford to purchase that coverage.

Mr. WALBERG. Thank you. I yield back.

Chairman SCOTT. Thank you. Mr. Morelle from New York.

Mr. MORELLE. Yes, thank you, Mr. Chairman, for holding this very important hearing, and thank you to the panelists for being here and for answering the questions, particularly Mr. Riedy. Thank you for your courage in being here and sharing your story with us.

Back in 1993 I co-sponsored and helped pass a law in New York that provided community rating for all New Yorkers that were in small business, the individual marketplace, as well as ending the practice of—well, beginning the practice of having protections for preexisting conditions. Something I am very proud of. So I took it as an article of faith that everywhere was like that, and then I became chair of the insurance committee about 15 years ago and during the time of the implementation of the ACA. I learned a great deal about what happens in the rest of the country. So this is very, very helpful in terms of understanding all of this.

The first comment I would just make around coverage is we use the word coverage as though it means the same thing to everyone. The truth is, I remember as insurance chair, when people would come to me and say I had out-of-network benefits and it said out of network services were covered, yet it only covered 25 percent of my bill and I have this huge balance that I have to pay. You learn quickly that coverage doesn't mean coverage, that it means different things to different people. And cost avoidance is a big part of trying to provide coverage.

But I wanted to just talk a little bit about the definition if I might. My daughter, Lauren, was diagnosed with triple negative breast cancer just a few years ago and she passed away about 17 months ago. I had never heard of triple negative breast cancer, but it is part of the diagnosis. And when you begin to look at treatment, you look at genetic panels and what you can learn from the genome. And it turned out that in Lauren's case while it wasn't passed on genetically, she did have a mutation in one of her genes.

And so perhaps Ms. Corlette might be able to answer this, is there a concern that genetic predispositions will be defined more broadly as preexisting conditions in the way that some insurers view this or some people view it?

Ms. CORLETTE. Well, there is a Federal law that was enacted before the ACA, the acronym, is GINA, the Genetic Information Nondiscrimination Act, that does prohibit insurance companies from discriminating against people based purely on genetic information.

Mr. MORELLE. And does that include then predispositions based on other things that would affect chronic conditions?

Ms. CORLETTE. With respect to the preexisting conditions that we are talking about today, most insurance companies require you actually be diagnosed with a specific condition before it would be underwritten. Although I will say for short-term plans, you know,

they will look at your medical history and even if you were not given a formal diagnosis they might say that you had the condition, you know, the cancer cell was in your body before you enrolled and might disenroll you because of that.

Mr. MORELLE. Yes, because it is certainly hard to tell when it manifests itself and—

Ms. CORLETTE. Exactly.

Mr. MORELLE [continuing]. when it actually becomes disease state. Also to my colleague, Mr. Courtney, mentioned as he showed the pamphlet, in the description had obesity, which that would be a preexisting condition presumably?

Ms. CORLETTE. Yes. Yes.

Mr. MORELLE. And that would be the case even if you had not exhibited or manifested any disease because of that condition, is that correct?

Ms. CORLETTE. Correct.

Mr. MORELLE. And obviously that is not genetic in nature, but that is effectively underwriting which could lead ultimately to preexisting conditions?

Ms. CORLETTE. Right.

Mr. MORELLE. And I did want to just mention coverage too because when you have community rating, and we don't even do an adjustment in New York for community rating, it is all the same. So that you have as you get older—as I am finding you have more medical conditions as you get older. Young, healthy people, obviously we want in the pools, and adverse selection often leads people to avoid coverage until they have a reason for it. But the larger the pool and the more that you essentially flatten the experience of the larger pool is really what insurance is all about. The avoidance of that with some of the plans that have either high deductibles or that in a sense sequesters the better risks is actually what causes the case of either uninsured or high premiums. Is that not right?

Ms. CORLETTE. That is exactly right. You said it better than I ever could.

Mr. MORELLE. And that is my real concern here, Mr. Chairman, members, is that as we talk about coverage, as I said, it is not all the same, and you could be left with significant balance billing for procedures where you thought you had coverage, and this notion of sort of shifting risk to other groups of less well people is essentially what I understand the Administration policy to be.

Would you care to comment on that?

Ms. CORLETTE. Yes. I mean with respect to association health plans, short-term plans, it is really about shifting the risk from young, healthy people to older and sicker people. So, it is sort of rearranging the deck chairs without addressing some of the underlying issues about cost. Which is they are real. We have a cost problem in this country. But just creating new winners and losers is I don't believe the answer.

Mr. MORELLE. Very good. Thank you. I yield back my time.

Chairman SCOTT. Thank you. The gentleman from Alabama, Mr. Byrne.

Mr. BYRNE. Thank you, Mr. Chairman. I appreciate you holding this hearing.

Ms. Turner, I am sort of just the facts type person, and I didn't get here until I was elected in 2013, so I am having to go back and sort of make sure I understand how we got where we are.

When Congress passed Medicaid and Medicare, embedded in those programs was protection for people with preexisting conditions. I think that is correct. And when they created some other public programs, like TRICARE, they did the same thing. And then I think I was told that when HIPAA was passed in 1996, bipartisan bill, that we provided similar protection to people that are in-group plans, employer-provided plans. Have I got that right?

Ms. TURNER. Absolutely.

Mr. BYRNE. So I asked my staff to go back and look at the most recent numbers we could get, which was 2017. Forty-nine percent of the people in America are under an employer provided plan. When you add up all the people on the public plans, like Medicare and Medicaid, it is another 36 percent. So if I am doing my math right, since at least 1996, 85 percent of the people in America have had protections on preexisting conditions as a result of bipartisan acts of the U.S. Congress. Have I got that right?

Ms. TURNER. Yes.

Mr. BYRNE. OK. So that is another 15 percent and every one of those people in the 15 percent is important. I do not think any of us can gain say that, but sometimes we start talking about this, we forget that 85 percent of the people in America have got the protections that they need. So when we look at what happened in the Affordable Care Act—and I was not here when it was passed, so I was not a part of that debate—I have actually talked to people in my district who were in that 15 percent. In fact, the very moment I was running for Congress is when those notices went out to people, who were told by the President of the United States that if they liked their health care plan they could keep it, they actually came up to me at a high school football game where I am passing out pamphlets, and showed me the notice they got from their insurance company that said we are canceling your health care plan. But here is our new one for you, and the cost was a multiple of what they were used to paying. And these people, while they were working people, they could not afford it. And ACA did not provide those type people with the sort of help they need financially to do it. So I have met those people across my district who now are uninsured because they can't pay their premiums.

So let me just ask you, are there individuals, including individuals with preexisting conditions, that the ACA might have actually materially hurt?

Ms. TURNER. There are people who say that the coverage that they had before, even in the individual market, was better than the coverage they have now because it is more affordable. Some of them are facing deductibles of $10,000. And they say that I might as well not be insured because I can't meet that deductible.

Another friend who had a liver transplant needs significant anti rejection medications and he says that a health savings account actually is beneficial to him because he knows what his out-of-pockets costs are going to be, he can pay that on a tax free basis, and his catastrophic coverage actually was much better because it allowed him to wee any doctor without so many restrictions.

So, yes, there are people who preferred the coverage they had before, but I absolutely agree with you that preserving the preexisting condition protections is vital. And also not frightening people to think that they might lose it. I had a friend write to me saying that she was worried if the court case were to be successful that she would lose her preexisting condition protection and Medicare. And there is no reason for her to be so frightened.

Mr. BYRNE. No, there have been scare tactics out there like that. It is unfortunate because even on Medicare you have got older people and they have got lots of other things that they are thinking about, and we don't need to be scaring them, we need to be helping them.

I have talked to many Members of Congress since I have been here. I have not met a single person in either party that doesn't want to protect people that have preexisting conditions. The question is how do you do it? What is the smartest way to do it? What is the most cost-effective way to do it? But when you get up and tell the people of the United States, if you like your healthcare plan, you can keep it, and then they get a notice that says no, I can't keep it, and the substitute is something I can't afford, you have materially hurt people in the United States. And everybody in this Congress, Democrat or Republican, we should all want to work together to make sure we help those people, because those are the good, hardworking people in America who depend on us to look after them.

I appreciate your testimony. And I yield back the balance of my time.

Chairman SCOTT. Thank you. The gentleman from California, Mr. Harder.

Mr. HARDER. Thank you, Mr. Chairman, and thank you to all of our witnesses for being here on such an important issue.

Protecting folks with preexisting conditions is the entire reason I ran for this office. On my district in the California Central Valley this is my highest priority. Over 100,000 people in our district have health insurance only thanks to the Affordable Care Act. And those 100,000 folks were at risk of losing their coverage if the Affordable Care Act was repealed, and it was only after that vote a year and a half ago, almost 2 years ago now, that I decided to get on in and see what I could do to fix that. And I think the reality is, is in a district like ours, where nearly 50 percent of our individuals have a condition that qualifies as a preexisting condition, this affects every single human being, every person in my community has a loved one who would be affected if the Affordable Care Act was threatened. Every single person, including me. In my case it is my little brother David. He was born 10 weeks premature, less than 2 pounds when he was first born, spent the first 2 years of his life in and out of a hospital, came out with a healthcare bill 104 pages long. And because of that he would be without insurance until he is 65 and on Medicare if we did not have protections for folks with preexisting conditions.

And, Mr. Riedy, I really was so touched to hear your story. I think your voice gives power to millions of folks. I think we need to be humanizing these statistics. And so when folks think about what life is really like with a preexisting condition, they are think-

ing about people like my little brother, they are thinking about people like you, and all of us, because the reality is each one of us has a loved one who would be affected by these changes.

And in your testimony you mentioned you had a cost of medical treatment $450,000 in 2018. Is that correct?

Mr. RIEDY. That is correct. That was just for the cost of medicines.

Mr. HARDER. One year, one year. And I think that, you know, in a district like ours, where we have a high rate of unemployment, we have a lot of folks that have real financial stress, there is a lot of folks that could be impacted by that.

I am very interested, based on your own experiences, Mr. Riedy, how do the annual lifetime caps affect patients with costly medical conditions?

Mr. RIEDY. So with the passing of the ACA and the ban on lifetime caps, it has—and annual caps, it has allowed me personally, and others with preexisting conditions, to have a better frame of mind to be able to focus on our health versus if I go and see this doctor, or I get sick and I have to go into the hospital or I have to have some costly procedure, what is that going to do, how close is that going to get me toward that cap, and then potentially if I get to that cap, what happens then. So not only are you dealing with having to fight to stay alive or have to focus on treatment regimens that take 3 to 4 hours a day in my case, you are also then focusing on the mental aspect of this also and trying to focus on if I get to this point am I going to have to make decisions basically that affect my care and my family's wellbeing versus essentially dying or not being able to access that care which then will shorten my life and others.

Mr. HARDER. What do you would believe would happen to people like yourself and the people you advocate for if the Affordable Care Act was undermined by the court in the Texas case?

Mr. RIEDY. You know, I worry if the court case is upheld, I worry that insurers will institute lifetime and annual caps again, that they will reinstitute the ability potentially for me to be denied coverage simply because I was born with a genetic disease and have a preexisting condition, and that I will lose the comfort knowing that no matter where I work or what happens to me that I can continue to be there for my family and focus on what needs to happen versus—to take care of myself versus what the cost of that medicine is that my doctor prescribed, or not even being able to go and see especially—the highly specialized care that I need to take care of my lungs and by body.

Mr. HARDER. Thank you for your powerful testimony and for putting a face on what this really looks like. I think there are so many of us affected, nearly 50 percent of my district, and of many others. And we talk about millions of Americans, we talk about the 100,000 people in our community that would be without insurance if the Affordable Care Act were repealed and if it were undermined by some of these efforts of litigation, but I think the most important thing that we need to be considering is really understanding the day to day lives of folks who are living through these challenges today and understanding how those lives would be so different if we had not passed the Affordable Care Act.

Thank you so much for your powerful testimony today.

Mr. Chairman, I yield back my time.

Chairman SCOTT. Thank you. The gentleman from Georgia, Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman, and thank you for having this hearing today. It is very enlightening. Obviously, you know, I have some preexisting conditions, I have family members that have preexisting conditions, so we are all very, very interested in how we go about making healthcare available to all Americans.

The question and the big debate is how do we pay for it. Obviously we have the resources in this country to provide—and, Mr. Riedy, thank you for your testimony—to provide excellent medical care and hopefully a cure. We are all praying for cures for Alzheimer's, for all types of issues that we are dealing with in this country. And we are spending a lot of money to try to find cures for those things. But in the meantime, what is the best way to provide health care?

Now, the question is, does the government do it more efficiently than the private sector? And I think, Ms. Turner, is there any information, like for every dollar of taxes that we pay, how much of that dollar gets back to take care of a patient under the Affordable Care Act.

Ms. TURNER. I have not seen—well, there is a medical loss ratio, so we know that based upon the company's size that either 20 or 15 percent of the money can only go to administration, the rest has to go to medical care.

Mr. ALLEN. Right.

Ms. TURNER. But I do think that it is important to look at the approach that the American Health Care Act that the House passed in 2017 took. It actually dedicated specific resources to help people that have high health care costs—$123 billion. A similar amount in a Senate bill that didn't make it through, but that would have separately subsidized and provided extra money for the people that have chronic healthcare conditions. The ACA put them in the same market with everybody else and that raised prices to the point that you are driving the healthy people out. So there is a lot of evidence that if you separately subsidize those with the highest cost and the highest risks, you can lower premiums for other, get more people covered, and then focus on providing the coordinated care that people with multiple health conditions actually need.

Mr. ALLEN. Exactly. And, you know, right now I think that Health and Human Services has a budget of about $1.2 trillion, the largest single piece of the Federal budget, and, you know, out of that $1.2 trillion I am interested—of course my background is the business world—and I am interested in exactly how much of that $1.2 trillion is taking care of Mr. Riedy. And I think we need to look at that and then we need to look at what would it cost if we returned health care back to the health professionals and we were able to, through programs deal directly in our health providers, deal directly with our health providers rather than got through HHS and these other agencies that have these huge budgets.

And, frankly, as I understand it, our health care in this country is much more expensive than compared to other industrialized countries in the world. Is that correct?

Ms. TURNER. That is correct. We are also the research center for the planet. The great majority of new prescription drugs, like the one that Mr. Riedy says is so valuable, are developed in the United States. We pay a disproportionate share both for the research and for the drugs, and also new medical technologies and other innovations.

Mr. ALLEN. Right. So we are subsidizing health care across the world? Would that be correct?

Ms. TURNER. Well—

Mr. ALLEN. How can we afford—we are $21 trillion in debt and, of course, you know, I do not know who is going to be paying my health care bills, but it is probably going to be one of my grandchildren or great-grandchildren, but we have got to solve this problem. We have the ability to take care—you know, I tell folks back home, we have got plenty of money to take care of folks, particularly those with preexisting conditions, I just think it is all in Washington, and we need to get it out in our States and our communities and make healthcare affordable.

And with that I yield back.

Chairman SCOTT. Thank you. Dr. Schrier.

Dr. SCHRIER. Thank you, Mr. Chairman, and thank you to our witnesses today.

I just want to say that I can't think of a more important topic to bring up today as our first hearing because one thing that I have heard about from all of my constituents is healthcare, and that is their No. 1 issue. And I sit here today not just as a Member of Congress, but also as a pediatrician, a doctor who is taking care of patients for the last two decades, and as a person with Type I diabetes. And so I really share a kinship with people in my district and in this country with preexisting conditions.

So, I can report to you first hand that my patients are worried. They are worried that either they or their loved ones will not be covered if they have a preexisting condition or that they will be priced out of the market, as we have been hearing a lot about, and they are worried even in these popular employer-based health plans that their prices are also going up and their deductibles are skyrocketing.

And so, you know, I came here to bring down costs and protect my patients and make sure that no family goes bankrupt because of medical expenses. And so, I hear about these solutions, like these short-term health plans. And you can imagine, as a pediatrician, that preventative care, essential health benefits, and mental health care, well woman care, these are all critical, and that is why they are essential health benefits.

And I just want to clarify, Dr. Gupta, you have not had to communicate anything for a while, so I thought I would give you a chance. Can you just be—very clearly, are those services covered under these short-term health plans?

Dr. GUPTA. Thank you for that questions. Certainly they do not have to be covered. I mean the idea of motherhood being a sort of preexisting condition comes back after a decade again. The idea well woman, well child preventative care, knowing that we are going through an opioid epidemic today that we are having a lot of adverse childhood experiences and a whole generation is going

to have to deal with as children and grow up. And that will be the future of this country. None of those things will be covered. Neither will be things like vaccinations. Those will not be covered. Mental health screenings, domestic violence screening will not be covered potentially. Of course mammograms, pap smears, none of those things have to be covered.

Dr. SCHRIER. Thank you. You are speaking my language. And then just also to clarify, do patients know that these are not covered when they buy these short-term less expensive health plans that are proposed to be a solution to skyrocketing medical costs?

Dr. GUPTA. That will certainly be in fine print, as was mentioned today. And I am sure that most of us are not going to realize until you get sick and then that will be the time that most patients will realize that they were not covered for those services.

Dr. SCHRIER. And to read that fine print you would need glasses like these.

OK, my next question is that I have seen in my own practice, you know, the classic story, a girl with a terrible rash whose mom brought her in and it had been weeks that they had been trying to deal with this at home with all the powders and creams and everything they possibly could. And when she finally came to me it was a disaster, she needed antibiotics and steroid creams. But she delayed care because of the cost of care. She knew that because of her deductible it would cost her a lot to come in and that she may as well try everything in the kitchen cabinet at home.

And so when I think about these short-term plans and that preventative care would not be covered—and I know how important those well child checks are—I just would like your opinion as to how many families will show up for that critically important primary care and preventative care if those are not provided for free.

Dr. GUPTA. We know from studies that compared to the insured population, uninsured individuals tend to delay their care. That leads to lack of those preventative services, ultimately poor outcomes, and more expensive outcomes, not just from health but also for financial reasons. And what we saw after ACA was the amount of uninsured childbearing women went down from about 20 percent to 13 percent. So additional 5.5 million women got the care for things like maternity care. So those things are happening now that we will again walk back several steps and we will end up the emergency rooms with uncompensated care, at doctors' offices, while mostly in primary care, where we already have shortages of tremendous amount across the field. And those offices will once again be seeing a lot of patients who do not have insurance and, like you have, I often provide care for those without regard to the level of insurance they have.

Dr. SCHRIER. Thank you, Dr. Gupta. And I yield back my time.

Chairman SCOTT. Thank you. The Gentleman from Kentucky, Mr. Comer.

Mr. COMER. Thank you, Mr. Chairman. And I would like to talk about healthcare in Kentucky. Obamacare, or the Affordable Care Act, however you want to pronounce it, in Kentucky was a great deal for people who got free health care via Medicaid. But it was a terrible deal for working Kentuckians who actually have to pay for their health care premiums. In Kentucky, 30 percent of the

State is on Medicaid. That is pretty much free health care. But the rest of Kentuckians in the State who are working, struggling to pay health care premiums, they do not have a very favorable opinion of the Affordable Care Act.

Ms. Turner, I would like to ask you a question addressing the rising cost of health care, including premiums, deductibles, and out-of-pocket expenses. This is a huge concern for most Americans and it should be a concern for the democrats. What options do you think policymakers should consider when discussing how to lower the cost of health insurance and provide a variety of affordable options, especially for employers and workers?

Ms. TURNER. I described in my testimony a plan that I have helped to develop with a number of my policy colleagues, called the health care choices plan. And it basically recognizes the States have a lot more knowledge about their individual markets and the needs of their citizens, and it is very difficult for Washington to finely tune legislation enough to let them do what they need to do. So we have recommended formula grants to the States to let them figure out how do they make sure that existing populations are supported. But they have the flexibility to be able to get coverage not only for the continued coverage for them, but to make sure that new people can come into the market and afford coverage, and quality coverage.

Mr. COMER. Mm-hmm. If there is one thing that I think all of us would agree on in both parties is that everyone should be protected with preexisting conditions in health care. No one should be denied coverage based on their medical history. Given that, and given current law, Ms. Turner, are any reforms needed to ensure that individuals with preexisting conditions have access to health coverage?

Ms. TURNER. One of the things that several States have done is request waivers to use some of the ACA money to more heavily subsidize those with high risks to make sure they can have access to care and coverage. I talked about Janet in my testimony who is now under ACA coverage in Colorado, but it is inferior coverage to the high-risk pool coverage she had before. States can fine-tune that, high-risk pools, invisible high-risk pools, reinsurance, to make sure those with the highest healthcare costs are covered. Devote money to them, you cannot only lower premiums for other but increase access for the healthy people we need to come into the market.

Mr. COMER. In Kentucky, prior to passage of the Affordable Care Act, we had a high-risk pool, called Kentucky Access, and it was successful. But it was eliminated with the passage of the Affordable Care Act.

Just to followup on that question, would you say there are other factors that affect consumer access to health care?

Ms. TURNER. Well, that is one of the reasons I believe these short-term limited duration plans are so important, because somebody may be, you know, in a bridge between—they have just graduated from college, they had coverage then, they don't have a job yet, they are older than 26. Somebody who is near Medicare eligibility needs bridge coverage, somebody who is starting a new busi-

ness needs to—there are people who need these temporary plans and that is another option.

Indiana had a great plan called the Health Indiana Plan, a State-based plan. An account to make sure that people could get the preventative care they need, but they also had major medical coverage. There are a lot of other options, but I think that the State creativity, working with healthcare providers, is really valuable.

Mr. COMER. Thank you very much. Mr. Chairman, I yield back.

Chairman SCOTT. Thank you. The Gentlelady from Illinois, Ms. Underwood.

Ms. UNDERWOOD. So, we have just heard from our colleagues, Ms. Foxx and Mr. Comer, who mentioned how they support protections for individuals with preexisting conditions. However, congressional Republicans and the Trump Administration have had relentless—attacked protections passed by the Affordable Care Act. And so many of my colleagues here voted more than 70 times to repeal parts of the ACA. Moreover, last August the Administration finalized a rule that expands short-term limited duration insurance, commonly known as junk plans. Junk plans do not have to comply with key Federal laws that protect patients and they can pose a serious risk to patients with preexisting conditions.

Earlier today, along with Representative DeSaulnier, my Democratic colleagues and I introduced my first legislation in Congress to overturn the Trump Administration's rule expanding junk plans. Insurers should never have the option to discriminate against patients with preexisting conditions.

So, Dr. Gupta, can you tell us more about why they are called junk plans and what kinds of consumer protections can junk plans exclude?

Dr. GUPTA. Well, thank you. I think part of the—what is important is not just the preexisting conditions protections, but also the affordability as well as the accessibility in terms of essential health benefits. So, none of this is covered or required to be covered in these short-term plans, or also as you termed them, junk plans. There are States that have taken a proactive lead, like California, Oregon, New York, New Jersey, who have actually worked to prohibit those plans in the way that they are today. And, obviously, other States will have to do more. Because what that does basically is sells people out there who may not be suspecting a bill of goods that they have no idea about. So, unless they read the fine print, when in so many ways stepping back to about a decade ago, and people when they find that they need the help that they need, they are not going to be able to get it because the preventative care, as well as a number of those essential health benefits, including maternity care, will not be covered.

For example, prior to the ACA only 11 States required maternity care in individual plans, and only 13 percent of the insurers' individual plans covered maternity care.

Ms. UNDERWOOD. That is why patients' groups, including the March of Dimes, the American Cancer Society, the American Heart Association are opposing the junk plan rule.

Mr. Chairman, at this time I would like to ask unanimous consent to enter a letter from those patient groups opposing the rule into the record.

Chairman SCOTT. Without objection.

Ms. UNDERWOOD. Thank you. Dr. Gupta, what effects can junk plans have on patient access to care, particularly patients with preexisting conditions?

Dr. GUPTA. Ultimately it will cost their lives or their bank account, or both. The challenge with that is when somebody needs the help, early help to be able to detect cancer, like breast cancer, colon cancer, or be immunized for important conditions that could be communicable—we are seeing outbreaks of measles, for example—those could get worse. And people we diagnose much later in their stage and then they will not be able to be covered by those because of the preexisting conditions clause missing, and therefore they will be—again, will lose life and it will cost us a lot more. It is just the most—the least effective way of administering healthcare.

Ms. UNDERWOOD. In fact, an analysis by the Los Angeles Times found that not a single group, not a single group representing patients, physicians, nurses, or hospitals supports the junk plan rule. And 90 percent of the comments from the public on this rule were either critical or opposed the rule outright.

So, Ms. Corlette, are you concerned that public opinion on junk plans was disregarded when the rule was written? What needs to be done to ensure the needs of patients with preexisting conditions are truly represented in this debate?

Ms. CORLETTE. Well, certainly with respect to the comments on the short-term plan rule, it would suggest that the Administration's mind was made up about what they wanted to do before the rule was finalized and the public comments did not make much of a difference there.

I do think there is a real concern that a lot of people who are healthy before they sign up for these plans, have an unexpected medical event, and are left on the hook for thousands, tens of thousands of dollars in unpaid medical bills.

Of course, for those who have preexisting conditions, they couldn't buy these plans even if they wanted to. They would have to buy in the ACA market, but the ACA market will be more expensive. CBO has said it will be about 3 percent surcharge on premiums as a result of these plans.

Ms. UNDERWOOD. Thank you, Mr. Chairman, and thank you to all the witnesses for being here.

I yield back.

Chairman SCOTT. OK, thank you. The gentleman from Texas, Mr. Wright.

Mr. WRIGHT. Thank you, Mr. Chairman.

Chairman SCOTT. Thank you.

Mr. WRIGHT. I want to thank all of you all for being here today. Mr. Riedy, God bless you and your family. I think it speaks to your character and your determination that you are even here today participating. So thank you.

Ms. Turner, I think you would agree that, you know, we should never have laws on the books that are unconstitutional, and when

the Supreme Court made its decision on the ACA, Chief Justice Roberts, of course, his opinion was that it was Constitutional by virtue of being a tax. I thought that was a very slender thread, but that is the opinion. If you take that thread away, then it follows that the law is unconstitutional. And as a Texas Congressman I am terribly proud of my State attorney general for leading the effort in this lawsuit. Because, again, if the reason it was determined that it was unconstitutional was that it is a tax and you take that away, doesn't it follow that it is no longer Constitutional?

What is your opinion, Ms. Turner?

Ms. TURNER. Well, this is going to go through the Courts to determine whether or not the fact that the Congress did in fact zero out the tax penalty for individual insurance does invalidate the law, but I think the important thing is that we have seen since then all of the efforts by you and others in Congress to repeal and replace the law. So I think we have seen that there are definitely places that improvement is needed and to try to find a way to replace the coverage that people are relying on, but to allow markets to work better so that healthy people are not being driven out.

Mr. WRIGHT. Yes, ma'am. And the key word there is replace. I think the assumption that if ACA had not passed or if it had been ruled unconstitutional, that nothing would have happened, that there would have been no improvements in healthcare, is a completely false narrative, just as if it were to go away tomorrow we are not going to revert back to the status quo of 2009 because there was always, even in 2009—I don't know if you were part of crafting or helping either side on that, I was here then. I was the chief of staff for the ranking Republican on Energy and Commerce Committee. I sat in some of those meetings, saw the markup. There was always Republican alternatives that included coverage for preexisting conditions, even going back to 2009.

So this narrative that we keep hearing that Republicans are somehow opposed to that or don't want it, is patently and demonstrably false, and it needs to stop because it is not true.

My last question is this, it has to do with the idea that is being advanced by the other side, and we heard it earlier today, about Medicare for all. Well, Medicare-for-all is Medicare for none. Would you agree with that? Can you speak to it?

Ms. TURNER. It certainly would not be the Medicare that seniors know now.

Mr. WRIGHT. If we go to socialized medicine, where it is all run by the government, then doesn't Medicare cease to exist?

Ms. TURNER. As I mentioned in my testimony, my colleague, Doug Badger, has done some research looking at these cross subsidies from the employer-based system with 170-some billion people participating. They pay a higher rate to physicians and hospitals that allow Medicare and Medicaid to save taxpayer money and to pay a lower rate. But if those reimbursement rates went across the board, 40 percent of physicians and hospitals would find that they couldn't even keep their doors open.

So we need the employer-based system.

Mr. WRIGHT. Absolutely.

Ms. TURNER. And the private sector, not only for its innovation but for the money that it provides to support existing public programs.

Mr. WRIGHT. Right. Thank you very much. Thank you, Mr. Chairman.

Chairman SCOTT. Thank you. The gentlelady from Georgia, Ms. McBath.

Ms. MCBATH. Thank you, Mr. Chairman. And I do want to thank you for holding this hearing today. And I would like to thank the witnesses who are here to discuss the importance of protecting access to healthcare for all Americans.

This is an issue that is deeply personal to me. I myself, like millions of Americans, live with a preexisting condition. As a two-time breast cancer survivor, I understand what it is like to have your life turned upside down by this very diagnosis. I was first diagnosed with stage 1 breast cancer in 2010. And after completing treatment my cancer returned again in 2012. My cancer was detected because of a routine mammogram. I will never forget the way that I felt when I first heard my doctor say the words stage 1 breast cancer.

For each of the two cancer diagnoses that I have received I underwent surgery through a procedure called a lumpectomy to remove the remaining cancer. And I received radiation treatment and drugs thereafter. I did it all while raising my family and working full-time. And I can tell you I was terrified. Despite being lucky and having good health insurance through my job, I was still worried about my financial security. I was concerned about making it to radiation treatments, sometimes every single day for weeks, and then back to work and then back home to raise my son, Jordan. It was exhausting, both physically and emotionally. But I had to do it, just like millions of Americans out there who share a similar story to mine.

I truly do not know what I would have done or what would have happened if I had lost that health insurance coverage. And I am happy to say today that I am cancer-free. But, Mr. Chairman, not everyone is as lucky as I am. And I am worried for Americans and for those in my State of Georgia who might not detect their cancer or chronic health condition early on, when it is most easily treatable.

The Centers for Disease Control and Prevention states that preventing diseases is critical to helping Americans live longer, healthier lives and keeping healthcare costs down. It is so important that Americans have access to the preventive services that are an integral part of the Affordable Care Act. These include screenings for certain cancers, screenings for Type 2 diabetes, and other critical health services. And I am worried about their future and their financial security.

We here in congress, we have a responsibility to protect people. That is what we must do.

Ms. Corlette, could you talk a little bit more about how the ACA protects patients and has created greater access to preventive services, like breast cancer screenings or high blood pressure screenings? Particularly how the ACA cost-sharing provisions im-

pacts and also ensures Americans have access to these types of services?

Ms. CORLETTE. Absolutely. Thank you for the question. So, the Affordable Care Act requires insurers both in the individual market and in the employer market to cover a set of evidence-based preventive services without any cost-sharing for the enrollee. And that includes many of the services that you mentioned in your Statement, but also vaccines, contraception, tobacco cessation counseling, a range of services that not only prevent disease but help keep people healthy over the long-term. Those services can also help diagnose issues that people have and help get them early treatment in order to get a better outcome at the end of the day.

So, if the ACA were overturned or this decision in the district court in Texas is upheld, insurance companies would no longer have to provide that protection and people would face cost-sharing. And we know, and Dr. Gupta mentioned, that if people do face coinsurance or cost-sharing for those services, they tend not to get them or they delay them.

Ms. MCBATH. Thank you. And my followup question is how could the Texas litigation impact American's access and affordability of these lifesaving services?

Ms. CORLETTE. If the Texas decision is upheld millions of people will lose their insurance, about 17 million in the first year and up to 32 million by 2026. It is well documented that people without insurance delay, forego care. Before the ACA about 22,000 people died each year simply for not having insurance.

For people with job-based coverage, they lose access to critical protections, like the lifetime and annual limits that Mr. Riedy discussed, the protection against excessive out-of-pocket costs—ACA has a cap on that every year—as well as the preventive services and essential health benefits that you mentioned.

Ms. MCBATH. Thank you. Thank you.

Chairman SCOTT. The gentleman from South Dakota, Mr. Johnson.

Mr. JOHNSON. Thank you, Mr. Chairman. Mr. Riedy, you spoke so eloquently about your family. Are any members of your family with you here today?

Mr. RIEDY. Yes, my father and mother and my wife are sitting behind me.

Mr. JOHNSON. I kind of suspected that was the case. And, of course, you were facing us during your testimony, and so I just want to take a minute to tell you, because you couldn't know, their faces were filled with an incredible pride during your testimony. And, of course, you should feel good because you did a good job. You should also feel very good because they clearly are very proud of you.

Mr. RIEDY. Thank you.

Mr. JOHNSON. Almost every member of the Committee that has spoken has done a nice job raising their voice in support of protections for people with preexisting conditions. Of course, I want to raise my voice to echo theirs. Critically important and I am glad we are having this conversation.

I also like how the panelists all in different ways have called forth this important connection between employer-based health coverage and some of these preexisting condition issues.

I was a little concerned, Ms. Turner, in your testimony you talked about how 65 percent of employers offered health insurance in 2001, you mentioned that number had come down in recent years. I assume affordability is a key driver. Are there others that are maybe not as intuitive to me?

Ms. TURNER. It is primarily affordability, and also because there are fewer carriers now offering coverage in the individual and small group markets. But one point that I think is so important about when employers do offer coverage, they have an incentive. They were offering coverage for preventive care before the ACA because they know it works. It is so much better to detect breast cancer at stage one than at stage four. So helping their employees stay healthy, making sure that they have access to preventive care, and being able to access the diagnostics that they need early on for their coverage. So I think that employer coverage brings particular value to our health sector without the mandates. They know this is important because it works.

Mr. JOHNSON. So I just want to make sure that I can square the math here. The number of employers how are offering this type of benefit has gone down. A number of people have talked about the how the number of people receiving that type of benefit has gone up. Is that just macRoeconomic trends, large employers getting larger, and smaller businesses being the ones more likely to drop this type of benefit?

Ms. TURNER. I could look further into the research, but based upon everything I have read since the ACA, the cost of compliance in providing health coverage to employees is significant. So it is not only the cost of the coverage, but also compliance. And if a company is hitting near that 50 employee threshold where the employer mandate triggers, they often will sometimes put workers on part-time, they will scale back their staff, to avoid having to trigger that employer mandate.

So I think in some ways the employer mandate has actually worked against smaller employers offering coverage. And without it and with more flexibility I think we would see more participation.

Mr. JOHNSON. This is an area of concern, and I suspect it is an area of concern for everybody on the Committee, regardless of party or region, because so many people, from Mr. Riedy to others, have talked about how well I had an employer-based coverage, or I had job-based coverage. It is clearly a really important leg of this stool about how we make sure Americans are covered, how they can get the healthcare service they need.

Are there things that we can do to strengthen employer-based coverage? Because the trends you are talking about we should not feel good about in this country right now.

Ms. TURNER. What employers want most is flexibility to meet the needs of their employees without having to charge so much that health insurance eats up their employees' pay increases. So they are looking for affordability, they want more competitors, they want more options rather than having to meet such specific benefit

requirements to really allow them to—there may be other benefits that their employees value more than the essential health benefits list. So giving them more flexibility to meet their employee needs and keep costs down would increase participation.

Mr. JOHNSON. Thank you very much. Well, Mr. Chairman, I just think this is a critical area for further study by the Committee. And, of course, I appreciate the time and I yield back.

Chairman SCOTT. Thank you. Gentlelady from Connecticut, Ms. Hayes.

Ms. HAYES. Thank you, Mr. Chairman, and thank you to all of the people who have come to share your testimony today. I really appreciate it on this very critical issue.

Before I begin my questioning, I cannot underscore what my colleague, Ms. Underwood, said before she left, that while we hear everyone talk about protecting preexisting conditions our Republican colleagues voted more than 70 times to either roll back or repeal the Affordable Care Act, which really undergirds those protections.

My questions this afternoon are for Dr. Gupta. In your testimony you talked about how the Affordable Care Act has improved the lives of millions of Americans, particularly women and children. And this was strengthened by those 10 essential health benefits that we all know about. Of those benefits, we have mental health and substance abuse treatment. Do you think that those are important benefits to protect?

Dr. GUPTA. Thank you for the question. Absolutely. I think one of the things we have yet to appreciate is the increase in tens of millions of people across this country who are suffering now from substance use disorder that may not have been the case even a decade ago. And a lot of the—when we look at the data, access issues, fear of being fired from their employer are some of the reasons that people do not seek care. So, it is a big stigma issue as well. For women, things like breastfeeding supplies, very simple things like a breast pump and not having to cost share on those things, are another one of those things that we should be working to protect, in addition to the maternity care benefits.

Ms. HAYES. Thank you. Because I know we are talking a lot about preexisting conditions and our conversations are centered around genetic conditions or health-related diseases. So I am happy to hear that you recognize that addiction is also something that really further exasperates those conditions. It is undeniable that we are in a crisis with opioid addiction. In my own home State of Connecticut we have had significant increases. Over the past 6 years our numbers have tripled. In 2017 my State marked a grim milestone of over 1,000 opioid-related deaths. And in June of last year we were on track to surpass that. In the district that I represent three of the top ten towns are the highest opioid deaths.

This is no stranger to me. I grew up in a family that struggled with addiction. In my own hometown 45 people died last year as a result of opioid-related deaths.

Does the current opioid crisis make the need for mental health and substance use disorder coverage more important?

Dr. GUPTA. Absolutely. And, again, when we talk about employer-based coverage, here is the real problem on the ground. When I am seeing patients at a charity clinic who have substance

use disorders they are unable to have gainful employment because of their addiction issues, which need to be treated in the first place. And that allows them to actually gain and have meaningful employment to begin with. So, I think it is very important for us to make sure that we have systems in place that allow the treatment and access to treatment for, you know, one of the biggest crises to face our generation today.

Ms. HAYES. I appreciate you viewing this as a crisis and talking about treatment and coverage and healthcare, as opposed to a criminal action, as we heard last week from our friends over at Purdue Pharma, who talked about people who were addicted to opioids as, "reckless criminals".

During your time at the Department of Health and Human Services in Virginia you led several important initiatives to address the opioid crisis in your State. Could you tell us what impact the Affordable Care Act had on access to treatment for substance abuse disorder and families, not just the individual, but I am the daughter of an addict, so how families were impacted by the protections provided by the Affordable Care Act.

Dr. GUPTA. Absolutely. In a State like West Virginia, which is not any different from a number of States that are having to deal with this crisis firsthand on the ground, we found that having access to treatment, being able to expand those treatments and make that available—a part of which was Medicaid expansion. West Virginia was one of the first States that—we worked very hard to ensure Medicaid expansion. Allowed a number of people to enter the treatment spectrum and we found that the access to mental health treatment, access to the medications, being able to be able to transport it and being paid for being able to transport for treatment, are some of those factors that help us remove the stigma of addiction and help us move forward in that. And it is very important that we provide—reduce all the barriers to treatment when it comes to a stigmatizing disease, such as addiction.

Ms. HAYES. Thank you for your time. Mr. Chair, I yield back.

Chairman SCOTT. Thank you. The gentleman from Pennsylvania, Mr. Meuser.

Mr. MEUSER. Thank you, Mr. Chairman, thank you Dr. Foxx, thank you to all testifying today.

Ms. Turner, I am Dan Meuser, Pennsylvania's 9th congressional district. And I appreciate you taking the time here, and all of you. I believe every American should have access to high-quality, affordable health care, regardless of health status, including preexisting conditions. Given current law, are there any reforms that you would feel, Ms. Turner, that are needed to ensure that individuals with preexisting conditions do in fact continue to have access to health care coverage?

Ms. TURNER. I don't think there is one particular answer, Congressman. I think they need a myriad of options. I think giving States the option to recreate their high-risk pools would be helpful to make sure people who have preexisting conditions have a place to go if their health insurance becomes so expensive. As Senator Bryce Reeves' constituent described, $4,000 a month premiums or deductibles that are $10,000. They need other options. And I think States also could do things like the Healthy Indiana Program, an

account-based plan that allows people resources to access primary care, but knowing that they have major medical coverage as well.

But I think the crucial issue is addressing cost and giving people more options, more flexibility, and giving companies the option to provide coverage that is more attractive, that healthy people want to get in the market, so they are not staying out of the market, putting more and more people who have high health costs in the market and driving up premiums for everyone.

Mr. MEUSER. That is encouraging to hear. Now that we have established that we are in agreement on preexisting conditions, I would like to ask you your thoughts on the Affordable Care Act's effect on association health plans. In Pennsylvania, for instance, the Pennsylvania Farm Bureau had 12,000 members in an association health plan and it worked very well, along with other organizations. The Trump administration has issued a final rule allowing for the use of AHPs, however, many Governors, democrat Governors it so happens to be, across the country, including in Pennsylvania, are blocking the formation of AHPs.

Can you speak to the importance of the efforts to allow AHPs and maybe comment technically as to why these efforts would be blocked?

Ms. TURNER. So far association health plans are available in 13 States, about two-dozen plans in all. And some States are considering invalidating or blocking these plans, which they have full right to do, just as they are short-term limited duration plans. But what they are doing is foreclosing options for people who are otherwise likely to simply be uninsured. If they don't have an affordable option their family cannot only face bankruptcy, but not having access to that good high quality care that private insurance brings.

So it is unfortunate if States take a view that because, I don't know, the Trump administration rules that therefore they should be opposed, because they are providing options for people who are desperate for coverage.

Mr. MEUSER. Yes. OK. That is unfortunate. Thank you.

Medicare Advantage. I have people coming into my office and throughout my district talking about, speaking about how terrific Medicare Advantage programs are, how relatively affordable they are versus other Medicare plans. And, as a matter of fact, the Medicare Advantage plans have decreased, reduced in cost by 6 percent this past year when other plans on average are going up 12 percent. So would you say that this is a successful example of private sector innovation? And could you offer any other insight on the effectiveness of Medicare Advantage.

Ms. TURNER. They were created, as you know, in 2003 through the Medicare Modernization Act and went into effect in 2006. And there was no real significant promotion of Medicare Advantage plans. It was offered as an option for private coverage to seniors, so they didn't have to be in something of a Swiss cheese of a program with a fee-for-service Medicare. They have been hugely popular. I think almost half of seniors now have individually selected on their own, without any mandates, Medicare Advantage plans. And these plans compete fiercely for seniors. They have to cover a basic level—not basic but very generous level of benefits and many of the plans offer much more comprehensive coverage than people

can get in traditional Medicare. And many of them also incorporate prescription drug coverage.

I think that seniors see it is crucially important because it also provides an environment for coordinated care, rather than going from doctor to doctor and fee-for-service traditional medicine Medicare. Maybe getting the same prescription with different names from physicians and then winding up in the hospital with drug toxicity, they have somebody looking out for them and being able to really coordinate and help manage their care.

Very, very beneficial. And, of course, these are private plans within Medicare.

Mr. MEUSER. OK. Do I have any more time, Mr. Chairman?

Chairman SCOTT. Not really.

Mr. MEUSER. OK. Well, I yield the remainder of my time.

Chairman SCOTT. Thank you. I appreciate it. The gentlelady from Florida, Secretary Shalala.

Ms. SHALALA. Thank you very much, Mr. Chairman. I don't want to add, a lot of my colleagues have asked the same questions I would have asked.

I do want to point out that Medicare Advantage gets a lot more money than traditional Medicare and therefore it is expected to provide a lot more benefits. It also pays dramatically for the kind of marketing that the private plans want to do. So, we are paying with taxpayer money for Medicare Advantage significantly. And most analysis has shown that we are overpaying for Medicare Advantage given the benefits that are provided.

I do have a couple of questions though. I want to ask Ms. Corlette, we focused here on preexisting conditions, but would coverage for preexisting conditions actually work very well if we didn't have the other consumer protections? I mean we could all agree on preexisting conditions, but if you don't take the caps off, preexisting conditions are limited. And Mr. Riedy would have a very difficult time with CF.

Ms. CORLETTE. Yes, absolutely. And, in fact, New York is a great example of a State that had a number of preexisting condition protections before the ACA was passed, but they had a very expensive individual market because they didn't have the other provisions that the ACA included, such as the subsidies to support people up to 400 percent of the Federal poverty level to buy insurance, as well as the individual mandate penalty.

So, it is important to note that the ACA included not just preexisting condition protections, but a number of provisions that were more holistically designed to try to make coverage accessible and affordable for people. All of those, of course, have been at least preliminarily ruled to be invalid by the Texas court.

Ms. SHALALA. Thank you very much. And, Dr. Gupta, yesterday the President said that he was going to invest some money in HIV drugs. And I want to ask you about that, because it is very important in my district. We have the highest incidence per capita, and therefore I am very supportive of any investment in HIV. But those investments don't work without a comprehensive plan around them. And could you talk a little about that?

Dr. GUPTA. Absolutely. Thank you for that question. So as opposed to the 1980's, where we had a challenge of diagnosing HIV,

figuring out how to treat it, and make it a condition. People were dying on the streets because of that. Now, we have a challenge of finding those individuals who may not know that they have HIV. So, screening—that is why we have moved to what we call universal screening and you really have to opt out of it, otherwise most of us need to get screened. The idea behind that is most people that may have HIV do not know they have HIV. And if they can be caught early and put in treatment it becomes a chronic condition you can live with. You don't have to die because of the complications now.

When you start to remove the other legs of that stool, in terms of essential health benefits, then obviously those people are going to not want to be screened for the HIV. The diagnosis will not occur and then they will not be treated. As a result they will continue to transmit the disease and we will result in having more cases than fewer cases and our conquest to eliminate HIV from the United States will not happen anytime soon.

Ms. SHALALA. Thank you very much. And, Ms. Turner, if I could ask a quick question about the flexibility you are talking about. Would it be OK with you if a State was willing to develop a plan that continued caps, had covered preexisting conditions but continued caps? Because, you know, private insurance is a mixed bag in this country. I have got half a million people in my own district that are covered by private insurance, but some of it is underinsurance because it has high deductibles. And how much flexibility would you give the States so that we would really recognize it as insurance and comprehensive insurance? Would you continue some of these consumer protections that we are talking about?

Ms. TURNER. I think that it is important to recognize that State officials have to answer to the same constituents when they are making changes, health policy changes that Federal officials do. And so that needs to be a conversation with their voters, and to make sure that they are answering the constituents' needs for affordable, quality coverage, but doing so in a way that may give them more flexibility.

Some States in Medicaid, as you know, and I am sure under your Secretaryship some of the waivers were approved to give States like Oregon, for example, a lot of flexibility within its Medicaid program and what benefits were covered. So I think States can better fine-tune the mandates than a Washington mandate. The Affordable Care Act has been changed already either by administrative order or by acts of Congress 70 times. So, I think needing to give the States the flexibility to answer the needs of their constituents and know that their constituents actually can be better heard at the State level, I think is important.

Ms. SHALALA. I should point out that the Oregon simply took the same package. It actually didn't mix up the package of benefits very much. I am asking you specifically about caps and about preexisting conditions. Do you think that States ought to be able and the other consumer protections ought to be able to waive those consumer protections and would it actually be comprehensive insurance at the end of the day if they had flexibility on those consumer protections including preexisting conditions?

Ms. TURNER. We see with States that are saying they don't want short-term limited duration plans, California and offered in their States, Pennsylvania, restrictions on association health plans. If States feel that those consumer protections are important, I believe that they will keep them and if they feel that there needs to be some flexibility along with consumer awareness and transparency, then I think States should have the option of figuring out what works best for their constituents.

Ms. SHALALA. So you wouldn't favor ERISA protections for—and overrule States—using ERISA protections?

Ms. TURNER. I think that right now we basically have under HIPAA we have the protections that allow people to go from their employer plan—

Ms. SHALALA. Right.

Ms. TURNER [continuing]. to another employer plan and maintain that continuity of coverage and not be discriminated against. So those protections are already on the books and because of the community rating within employer plans, people are protected to make sure that their health status does not affect their premium costs.

Ms. SHALALA. I yield.

Chairman SCOTT. Thank you. Gentleman from Wisconsin, Mr. Grothman.

Mr. GROTHMAN. OK, thank you. Moving now, Ms. Turner, and one more time, I think you've answered this, but it seems to me the Republicans, the Democrats are all favored, in favor of protecting coverage for preexisting conditions. Can you just one more time tell us, we have said it so many times but not as many times as the ads we have saying otherwise running against us in election. Under current law, are workers with preexisting conditions allowed to be charged more, denied coverage based on their condition?

Ms. TURNER. I'm sorry, repeat.

Mr. GROTHMAN. Under current law, are people allowed to be charged more, denied coverage based on their conditions?

Ms. TURNER. No, Congressman.

Mr. GROTHMAN. OK. So that is the current law right now. Good. Now I will give you some other general questions. I am from Wisconsin. In 2018 last year, Scott Walker worked with the Trump administration and CMS to approve a 1332 State innovation waiver, which caused our premiums to drop. Are you familiar with that situation?

Ms. TURNER. Yes, I am, sir.

Mr. GROTHMAN. Could you talk about what we did in Wisconsin?

Ms. TURNER. I mentioned actually in my testimony some of them, some of the impact that these plans have had and of course I can't find this chart when I'm looking for it. But they have been able to basically repurpose existing ACA money to help increase access to coverage or to improve access to coverage for people with chronic conditions, preexisting conditions, and therefore lower premiums in their general market.

So a number of States have—Wisconsin is often taking the lead in health policy innovations and waivers and I think that this is an important one to move forward with.

Mr. GROTHMAN. And at least I am told that premiums dropped a little over 4 percent, is that your?

Ms. TURNER. Premiums dropped and enrollment increased as a direct consequence.

Mr. GROTHMAN. Good. And in the past, before this type of thing, we saw incredible increases in premiums and open enrollment falling. Is that—we saw that in Wisconsin. Is that your nationwide?

Ms. TURNER. Because the premiums were so much higher—

Mr. GROTHMAN. Right. As the premiums—a lot of people just throw in the towel.

Ms. TURNER. People just can't afford it and they also—we talk about a high deductible. The deductibles are so high and the ACA plans that if people are not eligible for cost-sharing reduction subsidies they basically say they might as well not be insured because they can't afford to pay the first $10,000 every year out of pocket before coverage kicks in.

Mr. GROTHMAN. I am glad you mentioned association plans. My experience with health care in general, when you take a group, not a Statewide group because it is hard for the State to duplicate it, but when you take a business with a 1,000 employees or something, a lot of those innovative businesses were doing a very good job. One of the things they did is employer-based clinics which saved tremendous amount of money for a variety of reasons. Is there any way that you can see that sort of thing can be duplicated through something like Obamacare or is this the type of innovation that is why we want the vast majority of Americans hopefully still insured through their employer?

Ms. TURNER. Well, the Affordable Care Act did allow some innovation incentives for people to do—not association health plans, I'm blanking on the name of the creative coordinated care plans within Medicare. And because the rules that were written around the Affordable Care Act were so strict, even plans like the Mayo Clinic and Cleveland Clinic and others that had been—Geisinger, that had been very successful in managed, coordinated care, couldn't make it work.

So I do think that flexibility is really important and trusting employers—some employers have said for example that they feel it is worth flying their employee to another State and family members to get care at a center of excellence, of cardiac care, cancer care. So they really do try to innovate to get the best value and the best quality care.

Mr. GROTHMAN. It is another thing. I did mention employer-based clinics but these centers of value, flying people to other States because an employer has the ability to hire somebody and do a good job. Now I know there are a lot of people who always feel that setting up another big Federal bureaucracy is going to work after this seems to have failed like 120,000 times in a row, but what you are telling me is a way that the private insurance plans and for individual companies and hopefully to be duplicated by associated plans, they are able to find ways to reduce premiums and reduce costs that really as a practical matter are not being duplicated with a government bureaucracy.

Ms. TURNER. That is correct.

Mr. GROTHMAN. Thank you.

Chairman SCOTT. Thank you. The gentleman from Michigan, Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman. I would like to dig in a little more deeply to the Texas v. United States case and I have a question to start for Ms. Corlette. In a departure from long standing precedent of defending Federal law against constitutional challenges, the Trump Administration's Department of Justice filed a brief last year requesting that the court strike down several provisions of the ACA in the Texas case. Among the provisions that the administration argues should be overturned include guaranteed issue, community rating, discrimination based on health status and preexisting conditions exclusions.

Last week, President Trump told the New York Times that he is optimistic that the ongoing Texas lawsuit will terminate the Affordable Care Act. Would you say that the Justice Department's decision not to defend the ACA is consistent with Republican promises to protect patients with preexisting conditions?

Ms. CORLETTE. Well, I would say that the Justice Department's provision—position if it prevails would strike down the protections that the ACA provides for people with preexisting conditions. So no, it's not consistent.

Mr. LEVIN. And how does this, his statement reflect the Administration's approach to this issue?

Ms. CORLETTE. I—

Mr. LEVIN. Of preexisting conditions that we are here to talk about.

Ms. CORLETTE. I have, yes. I have a little trouble divining exactly what the Administration's position is given that there do seem to be differences between what President Trump has said and what the Justice Department position is so I am not sure I can comment.

Mr. LEVIN. And what they are actually doing. So you pointed out in your testimony that Republicans never have come up with a proposal to replace the ACA yet they continue with their efforts to unravel it, the most recent example being the Texas lawsuit.

During the last Congress when we were debating the Republican bill to repeal the ACA, Republicans put proposed segmenting the population and dumping sick patients into high risk pools. The CBO had the following assessment of this proposal: "Less healthy people would face extremely high premium. Over time it would become more difficult for less healthy people, including people with preexisting medical conditions in those States to purchase insurance because their premiums would continue to increase rapidly."

One of our witnesses, Ms. Turner, has put forth a similar proposal this morning or early this afternoon. Ms. Corlette, how do risk—high-risk pools stack up as an alternative to the coverage provided through the ACA?

Ms. CORLETTE. Sure. Well, we have a history of high-risk pools. Before the ACA there were about 35 States that had high-risk pools and they varied. They were different, but I can tell you that for people who were in high-risk pools, the premiums could be as much as two times the standard rate. They often had preexisting condition exclusions so the condition that got you denied coverage in the individual market you didn't get covered in the high-risk pool for up to a year. You had annual and lifetime limits quite often, high deductibles and often many of these high-risk pools lim-

ited enrollment. Even still, they operated at a loss so they needed to be subsidized by the government.

Mr. LEVIN. OK, thank you. I have a question for Mr. Riedy. In your testimony, you described the enormous cost of your medical treatments, totaling nearly $450,000 last year. Prior to the ACA plans in the both the individual and employer market were permitted to impose annual and lifetime limits on care and many of them did, including more than 90 percent of the plans in the individual market. You better than most people can speak to the real-world impact of these limits. Based on your personal experience, how do annual or lifetime limits on coverage impact patients with high-cost conditions?

Mr. RIEDY. Thank you for the question. Annual and lifetime caps for me personally if they were allowed to exist again would cause a severe financial burden on my family. Not just from the cost of having to pay for the care that I receive, but also from the impact that if I do reach that cap, what happens next? Do I have to pay for them out of pocket? And if I do then those costs can be unmanageable.

As you mentioned my care last year just for the medicines was $450,0000. That is a lot of money to take and so the impacts of those caps, having them now provide peace of mind. They also know that I can continue to receive the highly specialized care and that I have access to that coverage that allows me to get that care.

Mr. LEVIN. I can't thank you enough for coming and sharing your story with us and with the American people. And just in a note of solidarity, I like the gentlewoman from Georgia who spoke earlier, I am a two-time cancer survivor but also Mary and I have four kids. The two oldest both have Crohn's disease and have for 14 years and we would have gone bankrupt multiple times over just trying to pay for their medications if they weren't covered and because of, you know, caps. Lifetime, we would have blown by lifetime caps already so I really thank you for sharing your story. I yield back, Mr. Chairman.

Chairman SCOTT. Thank you. The gentleman from Kansas, Mr. Watkins.

Mr. WATKINS. Thank you, Mr. Chairman. My question is for Ms. Turner. Ma'am, I represent Kansas and in Kansas, Kansans with preexisting conditions face a number of challenges and hardships. And I am glad that a lot of Democrats and Republicans agree that Americans with preexisting conditions should and have been for years been protected, for decades actually. And so in that of course even before the Affordable Care Act so unfortunately since its passage, the ACA continues to be problematic. Premiums continue to rise and the answer I believe is not to double down on ACA but and seek a one size fits all government-run health care regime.

Therefore, Ms. Turner, since the passage of Obamacare, can you speak to the lack of actual affordability for the vast majority of Americans? Also the rate of continued premium increases because of the law?

Ms. TURNER. Premiums in the exchange markets have about doubled on average since the law went into—since the exchanges took effect in 2014. That is much higher than in the regular mar-

ket and certainly before that. And a consequence of that is that it's driving more and more healthy people out of the market.

The ACA as you know forces young people to pay a disproportionally high amount for their coverage because of the three-to-one age rating in the exchanges. And so we are losing—if young people are not eligible for their parent's coverage and trying to afford premiums on their own, they're paying a disproportionate amount for people who are older and sicker and therefore they're dropping out as well. So I think it is crucial if we really want to increase access to health coverage that we figure out a way to get cost down and to attract the healthy people into the market.

Senator Reeve's constituent in Virginia, he doesn't want to drop out of health insurance market but he can't afford $4,000 a month for premiums and having no choices of coverage. Some people need more choices. They need to be able to have more flexibility with benefits to protect their family and they need some of these bridge plans like association health plans and short-term limited duration plans.

Mr. WATKINS. Thank you. I also want to touch on our increasingly strong economy propelled by comprehensive tax cuts and regulatory reform. In fact, CNBC recently noted that January job reports just last week payroll surged by 304,000 smashing estimates. Thanks to recent pro-growth Federal policy changes, more and more Americans are finally finding good paying jobs. Many of these jobs offer generous employer sponsored healthcare. So all the employers simply know that they can—that they have to be competitive to attract good HR. So, Ms. Turner, can a strong jobs market spurred by pro-growth policies lead to increased coverage rates nationally for employees—employers with preexisting coverage? What are some policies that can continue fueling work force participation?

Ms. TURNER. You are absolutely right that employees highly value the, their workplace coverage and the workplace—the H.R. departments, especially for big companies work tirelessly to try to negotiate the best benefits, the best drug formulary and the access to the highest quality hospitals for their employees to attract them so that they won't go to a competitor. And there are how many, 2 million jobs, two and a half million jobs that aren't filled now and employers can't even find the workers to fill them. So being able to offer attractive, affordable health coverage with the flexibility to meet the needs of their workers, and having providers that are competing for that business to get, to offer those lower costs, higher value plans, I think is really a crucial part of a thriving economy.

Mr. WATKINS. Thank you, Ms. Turner. I yield back, Mr. Chairman.

Chairman SCOTT. Thank you. The gentleman from Maryland, Mr. Trone.

Mr. TRONE. I thank you, Mr. Chairman. Ms. Corlette, 30 years ago I started my business with my wife and two little girls and I know firsthand starting a business can be scary without the fear you are going to be able to afford healthcare for yourself and your family. You mentioned prior to the ACA people were often tied to jobs they'd have otherwise left but simply because they needed to maintain healthcare, access to affordable health insurance. Could

you elaborate on what the ACA's protections for patients with preexisting conditions has meant for entrepreneurship, startups, small business creation?

Ms. CORLETTE. Sure. So, before the ACA, if you were leaving a job-based plan, you were required to maintain what was called COBRA coverage which was continuation coverage, but you had to pay the full premium. And for most people that was unaffordable. And so, people often had a lapse in coverage and then if you had a preexisting condition it was almost impossible to find an individual market plan to cover you and your family.

With the ACA you can now if you have a business idea or want to go out on your own and start a consultancy or invent something, you can do so without having to worry that your preexisting condition would cause you to be denied or have a preexisting condition imposed on your—exclusion imposed on your policy.

Mr. TRONE. So, Dr. Gupta, the opioid epidemic as you spoke about and you are from West Virginia. My district borders western Maryland so we are right there together in the heart of the opioid epidemic on I–81. I lost my nephew, age 24, to a fentanyl overdose a couple years ago and so many folks in my district have been adversely affected by this tragedy.

With the ACA, we closed a lot of gaps in coverage, especially in the area of behavioral health. And I think that is so important and it is all part and parcel of this disaster substance disorders. If the ACA was gone, what do you see as the human toll?

Dr. GUPTA. Thank you for that question. Certainly we understand, you know, States with border counties populations don't treat those as States, they are one community within those areas. So, it's very important for people to be able to move across and not have to worry about what is the State regulation in this State and the State regulation in that State? ACA allows that consistency to happen State to State. The mental health protections as well as the ability to get the help that need and people would have so many other challenges ongoing at the same time. ACA really allows that to happen and I think that is the most important piece as we are combatting this opioid crisis is to be able to not have any extra barriers in terms of coverage and accessibility to care. As the good treatments are existing and more come up, we have got to be able to have the access to provide tens of millions of people who are suffering and dying actually, tens of thousands per year to be able to save them and get them back to work.

Mr. TRONE. As we put together legislation on opioids to address that, what do you see as a couple key points that should be in that to address the mental health connectivity which was so crucial and part and parcel of this at all times?

Dr. GUPTA. I think it is very important for us to go back to see what we did with HIV. We realized HIV was much more of a social determinant aspect of this in the 80's and we put together, you know, the Ryan White Care Act for example, that not just took care of you as an individual, your medication, but you—looked at your house and your access and all those things.

So I think it is very important when you look at this crisis, we are looking at housing, we are looking at access, daycare, all of those tools that surround somebody who is suffering from addiction

to be able to be provided so that they can get into treatment and then they can have a successful, fair chance of recovery and back into employment.

So, it is a lot more than just pills or just counseling. There is a societal response that we must have to this crisis in order to address it and I think that is the part that we can do more, not less.

Mr. TRONE. OK, thank you. I yield the balance of my time.

Chairman SCOTT. Thank you. The gentleman from Indiana, Mr. Fulcher.

Mr. FULCHER. Thank you, Mr. Chairman, and panelists.

Chairman SCOTT. Excuse me, Idaho. Excuse me.

Mr. FULCHER. Yes, it is a common mistake. Thank you. Panelists take heart. I think the end is near. It is coming close here OK and please forgive the lack of attendance by some of us on the front end. I, for one, am still struggling with the multiple committees as the same time. And so please know that wasn't rudeness.

My question and I will probably address this to Ms. Turner because I know some of this has been covered and I am going to shorten things up because Mr. Watkins hit part of that. But in our State of Idaho, 2012 I think it was we—I believe we were the only State with Republican leadership in the House, the Senate, and the Governor's office that embraced the State-based exchange. And I was in the Senate leadership role at that time and in hindsight it just hasn't worked out well for us.

Our insurance premiums across the board have averaged somewhere between a 15 and a 27 percent per year increase. And so as we speak right now, in our State, there is a lot of things on the table. It is—that have been—that are being discussed right now. Alternatives to try to figure out a better path and I would just like to get your counsel, your input, on some of those things and I will just list a few. But the expansion of HSAs, medical memberships, medishare, charity care. The expansion of insurance procurement across State lines which in our State we can't do, high-risk pool reform. Those types of things which are—they are more market-based and given our history and our struggle with the status quo that there is, your thoughts, your counsel on that type of an approach.

Ms. TURNER. States do talk about the difficulty of figuring out how to address the needs of their State but it's even more than the State. It's sometimes at a county level. You have rural counties who have very different problems then Cincinnati and Canton and Cleveland. They've really need to have the resources and the flexibility to meet the needs of those areas.

And I want to really reinforce what Dr. Gupta was saying about the social determinants of health. We put so much money just into health care when people may actually need other kinds of supports to make their lives work better. And I believe that Ohio is one of the States that has—is implementing work requirements as well for Medicaid. And people who work with these communities say that is a valuable thing to make sure that people have someplace to go once they get through rehabilitation treatment, to have a job, something to give stability to their life. Help them with housing.

If States had more flexibility and I believe the Trump Administration is working to do that. As we have said before, Congress had

repeatedly voted for money to dedicate money to high-risk pools. Many States that were doing—the States that were doing high-risk pools in the past were doing it all with State money. With the ACA there is new money to put on the table to make those risk pools work better so that you can provide dedicated resources for them and more comprehensive care for chronic conditions.

So care management for those high end patients, being able to have more flexibility, to provide the kinds of benefits structures that people actually want to purchase to protect themselves and their families I think are really crucial. And hopefully we can work with Ohio and other States in trying to think about what some of those waiver options might be to work—make it work better for your State.

Mr. FULCHER. Thank you. Mr. Chairman, a quick followup and I will—thank you. Ms. Turner, in a few words because I am going to yield my time here in just a second. But that makes sense. But when it comes right down to it, should we be focusing on solutions that come out of this room and out of this building and out of the building next door or should be focusing on more market—enabling market-based solutions to try to improve our situation?

Ms. TURNER. We see in Medicare advantage for example that market-based solutions to provide more comprehensive care and I believe it is really based upon a formula very close to what traditional Medicare pays for Medicare advantage, can give incentives to begin to find the same kinds of cost efficiencies in the health sector that we see at other sectors of the economy.

When you have so much of the time of health care providers and administrators focused on following Washington's rules rather than figuring out what is best for the patient, what is best for our State that it really takes away time and energy from solving the problem.

Mr. FULCHER. Thank you, panelists, Ms. Turner. Mr. Chairman, I yield back.

Chairman SCOTT. Thank you. Gentlelady from Michigan, Ms. Stevens.

Mr. STEVENS. I would like to take a minute to thank our panelists today. Ms. Corlette, your expertise and knowledge was—is so welcome and we thank you for taking the time.

Mr. Riedy, thank you for your courage and your words of wisdom and sharing your personal story. It was a delight to be in this room with your family who was looking at you with very proud eyes. You are one of the reasons why the ACA was so critical and critical to every American taxpayer and American worker and I admire you from the bottom of my heart.

And, Ms. Turner, I want to thank you for your eloquence and answering a lot of questions today. And, Dr. Gupta, thank you for being here.

As we are here examining threats to workers with preexisting conditions, this topic could not be more critical as our Ranking Member Foxx indicated. We have a healthy economy and the health of our taxpayers and our workers is paramount.

And Dr. Gupta, I would like to take my questions to you and your expertise which we are delighted to have in the room today. In your testimony, you discussed the issue of high-risk pregnancy

and delivery and how women prior to the enactment of the ACA often found that, you know, they reached their policy's cap. They would reach their policy's cap on the amount of care provided. They would find themselves exposed financially, unsupported in the workplace, and generally pushed to a brink. And so, I would like to ask you, what is the cost of high-risk pregnancy and how likely are women to run up against these caps in the absence of the ACA protections.

Dr. GUPTA. Certainly, thank you for that question. March of Dimes certainly is doing a lot of work around this because we know that maternal mortality and morbidity amongst the 49 developed countries in the world, we are number 49. We are actually three times mortality of the next country in line which is UK. So we are really in a bad shape right now. For—we have women dying every single day.

The cost can be tremendous and when we look at the cost really it is not just human lives lost, but we are talking about one complicated pregnancy can cause that woman to lose potentially her absolutely full annual lifetime limits. So, she may not have coverage for the rest of the year and have to take care of not just the baby but the rest of the family.

Same way we go back to the severe prematurity. One simple birth with severe prematurity can land a child, an infant for multiple months in a neonatal ICU. So, when the baby returns home for the first time when there should be a cause for celebration, it would then be a cause that the baby could meet his or hers lifetime limits on care and not be insurable until Medicare. And that's just a terrible thing to think about and those are the challenges we are dealing with where we need to be making progress to work in those maternity care deserts.

We have a third of the counties in this country or 1,000 counties, 5 million women, 150,000 babies that are being born what no obstetric care. And so that we are actually, you know, talking about walking backwards.

Mr. STEVENS. Well, and not only is this a cost to the mother and the family, it is a cost to the employer as we, you know, are talking about the workforce and our economy writ large. And, Dr. Gupta, as you know, the Affordable Care Act requires insurers to cover preventative health services without cost-sharing and these obviously include family planning, well women visits, screenings for domestic violence and other crucial health services.

And I, just to back this out a minute, I would love for you to just reflect on how pregnant women and other new members—mothers, excuse me, utilize these services and what impact would overturning these provisions maybe through the Texas litigation have on these women?

Dr. GUPTA. So first of all, just the idea of preconception care to be healthy in order to get pregnant is very important. That would not happen. Then within prenatal care the notion of having things like vitamin—folic acid and vitamins, which we think is very basic, we recommend that all across the globe, yet we can have women that can have, deliver and cause real harm to the babies developing because of neural tube defects and other things that are not being provided. Throughout the prenatal care we know the amount of vis-

its that happen with the doctor's office and this following a standard of care leads to better delivery, better care of not just the mother but also the baby as a result, getting the family dyad back together, the mom and baby. None of that would be possible if we were to remove that.

And obviously one of the things that used to happen was the only time you could get into Medicaid was if you were—if you got pregnant and then it would be removed the coverage right after. Now we have 60 days, up to 60 days coverage post-partum. When we are dealing with challenges of post-partum depression, suicide, post-partum hemorrhage, hypertension, eclampsia, heart conditions, it's very critical for us to build on that coverage post-partum up to a year because of the increasing maternal mortality that is happening.

This is still the most dangerous place for a woman to have birth in the developed world. And we need to be working again not at removing that but actually developing more steps but at this time, removal of ACA provisions will cost women and their children not only just their jobs but potentially their lives.

Mr. STEVENS. Yes. Well, Dr. Gupta, while you don't share my gender, I appreciate you sharing the stories of women and mothers and making that at the forefront of our minds today. Thank you.

Chairman SCOTT. Thank you. The gentlelady from Nevada, Ms. Lee.

Mr. LEE. Thank you. I wanted to first thank all of the panelists today for your testimony and answering the questions. And, Mr. Riedy, I wanted to speak directly to you. First of all, CF has had a place in my family. My husband lost a cousin about 30 years ago before groundbreaking technologies and treatments were available. And more importantly, my sister, Mary Lester, is a respiratory therapist at Keck Medical Center at USC and dealing with adult cystic fibrosis. So, through her years, through my years and I have experienced alongside her many of the struggles that patients like you go through. So, thank you very much for being here and your testimony.

I wanted to ask, in your testimony you pointed out that you're fortunate to have comprehensive health coverage through your wife's employer. If your wife were to change jobs, choose to start a small business or possibly take time off for education, you might end up in a situation where you would have to change this coverage. And I wanted to know from you how do the Affordable Care Acts protections for patients with preexisting conditions provide peace of mind that you would never be without coverage?

Mr. RIEDY. Thank you for that question. Knowing that my wife or I could switch employers and still be adequately covered, it gives us peace of mind that allows us to be flexible and explore new opportunities potentially that before the ACA may not have existed. And without the ACA, you know, there is always that fear that leaving a job if I went to another one that I could still be denied insurance because of my preexisting condition or if my wife changed jobs, you know, would they deny me coverage because of my preexisting condition.

Mr. LEE. And thank you. And to followup on that, what impact would an adverse decision in Texas case have on your wife's ability to change jobs?

Mr. RIEDY. Well, if the ACA was—if the ruling stands, my wife would have less of the opportunity to explore new opportunities. She is a teacher so she is at a great place right now but if she had to—if she wanted to do something other than teach or switch employers there's still that fear that we may be or I may be denied coverage or access to it. So, it could lock her into where she is.

Mr. LEE. Lock her in. All right, thank you. One other question. According to the Department of Health and Human Services, the number of Americans with preexisting conditions ranges from at least 23 percent, 61 million people to as many as 133 million people. And prior to the Affordable Care Act these Americans with preexisting conditions could be denied coverage or charged an exorbitant premium to get coverage, something that my parents had experience both having high blood pressure at one point in their lives.

Some families have even declared bankruptcy from high medical bills due to having a preexisting condition. Today, however, insurance companies cannot discriminate against people based on their medical history.

Mr. Riedy, without employer-sponsored health insurance or insurance through your family prior to the Affordable Care Act, do you believe you would have been able to attain affordable health insurance?

Mr. RIEDY. Before the ACA I would have likely been denied coverage because of my preexisting condition without the access to employer-sponsored health coverage. And the ACA provides me with the opportunity to be adequately covered on the individual market I'm currently in. Without them I don't know if that would be possible.

Mr. LEE. Well, thank you so much for your testimony. I want to say I texted my sister to tell her I was going to be speaking with you today and she sent me this message back that said please make sure we help people with cystic fibrosis because these patient needs to have their medical needs met and it is extremely expensive illness. She said they didn't cause this disease, but they must fight it and so thank you for your courage for being here. I appreciate it.

Chairman SCOTT. Thank you. The gentlelady from Massachusetts, Ms. Trahan.

Ms. TRAHAN. Thank you. Thank you, Mr. Chairman, for having this hearing and thank you, everyone, for hanging in for a long hearing. Part of the challenge of being later in the program and new here is so many of the thoughtful inquiries have already been made but I do have a couple of questions. I am a mother of two young girls, 8 and 4 as well as three grown stepsons who have benefited from the ACA and being able to stay on my health plan as they enter the workforce.

Before the ACA women were often charged more than men just because of their gender and some couldn't even get coverage on the individual market. For women of childbearing age, the discrimination was particularly blatant, and the vast majority of plans ex-

cluded maternity coverage of any kind. And I appreciate my colleague from Michigan and her inquiry around maternal care.

Dr. Gupta, I am wondering if you could just explain to us what it was like for women to get health insurance coverage before ACA and how many plans covered maternity coverage in the individual market and what improvements have women and their families seen since ACA?

Dr. GUPTA. Certainly, thank you for that. We know that prior to the ACA, only 11 States mandated the coverage of maternity care. Only 13 percent of the individual health market actually covered maternity care. We know that at that time obviously the gender of being female was a preexisting condition in effect. We also know that 47 percent of people who tried, adults who try to get coverage with preexisting condition were either denied, charged more or were precluded from at least one condition. That's from the Commonwealth Fund Study. So, we know that this was a big problem.

Since then, March of Dimes did a study in 2015 and found that between 2013 and 2015 the uninsured coverage for childbearing age women went down from about 20 million to 13 million, I'm sorry 20 percent to 13 percent. That means that another 5 and a half million of childbearing age gained coverage. Not only that, the unmet needs actually went down by 10 percent points of those women. So clearly that has been a big gain.

I would say when we talk about preexisting conditions, health inequities are the first cause of preexisting conditions. And when I talk about maternal mortality, a black woman in this country is more likely to die—three to four times more than a white woman. So, we still have for healthcare institutions across and healthcare systems across the country, today, race is a preexisting condition and we need to continue to work on that and I think that is a critical piece that I must bring up as well.

Ms. TRAHAN. Thank you. Thank you, Dr. Gupta. and, Ms. Corlette, to borrow a phrase that is going around a lot, the dignity of work is something that means a lot of me. And I am the daughter of a union ironworker. My mom worked multiple part-time jobs while raising my sisters and me. I am constantly thinking about how are we going to support work and labor as it transitions to the future and what the future of work actually looks like?

We talk a lot about our economy and adding more jobs but those don't always translate into employer-sponsored plans. So, a recent Department of Labor survey found that 10 percent of the workforce are categorized as either independent contractors or self-employed. This represents a growing segment of the workforce, in fact more than half of all ACA marketplace enrollees are small business owners, self-employed individuals or small business employees.

I am wondering if you have looked at any additional research on the impact of the Texas lawsuit or even just the 70 plus ACA repeal attempts would have on the future of work? And also, if we have time, can you discuss the impact of removing preexisting condition protections for gig economy workers, independent contractors specifically?

Ms. CORLETTE. Sure. Thank you. It's a great question. So, for folks who do have job-based coverage, there are a couple of things to be concerned about if the Texas court decision stands. One of

course is that people could lose—with chronic or high-cost health needs could lose some of the protections that Mr. Riedy has spoken so eloquently about. The other issue of course is job lock, and this is a phenomenon that was well-documented before the ACA where folks sort of hung onto their jobs and their job-based coverage because of the uncertainty of the individual market. And they may have had a great business idea or been a terrific entrepreneur but did not pursue that because of their need to maintain job-based coverage.

Ms. TRAHAN. Great. Thank you. Thank you, Mr. Chairman, I yield back.

Chairman SCOTT. Thank you. The gentlelady from North Carolina, Dr. Adams.

Ms. ADAMS. Thank you, Mr. Chairman and thank you all very much for your testimony and for sitting out with us, we appreciate that very much. Mr. Riedy, thank you so much for sharing your story.

Mr. Chairman, I would like to enter into the record first from the—some organizations that have commented regarding the preexisting conditions and the GOP plan. First, the American Cancer Society Action Network who says that these protections are hollow if patients and survivors can't afford insurance. From the American HealthCare Association, the plan would do just the opposite and not serve the health needs of all Americans. And then they also say that the greatest achievement of the ACA is protecting those with preexisting conditions. The National Disabilities Rights Network says that GOP plan permits discrimination against people with disabilities in the insurance market for preexisting conditions and I would like to enter this into the record, Mr. Chairman.

Thank you. Let me just say as I have listened to you, all of you I thought about Dr. Martin Luther King, Jr., who talked about healthcare and inequities and who said that "of all the forms of inequality, injustice in healthcare is the most shocking and most inhumane" and indeed it is. I do want to just mention the impact that ACA has had on communities of color, in particular the protections of those with preexisting conditions.

I am a diabetic and that's an illness that was considered, is considered a preexisting condition. It is very prevalent in my family. I had a sister who suffered with sickle cell, from sickle cell anemia, a preexisting condition who passed away before she was 27. African-Americans are 80 percent more likely than Whites to have been diagnosed with diabetes. About 365 African Americans suffer with sickle cell anemia. Latin—Latino Americans have the highest rates of cervical cancer and Asian women are at the highest risk of osteoporosis.

Simply put, the Affordable Care Act has saved lives and has provided healthcare to millions who previously thought affordable treatment was just a dream. Folks like me, families that grew up who didn't have healthcare at all, no health insurance, having to go to the emergency room to get our care.

Dr. Gupta just one or two questions. For those with preexisting conditions or minority communities, how many more people with chronic illnesses have been covered and have those who suffer from chronic ailments seen improvements in their conditions as a result?

Dr. GUPTA. I can tell you that there has been a great progress made in that and I will certainly get you the exact numbers but the great progress made in that and the ability to again, level the playing field in our pursuit to level the playing field to get people to be covered. And we, I say that because these conditions are a part and representative of your socioeconomic condition. They're representative oftentimes of the culture we come from and lots of other things. What we call social determinants of health, education level. So being able to provide the basic healthcare that has happened as part of the health ACA has allowed our communities of color actually to be—have one less thing to worry about. So that's one of the things.

The other piece I will go back to, you know, as March of Dimes we are focused on the health of moms and babies and nowhere is it more evident, the disparities and health inequities when we look at moms and babies. As I mentioned, three times to four times more likely to die if you're a black woman. Same way prematurely. Twice as likely to die if you're a premature child who is African-American. So, these are the type of things that we are fighting for and I think it is very important to understand that this will take us many steps backwards and we need to be moving forwards.

Ms. ADAMS. Great, thank you very much. Wanted to just, you know, note that since the President assumed office we have seen a constant attack against ACA. So much so that we are seeing a reversal in quite a bit of the progress that we have made and just wanted you to just briefly comment on how this reversal in progress has impacted people of color specifically.

Dr. GUPTA. I think what we are—once again will end up happening, we will have individuals who will be dependent again on emergency care and urgent care as a result of which screenings will not happen, preventive visits will not happen. As a result of which we will not have—be able to catch those diseases early. It will be delayed, it will be more expensive and it will cost more lives. As Ms. Corlette eloquently pointed out a couple of times that we have clear data for ACA that when people were uninsured there were about, over 20,000, 22,000 people we know in this country were dying every year because of the lack of insurance per say. We will go back to that.

Ms. Adams. Thank you very much. I yield back, Mr. Chairman.

Chairman SCOTT. Thank you. Gentlelady from Minnesota, Ms. Omar.

Ms. OMAR. Thank you, Chair. Thank you all for being here. Thank you for having this really important, critical conversation but sometimes frustrating conversation. And I say frustrating because of two reasons. One, to see the disconnect between what some of my colleagues would say in committee about healthcare and what their votes say about where their priorities and their values are, seems very, very frustrating for me.

And the second is for us to have conversations about policy that have real impact on humans but to not really think about the humans that we are talking about in this discussion. So I am one that sees healthcare as a human right and I want to take some time for us to humanize this particular conversation because, you know, there are—there are people who will talk about the costs, they will

talk about, you know, what struggles corporations will have or companies will have or a small businesses or all of these kind of things. But oftentimes we don't talk about the kind of stresses and the traumas that people like yourself, Mr. Riedy, have lived with as you not only deal with getting the diagnosis and figuring out how you go on with life, with the condition that could be a hindrance to your day-to-day life or could, you know, maybe end your life.

So, what I wanted to do was maybe have you walk us through what it must have been like to go through the process to receive those letters from insurance companies before the passage of the ACA.

Mr. RIEDY. Well, thank you for the question. And this was, back in 2007 and to know—have spent 7 days in the hospital and to know that—what the cost of that care is and then after that I also spent 14 days at home on IV antibiotics at home which required a home healthcare nurse who came every couple days to draw blood and just check on the dressing and the IV and everything.

But to receive information that describes the cost of your care A, is a shock to see how much it actually costs. But then to see how that is then compiled toward a limit of what an insurance company or someone is willing to pay is worrisome and scary because you know that without that care or access to—without access to the coverage that will give you that care, it will be much harder for you to stand a chance. And not just for me but for others with CF or with other preexisting conditions that faced those same struggles.

It takes a toll not only on us as people but also on our families and those that love us because it, it's not just me that would sit and think about it. It's my wife, right. And my kids are—at the time at 2007 they weren't alive yet. But now if that was to happen again, that puts an unnecessary burden on them as well.

And having the knowledge that there are no caps and not having to receive those letters anymore allows us to focus on our family and to continue to seek the best coverage and care that allows – and medicines that are highly specialized to target what the issues are with my disease and to help prolong my life so that like I mentioned earlier I can see my children grow up and go to college and not fear that I may have to make a decision one day so that they can continue to grow and me not have to have that coverage.

Ms. OMAR. Thank you. I see an immorality in the way that we are creating policy without taking in the actual impact that it has on the people's lives. We take a constitutional oath to protect the safety and the wellbeing of the people that we serve. So, thank you so much for sharing your story and I will tell you that you have people here in Congress who will make sure to constantly center that. So, thank you. I yield back.

Chairman SCOTT. Thank you. And I recognize myself now for questions and the vote has been called so these are going to be some quick questions. Appreciate some quick answers.

Ms. Corlette, you mentioned the New York situation where they covered—they guaranteed issue notwithstanding the preexisting condition and when the Affordable Care Act came in, is it true that the cost for individual insurance dropped more than 50 percent?

Ms. CORLETTE. Yes. It's true.

Chairman SCOTT. The effect of the Texas case, is it true that if the case is upheld there will be no protection, national protection against—for preexisting conditions?

Ms. CORLETTE. The ACA protections will be stuck down, yes.

Chairman SCOTT. Now we have heard that if it is unconstitutional the court would provide some transition time. Is there any—you are a lawyer, is there any guarantee that there would be a transition time if they call it unconstitutional?

Ms. CORLETTE. There is no such guarantee.

Chairman SCOTT. Now the repeal and replace, are you familiar with the American HealthCare Act that passed the House?

Ms. CORLETTE. I do remember it, yes.

Chairman SCOTT. OK. Is it true that if that had passed 23 million fewer people would have insurance, costs would go up about 20 percent the first year, and there would be fewer consumer protections?

Ms. CORLETTE. I don't remember the exact numbers but that sounds like what I remember, yes.

Chairman SCOTT. And we have heard a citation in the bill that protects people with preexisting conditions but what wasn't read was an ability for States to waive that protection, so if you are unlucky enough to be in the wrong State that you could have no protection against preexisting conditions. Is that right?

Ms. CORLETTE. Right.

Chairman SCOTT. 11 million people who have, who got coverage through Medicaid expansion would they lose their coverage?

Ms. CORLETTE. Yes.

Chairman SCOTT. And the 10 essential benefits including prescription drugs, mental health, maternal and newborn care, preventive care, would those evaporate if the bill, if the law—if the ruling is upheld?

Ms. CORLETTE. Yes.

Chairman SCOTT. And we have heard about essential benefits and Dr. Gupta has been very articulate on that. If maternal and—maternity care were optional, who would buy it?

Ms. CORLETTE. Well, who would offer it is the first question? Insurance companies generally would not offer it. And if they did, it would typically be as what is called a rider and the cost would be exorbitant.

Chairman SCOTT. Because the only people that would buy it would be those who expect to have a baby in the next year.

Ms. CORLETTE. Right.

Chairman SCOTT. And the cost would be not insurance but essentially prepaid maternity care.

Ms. CORLETTE. That's exactly right.

Chairman SCOTT. And that is why it would be unaffordable. Now on the association plans, as I understand it you can get a healthy group, young healthy men and who would pay less. The arithmetic therefore says everybody left behind would pay more. Is that right?

Ms. CORLETTE. That's correct.

Chairman SCOTT. Now the navigators which you mentioned are community-based organizations that help consumers sign up for coverage. Language recently published by the Centers of Medicaid and Medicare—Medicare and Medicaid—states that priority will be

granted and funding organizations that promote "coverage options in addition to marketplace plans such as association health plans, short term limited duration insurance." Is that consistent with the original purpose of the navigators?

Ms. CORLETTE. No. Navigators are supposed to help people enroll in marketplace coverage.

Chairman SCOTT. The—you know what has happened to the rate of bankruptcy because of medical bills as a result of the Affordable Care Act?

Ms. CORLETTE. I don't have that data at my fingertips, but it has gone down.

Chairman SCOTT. And can you say another word about job lock and why the Affordable Care Act gives people, particularly entrepreneurs the opportunity to switch jobs?

Ms. CORLETTE. Sure. So, for people who have a preexisting condition themselves or somebody in their family who has a health condition, economists documented this phenomenon called job lock which prior to the ACA led a lot of people to stay with job-based coverage even if that job was not optimally deploying their skills or talents.

Since the ACA if you are an entrepreneur or you want to start your own business, you can do so without worrying about coverage for your preexisting condition and if you are at least initially not earning much income, you can qualify for subsidies or even Medicaid.

Chairman SCOTT. Thank you. I would like to thank our witnesses for their testimony. I now recognize the distinguished ranking member for closing comments.

Mrs. FOXX. Thank you, Mr. Chairman, and I want to thank our witnesses also for being here. I particularly appreciate the opportunity that this hearing has given for Republicans to set the record straight on our position on preexisting conditions.

I believe most every member spoke to it but we know that every member believes in coverage for preexisting conditions both those of us who were here to vote for the replace bill and the other, and the numerous replacement bills that we have offered.

There is so much to say to correct the record here that there is not enough time. Perhaps I will submit some things for the record but I want to point out that if the court rules the ACA illegal, it would not repeal ERISA. It would not repeal HIPAA. There are safeguards in both of those pieces of legislation for preexisting conditions. Some of our witnesses have been extremely careful in how they have answered those questions and I appreciate that because they have been very careful not to completely mislead people about that situation. Contrary to what has been said about the work of Republicans, we have made provisions in all our proposals and past legislation that protects people with preexisting conditions. And I think it is important we continue to say that.

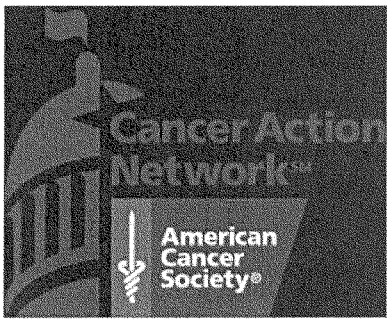
The Affordable Care Act was built on lies. If you like your insurance, you can keep your insurance. If you like your doctor, you can keep your doctor. All of those things were said and they—or costs will be lowered. Those were not true. The ACA ordered people into a one-size-fits-all plan which increased costs dramatically and we know that. What America—what Republicans have done is to offer

Americans freedom and choice. And what we should have been talking about today was what the ACA has done to raise the costs of healthcare and make it less affordable and less accessible. And with that again I thank the witnesses and I yield back.

Chairman SCOTT. Thank you. Again, I want to thank the witnesses and members for their participation. What we have heard I think is a very valuable. The hearing has allowed us to take stock of where we are, to examine the attacks on preexisting conditions through unnecessary litigation, harmful rules that have a negative impact on those with preexisting conditions and I think we should try to improve and protect the healthcare that we have now and not jeopardize it.

It is obvious that even the employer-based coverage with the protection for preexisting condition, those with employer-based coverage if we don't have the individuals covered, we will have uncompensated cost-shifting so they will be paying more if these, all off these other protections are repealed. If there is no further business to come before the committee, the hearing is now adjourned.

[Additional submissions by Ms. Adams follow:]



House Health Bill Would Lead to Less Coverage, Higher Patient Costs

PROPOSED MEDICAID RESTRUCTURE WOULD LEAVE NATION'S MOST VULNERABLE UNCOVERED

March 7, 2017

Washington, D.C., March 7, 2016—The legislation released by the House Energy and Commerce and Ways and Means Committees, while preserving some patient protections, will have the net effect of shifting health insurance costs to low and middle-income patients, significantly reduce the standards of what constitutes quality insurance, curtail the Medicaid expansion and over time substantially reduce over-all Medicaid funding.

A statement from Chris Hansen, president of ACS CAN, follows:

"The bills released by the House Energy and Commerce Committee and the House Ways and Means Committee retain key patient protections prohibiting insurers from charging more based on health status and prohibiting pre-existing condition exclusions. However, these protections are hollow if patients and survivors can't afford insurance that covers the health care services they need to treat their cancer diagnosis.

"ACS CAN has long advocated that any changes to the health care law should provide equal or better coverage for cancer prevention, treatment and follow-up care than what is currently available. These bills have the potential to significantly alter the affordability, availability and quality of health insurance available to cancer patients and survivors. Changing the income-based subsidy to a flat tax credit, combined with reducing the standards for quality insurance could return cancer patients to a world where many are unable to afford meaningful insurance or are left to buy coverage that doesn't meet their health needs.

"In 2015, approximately 1.5 million people with a history of cancer between 18-64 years old relied on Medicaid for their insurance. Nearly one-third of childhood cancer patients are insured through Medicaid at the time of diagnosis. The proposed repeal of Medicaid

expansion along with significant federal funding changes could leave the nation's lowest income cancer patients without access to preventive, curative and follow-up health care.

"Moreover, reduced federal funding combined with state-specific eligibility and enrollment restrictions will likely result in fewer cancer patients accessing needed health care. For low-income individuals these changes could be the difference between an early diagnosis when outcomes are better and costs are less or a late diagnosis where costs are higher and survival less likely.

"According to multiple independent analyses, 30 million individuals, including many cancer patients and survivors, now have insurance facilitated by current law. ACS CAN will continue to urge lawmakers to strengthen and improve the law in a way that reduces the national cancer burden."

ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN gives ordinary people extraordinary power to fight cancer with the training and tools they need to make their voices heard. For more information, visit **https://www.fightcancer.org/**.

STATEMENT

House Republican Health Care Bill a Dangerous Step in the Wrong Direction, Would Harm Women and Children While Shifting Costs onto Hard Working Families

March 7, 2017

Health Care
Emily Hecker, 202/371-1999

Statement from Kristin Rowe-Finkbeiner, executive director and CEO of MomsRising.org, a national online and on-the-ground organization of more than 1 million mothers and their families, on House Republican's Affordable Care Act replacement plan

"The House Republican plan to obliterate the Affordable Care Act and replace it with a plan that would make health insurance less affordable, less accessible, and less comprehensive is a dangerous step in the wrong direction. This bill would create a health care crisis by throwing millions of people off of their insurance. If it is enacted, fewer people would be covered and those who do have insurance would have weaker protections and face significantly higher costs. It is now clear why House Republicans tried to hide this bill for so long. Congress must reject it immediately.

"The American Health Care Act makes a mockery of every campaign promise Donald Trump made about health care. It sets the stage for deep, punitive, permanent cuts to Medicaid in just a few years, which would cause grave harm resulting in rationing care for some of the most vulnerable people in our country: Black, Latinx, Asian, Native American, LGBTQ+, and low-income families; as well as pregnant women, people with disabilities, rural communities, and the elderly. The Republican plan would allow insurance companies to raise premiums and out-of-pocket costs, especially for seniors. The only winners would be the wealthy, and the losers, as too often is the case, would be women, communities of color, and all those who struggle to pay for health coverage and care.

"The GOP plan would put coverage out of reach for millions of families. It undermines one of the Affordable Care Act's (ACA's) greatest achievements—granting protection to those with pre-existing conditions—by forcing those with any significant gap in their insurance coverage to pay hefty penalties. Experts agree, this could lead to a toxic health care environment in which only those who are sick and can afford coverage get the health care they need.

"It would be devastating for people like MomsRising member Helena of Plantation, FL, who is a self-employed, single mother of three. Helena could not afford health insurance but, once the ACA was implemented, she applied and was approved, with her kids, for Medicaid coverage. But because Florida didn't participate in the Medicaid expansion, she was 'kicked off' in 2016. Luckily, she says, 'I was able to get coverage under the

ACA, and qualified for the tax credit, so I'm still insured. I worry that my insurance will be taken away, and that my kids will no longer be covered.'

"Further harming the health of women and families, the American Health Care Act would defund Planned Parenthood, cutting off health care—including birth control, cancer screenings and other essential health services—for millions of women who have no other health care provider.

"Simply put, this legislation would mean America's moms and families pay more for less comprehensive coverage, putting our families' and country's economic security at risk.

"MomsRising members have put pressure on Congress since January to reject a repeal of the ACA. Last month, our members delivered books with hundreds of stories from people who rely on the ACA, Medicaid, Medicare and CHIP to congressional offices in Washington D.C. and across the country to educate lawmakers about the impact of those programs. Thousands more have sent letters and made phone calls urging representatives to protect our health care coverage. We will work tirelessly to ensure that the American Health Care Act does not become law. Every lawmaker who supports it will have to answer to constituents."

# # # #

MomsRising.org is an on-the-ground and online grassroots organization of more than a million people who are working to increase family economic security, decrease discrimination against women and moms, and to build a nation where businesses and families can thrive. Established in 2006, MomsRising and its members are organizing and speaking out to improve public policy and to change the national dialogue on issues that are critically important to America's families, including criminal justice reform, immigration policy reform, and gun safety. MomsRising is working for paid family and medical leave, affordable, high quality childcare and early learning, and for an end to the wage and hiring discrimination which penalizes women — particularly moms and women of color — and so many others. MomsRising advocates for access to healthy food for all kids, health care for all, earned sick days, and breastfeeding rights so that all children can have a healthy start. MomsRising maintains a Spanish language website: MamásConPoder.org. Sign up online atwww.MomsRising.org — and follow us on our blog, and on Twitterand Facebook.

National Disability Rights Network Opposes American Health Care Act

For Immediate Release
March 7, 2017

Contact: David Card
202.408.9514 x122
press@ndrn.org

WASHINGTON – NDRN Statement on the American Health Care Act:

"The legislation revealed by House Republicans last night is a giant step backwards in the treatment and care of individuals with disabilities.

"It repeals the expanded Medicaid match that encourages the community integration of people with disabilities and counters biases that lead to institutionalization. It permits discrimination against people with disabilities in the insurance market for their pre-existing conditions. It caps Medicaid funding which means a sharp reduction in services and availability of this important health care lifeline for children and adults with disabilities. In short, this plan is terrible.

"The National Disability Rights Network urges the House not to send people with disabilities back to a time when it was nearly impossible for us to obtain health insurance, live in the home of our choice or participate in community life. We will never go back to those days. Never."

# # #

The National Disability Rights Network (NDRN) is the nonprofit membership organization for the federally mandated Protection and Advocacy (P&A) Systems and the Client Assistance Programs (CAP) for individuals with disabilities. Collectively, the Network is the largest provider of legally based advocacy services to people with disabilities in the United States.

[Additional submission by Ms. Jayapal follows:]

APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

WRITTEN STATEMENT FOR THE RECORD
http://www.apiahf.org/
FOR THE HEARING ENTITLED "EXAMINING THREATS TO WORKERS WITH PRE-EXISTING CONDITIONS"

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON EDUCATION AND LABOR

FEBRUARY 6, 2019

BY THE
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM
1629 K STREET NW, SUITE 400
WASHINGTON, DC 20006

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the February 5, 2019 hearing before the House Education & Labor Committee "Examining Threats to Workers with Pre-Existing Conditions."

The Affordable Care Act has served not only as one of the most transformational laws in our nation's public health, expanding coverage to nearly 20 million people, but as a civil rights law protecting the health and well-being of the most vulnerable. APIAHF is the oldest and largest health policy and public health organization working with Asian American (AA), Native Hawaiian and Pacific Islander (NHPI) communities across the nation and its Pacific jurisdictions. With more than 150 community-based organizational partners in over 28 states and territories, APIAHF provides a voice in the nation's capital for underserved AA and NHPI communities and works toward health equity and health justice for all.

For over 6 years, APIAHF has partnered with organizations helping consumers enroll in health coverage, including Affordable Care Act (ACA) Marketplace plans, Medicaid and the Children's Health Insurance Program (CHIP). As part of these efforts, we co-founded *Action for Health Justice* with the Association of Asian Pacific Community Health Centers (AAPCHO), Asian Americans Advancing Justice and Asians Americans Advancing Justice – Los Angeles. As part of *Action for Health Justice*, we worked with 72 community based organizations and health centers and countless local assistors to inform efforts by the U.S. Department of Health and Human Services to reduce barriers for AA and NHPI individuals navigating an often deeply complex enrollment process.

Our experience in working with partners as part of *Action for Health Justice* and successive enrollment periods has provided real stories that relay the impact the ACA has had on the lives of countless AAs and NHPIs. Through this experience, and others first hand, we know both the importance of health insurance for individuals who have complex chronic conditions and who may be low-income, immigrant or limited English proficient, whether they get their coverage through employer-sponsored plans, the Marketplace, Medicaid, Medicare or CHIP.

From our work with AA and & NHPI communities, we understand the role the ACA has played in improving access to health insurance for communities of color across the nation and for diverse American workers. Prior to the ACA, people of color were much more likely to be uninsured than whites. Since 2010, the uninsured rate has fallen from 15.1 percent to 6.4 percent in 2017 for AAs and from 14.5 percent to 8.3 percent for NHPIs, higher than any other racial group.[1] Individual subgroups of AAs and NHPIs have experienced their rates of uninsurance being cut by at least half, including Nepalese, Samoan, and Hmong Americans.[2]

As an organization that has worked for over 32 years at the federal, state, and local levels to advance sensible policies that reduce health disparities and promote health equity, we are deeply troubled by the District Court's ruling in *Texas vs. U.S.*, challenging the constitutionality of the entire ACA, including protections for persons with pre-existing conditions. In the nearly nine years since the ACA became law, millions have gained coverage and the law has touched the lives of nearly every American, providing critical protections against insurance company practices, protecting seniors from high cost-sharing in Medicare, improving the quality of care and strengthening civil rights protections. Many of these provisions protect American workers, who while they had partial protections against pre-existing conditions prior to the ACA, those protections required workers to maintain continuous coverage or otherwise imposed mandatory waiting periods. The ACA's guaranteed issue and community rating provisions, along with the entire law could be overturned if the ACA were to be found unconstitutional and would send a shockwave through the U.S. healthcare system. At least 20 million Americans could lose their coverage.

At Risk: Stories from the Community

Millions of AAs and NHPIs could be at risk for losing coverage and their connection to health care if the ACA's pre-existing conditions were overturned. These include people like:

Mr. Nguyen and his family of four in Alabama. Mr. Nguyen had been living with diabetes for years prior to the ACA and always struggled to keep his condition in check because he couldn't afford a doctor. That changed when he was able to afford a plan under the ACA and one that offered him coverage for his pre-existing condition: diabetes.

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[1] Comparison of American Community Survey 2011-2015 5-year estimates to 2017 American Community Survey 1-year estimates.
[2] *Id.*

Prior to the ACA, Ms. Lejjena, a mother of three in Oregon, "used to hesitate seeking medical attention until it was an emergency and I ended up hospitalized. Obamacare offered us the opportunity to obtain medical insurance for the first time and peace of mind that we can seek medical care for our children and selves." All that could change if the ACA's protections were overturned as Ms. Lejjena, like so many Americans, overcame a bout of pneumonia years ago, a deniable condition before the ACA.

And there is Khamsay Chanthasaly, who in December 2015, was diagnosed with a rare case of breast cancer in men. It started on Christmas Eve, when he was admitted to hospital following an unbearable pain in his back and legs. "At first, I was depressed and hopeless. We didn't have enough money to pay for the treatments. Even before I was diagnosed with breast cancer, we could barely cover the living cost with the money that we earned." He was able to enroll in Medicaid coverage thanks to the ACA.

Marina Wena in Arkansas lives paycheck-to-paycheck. She also lives with heart disease, type 2 diabetes and a kidney condition that requires ongoing dialysis. Before the ACA, she often went to the emergency room for dialysis treatment as she couldn't afford coverage." The ACA gives me hope. Since I was covered by the ACA, I haven't missed taking my medications. I am a very healthy person nowadays and friends that meet me are surprised to see how healthy I am. This is the story of my life with health insurance!"

These are just examples of the lives that have changed thanks to the ACA and what is at risk if those protections are overturned.

Overturning Pre-Existing Condition Protections Would Disproportionately Harm Racial and Ethnic Minorities

Living with a pre-existing condition is a fact of life for more than 130 million Americans, including millions of AAs and NHPIs – the fastest growing groups in the country.[3] The Kaiser Family Foundation had previously estimated that 27% of adults under age 65 have health conditions that would lead them to be likely uninsurable under pre-ACA rules.[4]

Racial and ethnic minorities, including AAs and NHPIs disproportionately experience a number of chronic conditions due to factors including poverty, inability to afford quality coverage, and challenges accessing culturally competent care, among others.

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[3] Center for American Progress, *Number of Americans with Medical Conditions by Congressional District,* 2017, *available at*: https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/.

[4] Kaiser Family Foundation, *Pre-Existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,* 2016, *available at:* https://www.kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/.

The AA and NHPI community speaks over 100 different languages and traces their heritage to more than 50 different countries. Language barriers, lack of cultural competency, poverty, and immigration status all affect the ability of AAs and NHPIs to access coverage and care.

Overturning the ACA's protections for pre-existing conditions would deepen those disparities by turning back the clock on coverage gains that have substantially reduced uninsurance amongst communities of color by locking individuals with health conditions out of coverage.

AAs and NHPIs have a higher likelihood of suffering from a number of chronic conditions requiring routine access to care and underscoring the importance of early prevention, diagnosis and connection to treatment. NHPIs have the highest age-adjusted percentage of people with diabetes (20.6%), more than 3 times that of Whites (6.8%).[5] Fourteen percent of Indian Americans have diabetes, a rate higher than that of nearly all other racial groups.[6]

AAs and NHPIs are the only racial group for whom cancer is the leading cause of death.[7] Certain AA and NHPI subpopulations suffer from even greater health disparities. Vietnamese women have cervical cancer rates five times higher than White women.[8] NHPIs are 30% more likely to be diagnosed with cancer than whites.[9] Allowing insurance companies to discriminate and deny coverage on the basis of a pre-existing condition would make coverage prohibitive for these individuals.

Discriminating against people with pre-existing conditions like HIV/AIDS wouldn't just hurt the people living with the condition and their families, it could interfere with and even discourage people from getting tested and linked to treatment – which could be deadly. Of the 15,800 AAs estimated to be living with HIV in the United States in 2015, only 80 percent had received a diagnosis, a lower percentage than for any other race/ethnicity.[10] 1 in 33 NHPI men will be diagnosed with an HIV infection in their lifetime, compared to 1 in 102 white men.[11] 1 in 5 AAs living with HIV does not know they have it, compared to 1 in 7 for all groups.[12] Of AAs living with HIV in 2014, 57% received HIV medical care, 46% were retained in HIV care, and 51% had

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[5] Asian and Pacific Islander American Health Forum, *Native Hawaiian and Pacific Islander Health Disparities*, 2010, *available at*: www.apiahf.org/sites/default/files/NHPI_Report08a_2010.pdf

[6] Spanakis, Elias and Sherita Hill Golden, *Race/Ethnic Difference in Diabetes and Diabetic Complications*. Curr Diab Rep. 13(6), 2013, *available at*: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3830901/

[7] Heron, Melonie, *Deaths: Leading Causes for 2014. National Vital Statistics Reports* Volume 65, Number 5. United States Centers for Disease Control, 2016.

[8] Miller BA et al., *Racial/Ethnic Patterns of Cancer in the United States, 1988-1992*, 1996, *available at*: https://seer.cancer.gov/archive/publications/ethnicity/

[9] U.S. Department of Health & Human Services: Office of Minority Health, *Cancer and Native Hawaiians/Pacific Islanders*, March 29, 2016, *available at*: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=76.

[10] Centers for Disease Control and Prevention, *HIV Among Asians*, *available at*: https://www.cdc.gov/hiv/group/racialethnic/asians/index.html

[11] *Id.*

[12] *Id.*

achieved viral suppression.[13] Removing protections for pre-existing conditions could threaten public health efforts by creating delays and barriers in testing and linkage to care.

For questions contact Amina Ferati, Senior Director of Government Relations & Policy aferati@apiahf.org (202-466-3550).

[13] *Id.*

[Additional submission by Ms. Underwood follows:]



Final rule on short-term insurance plans will leave patients with high costs, less coverage

WASHINGTON, D.C., August 1, 2018 — *Today the U.S. Departments of Labor, Treasury, and Health and Human Services issued a final rule that would expand the use of "short-term, limited-duration insurance plans". More than 25 patient and consumer groups representing millions of people with pre-existing health conditions issued the following statement:*

"Our organizations, representing more than 100 million American consumers, providers, and patients, are deeply troubled by the administration's decision to finalize a short-term, limited-duration insurance (short-term) rule. Despite serious concerns expressed by individuals and organizations across the entire spectrum of our health care system, the administration has finalized a rule that will reintroduce health insurance discrimination based on gender, health status, age, and pre-existing conditions.

"A striking 98 percent of stakeholder groups who commented, including many of our organizations, either expressed extreme concerns with the rule or outright opposed it as drafted, emphasizing its negative impact on patients and consumers. The administration has disregarded those warnings and issued a final rule with few changes, aside from limiting renewals of short-term coverage to up to 3 years— which does nothing to resolve the fundamental problems with this policy. This rule will siphon younger and healthier individuals out of the individual market risk pool, forcing patients with preexisting health conditions to pay far higher costs for the comprehensive coverage they obtain through the insurance marketplaces. It will also expose those younger, healthier individuals to the significant risk that their health plan will fail to cover critically necessary care if they fall ill or develop a serious medical condition.

"Allowing short-term plans to proliferate offers no relief from the problems that plague our health care system, and instead will exacerbate the affordability concerns for unsubsidized individuals even as many states are implementing reinsurance programs to lower costs. We are dismayed that the administration has chosen a course of action to further dismantle rather than stabilize the health insurance marketplace, potentially costing the millions of Americans our organizations represent their coverage or even their health. We now call upon states to stand up for the patients left behind by this rule and take action to protect patients, stabilize the marketplaces, and bring down costs for consumers."

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Adult Congenital Heart Association
Alpha-1 Foundation
American Cancer Society Cancer Action Network
American Diabetes Association
American Heart Association
American Liver Foundation
American Lung Association
Arthritis Foundation
COPD Foundation
Crohn's & Colitis Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Family Voices
Hemophilia Federation of America
Leukemia & Lymphoma Society
Lutheran Services in America
March of Dimes
National Alliance on Mental Illness
National Health Council
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
United Way Worldwide
WomenHeart: The National Coalition for Woman with Heart Disease

[Questions submitted for the record and their responses follow:]

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February 28, 2019

Ms. Grace-Marie Turner
President
Galen Institute
P.O. Box 130
Paeonian Springs, VA 20129

Dear Ms. Turner:

I would like to thank you for testifying at the February 6, 2019, Committee on Education and Labor hearing on "Examining Threats to Workers with Preexisting Conditions."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later Thursday, March 14, 2019, for inclusion in the official hearing record. Your response should be sent to Daniel Foster or Carrie Hughes of the Committee staff. They can be contacted at 202-225-3725 should you have any questions.

We appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT
Chairman

Enclosure

Committee on Education and Labor Hearing
""Examining Threats to Workers with Preexisting Conditions"
Wednesday, February 6, 2019
10:15 a.m.

Rep. Brett Guthrie (R-KY)

1. The real issue facing American workers and families is addressing the rising cost of health care. In 2017, the average individual premium for employer-sponsored coverage increased by 3 percent, and the average family premium for employer-sponsored coverage increased by 5 percent, according to the Kaiser Family Foundation. Meanwhile, the average ACA Exchange premium increased by about 30 percent. Why have employer coverage costs increased at a lower rate, and what incentives do employers have to keep costs down for themselves and their employees?

2. It's one thing to have access to health coverage, but another to be able to afford it and use it when you really need it. While preexisting conditions protections work to ensure individuals can obtain health care coverage, are there other limitations to access, such as cost or provider shortages? In what ways are health care options limited, even for covered individuals, and how can policymakers and the private sector work together to address those challenges?

Rep. Lloyd K. Smucker (R-PA)

1. Employer-based health insurance is one of the most desired benefits that employers can offer to their workers, and workers have a high rate of satisfaction with the coverage that they receive. A recent study by America's Health Insurance Plans (AHIP) found that 71 percent of workers are satisfied with their coverage, 56 percent indicated that coverage is a key factor in their choice to remain at their current job, and 46 percent responded that health insurance was the deciding factor or a positive influence when choosing their current job. What role does health insurance play in a strong economy? What are the benefits of allowing workers that are happy with their coverage to keep it?

2. The ACA has driven up health care costs across the board, including costs absorbed by employer-sponsored plans. Can you speak to how much the ACA has driven up costs in other health care markets? Can you describe some of the steps employers have taken in the aftermath of the ACA to help maintain affordable and high-quality care for their workers?

[Ms. Turner response to questions submitted for the record follow:]

GALEN
INSTITUTE

A not-for-profit health and tax policy research organization

March 15, 2019

Chairman Robert C. "Bobby" Scott
Committee on Education and Labor
U.S. House of Representatives
2176 Rayburn House Office Building
Washington, D.C. 20151-6100

Dear Chairman Scott:

Thank you again for inviting my testimony before your committee's hearing on "Examining Threats to Workers with Preexisting Conditions" on February 6, 2019.

Per your request, I have provided responses below to the follow-up questions from Committee members.

I welcome the opportunity to work with you to achieve the goals of better access to more affordable coverage and better protection for those with pre-existing conditions.

Sincerely,

President
Galen Institute

Officers: Grace-Marie Turner, *President* • Beth Haynes, M.D., *Treasurer* • John S. Hoff, Esq., *Secretary*
P.O. Box 130 • Paeonian Springs, VA 20129 • Phone 703-687-4665 • www.galen.org • AmericanHealthCareChoices.org

To Rep. Brett Guthrie's first question about health costs and incentives employers have to keep costs down:

The vast majority of workers—89 percent according to the Kaiser survey—worked for companies that sponsored health coverage in 2016. An estimated 79 percent of those employees were eligible to enroll in their firm's plan. In 2016, at least 173 million Americans received health coverage through the workplace, a benefit that is highly valued by workers, dependents, and retirees.

My colleague Doug Badger has produced an important paper that provides this and other data as well as a history of the evolution of employer-sponsored insurance (ESI) in the United States and the value that it brings to employees as well as to those in public health plans. I would request that this paper, "Replacing Employer-Sponsored Health Insurance with Government-Financed Coverage: Considerations for Policymakers" be included in the record.

As Rep. Guthrie points out, the average individual premium for ESI increased by only 3% in 2017 and the average family premium increased by 5% at a time that premiums were increasing by 30% in ACA exchanges.

One of the reasons ESI costs are rising more slowly and that the coverage is so highly valued by employees is because employers have more flexibility to balance costs and coverage options—much more so than do publicly-supported and regulated health insurance programs.

Companies that can self-insure are better able to design plans that meet the needs of their employees while negotiating pricing discounts with hospitals and other providers. Employers are not immune from underlying rising costs throughout the health sector, of course, but are better able to negotiate lower costs, higher quality, and better value.

Employers provide health insurance that provides protection for their employees from medical costs as well as wellness incentives and coordinated care for those with acute or chronic medical conditions. Employees can get better treatment, often at lower costs, because employer plans are negotiating on their behalf. For example, many employers contract with centers of excellence for surgical care, oncology treatment, etc., and others have in-house clinics to make sure employees have easy and affordable access to routine and preventive care. Still others provide financial incentives for participation in wellness programs.

Employer-based health insurance is part of the mosaic of health insurance coverage in our large and diverse country. But its success in providing coverage that employees value and its ability to negotiate prices with competing health plans provides a lesson: Greater flexibility, more competition, and a greater focus on value provides a path to lower costs. A key factor in their success is their ability to continue to innovate.

To Rep. Guthrie's second question about preexisting condition protections and their limitations:

In my testimony, I recounted the story of a woman living in Colorado who experienced significant problems with access care in her ACA plan. She found narrow networks that didn't allow her to see the doctors that provided her with continuity of care, she faced severe limitations on access to the medicines she needed, and found multiple barriers in getting authorization for other treatments. She said the Colorado High Risk Pool she previously had (and which was closed after the ACA took effect) provided better access to all of these services than her more-expensive ACA plan. The ACA's pre-existing condition protections came at a high price for her.

I think her story is worth repeating. Janet told us:

"In 1999, I was diagnosed with Hepatitis C, which made me ineligible for insurance (denied for pre-existing conditions). I live in Colorado, and they had a high-risk pool that covered people like me. I applied for that and was accepted," she said.

"My premiums in 2010 were $275/month with a total out of pocket of $2,500. [While I was on] this plan, my liver failed, and I needed a liver transplant. It was approved without a question. My $600,000 transplant was covered 100% with a $2,500 out of pocket maximum!"

When Obamacare went into effect, Colorado's high-risk pool was closed. "I was forced into the regular marketplace that everyone was telling me was a good thing because I couldn't get denied. I think my first year on that policy, my premiums were in the $450 range—which I thought wasn't too terrible, but still more than I had been paying.

"The thing I noticed from the start was that instead of full coverage, almost everything I needed was denied, which threw me into the world of having to appeal (sometimes several times) to get the basic care I needed.

"Since then, my premiums skyrocketed. In 2017, I paid $735 a month with total out-of-pocket costs of $5,500. In 2018, my premiums went up to $1,100 a month with a deductible of $6,300. Once I hit that mark, I'm covered 80%.

"Further, none of my anti-rejection meds are on the formulary of my insurance. If I could not afford them, my body would most certainly reject my liver, causing another liver transplant that would not be covered 100%.

"I don't get any credits from the government to reduce my premiums. Those of us who are self employed but make more than the threshold for tax credits wind up footing the whole bill ourselves. I have to spend $19,500 before my insurance pays anything, and it doesn't cover all my prescription costs. My old plan was almost a third of what I have to pay now.

"I have many friends and work associates in the same boat as me. Many of them are doing without insurance and are betting that they won't need more than what they can afford to pay out of pocket. I cannot do that, because if something happened and I needed another transplant, it would bankrupt my family."

Janet has coverage for pre-existing conditions, but her access to care under the ACA is inferior to the state high-risk pool coverage she had before, and the cost of her coverage is much higher.

There are better ways to provide pre-existing conditions protections than government dictates that lead to unintended consequences of higher costs and restricted access to care.

You asked what steps policymakers can take: Under the ACA's Section 1334 State Innovation authority, several states are employing various risk mitigation strategies to finance coverage for those with high health costs, repurposing federal money to pay medical bills for residents in poor health. By separately subsidizing those with the highest health costs, they can lower premiums for individual health insurance, and the lower premiums also mean increased enrollment.

There are many factors driving up health costs, of course, but these strategies offer targeted solutions. As costs continue to rise in the individual and small group markets that are most exposed to ACA mandates and regulations, more and more healthy people are being driven out of coverage, causing a further upward spiral for those remaining in the insurance pools. I encourage the committee to investigate these options which can provide lower costs and better access to coverage than the heavily-regulated ACA system.

To Rep. Smucker's first question about employer-sponsored insurance, employee satisfaction, and ESI's role in a strong economy:

Rep. Smucker cites a survey by Americas Health Insurance Plans (AHIP) showing the high value that employees place on their employment-based health benefits, with 71 percent satisfied with their coverage. ESI is a key factor for many employees in remaining in their jobs and is a tool employers value in recruiting employees.

In 2018, there are more jobs than people out of work, something the American economy has never experienced before. According to the Bureau of Labor Statistics, last June there are 6.7 million job openings and just 6.4 million available workers to fill them. The National Association of Manufacturers warns that 2.4 million manufacturing jobs could go unfilled between now and 2028, according to a study from the consultancy firm Deloitte.

Job training and education reform are, of course, vital components of a solution. But if the American economy is to remain strong and competitive in the global economy,

companies must be able to attract top talent, and quality health insurance is an important benefit to do that.

Employees value their job-based health insurance and taking away this tool would make it even harder for employers to attract top talent.

Efforts to end employer-sponsored health insurance and replace it with a government-run plan would experience a strong backlash from employees. A survey conducted by the Kaiser Family Foundation found that 56 percent of Americans support a "national health plan, sometimes called Medicare for All." But when people are told that it would eliminate private health insurance and require people to pay more in taxes, support fell to 37 percent, and it dropped to 26 percent if the government plan meant delays medical treatment.

The Employee Retirement Income Security Act of 1974 (ERISA) provides protection for employers to structure coverage to meet the needs and pocketbooks of their employees.

ESI is part of an employee's compensation package and, when costs go up, that can mean smaller wage increases for workers. This is especially a problem for companies with lower-wage workers. Employers and employees have a common interest: Getting the best health benefits for the lowest costs, and employers negotiate with competing health plans to find the right balance. Innovation, flexibility, and strong negotiating power are key components of the success of employer-sponsored health insurance.

Those with ESI receive a generous tax benefit supporting their coverage, and many workers who do not have ESI find health coverage increasingly out of reach, especially those purchasing coverage in the individual market.

A net of three million people dropped coverage in the individual health insurance market between 2015 and 2018. According to a study published by the Kaiser Family on "Changes in Enrollment in the Individual Health Insurance Market," there were 17.4 million policyholders in the individual market in 2015, dropping to 14.4 million by the first quarter of 2018. Clearly more solutions are needed to help them, but eliminating ESI or exposing it to the same mandates and regulations that have driven up costs in the individual market are not the right answers.

To Rep. Smucker's second question about the ACA and health costs:

As Rep. Guthrie pointed out in an earlier question, the average individual premium for ESI increased by only 3% in 2017, and the average family premium increased by 5% at a time that premiums were increasing by 30% in ACA exchanges.

In order to address health costs, employers have increased co-payments, co-insurance, and deductibles for their workers. While still high, they are not nearly as high as those in

the ACA exchanges. A prime focus of employers is seeing better value for health care dollars.

The average annual deductible for employer-sponsored insurance was about $1,800 in 2017, according to a new analysis from the University of Minnesota State Health Access Data Assistance Center. Nearly half of workers enrolled in employer-sponsored insurance plans had a deductible of at least $1,300 for an individual or $2,600 for a family. But compare that with average deductibles in the ACA exchanges. The most affordable Bronze plans have deductibles of more than $5,800 for individuals and $12,000 for families. Even in the most popular Silver plans, deductibles are $4,000 and more than $8,300 respectively.

Employers work hard to provide the best health benefits at the lowest costs to their employees, but underlying forces in our health sector drive up cost, including hospital consolidation which can lead to monopoly pricing, and employer plans are impacted. These consolidations interfere with keeping prices in check for both public and private plans and would be a worthy area for anti-trust investigations.

Companies that self-insure are better able to design plans that meet the needs of their employees while negotiating pricing discounts with hospitals, drug plans, and other providers. Employers also offer wellness incentives and often provide coordinated care for those with acute or chronic medical conditions. Employees can get better treatment, often at lower costs, because employer plans are negotiating on their behalf.

Competition is a stronger force than government-set prices in forcing providers to provide the best service for the lowest costs, as we see in so many other sectors of the economy.

[Whereupon, at 1:49 p.m., the committee was adjourned.]