

**PROTECTING AMERICANS WITH
PREEXISTING CONDITIONS**

HEARING
BEFORE THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED SIXTEENTH CONGRESS
FIRST SESSION

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PROTECTING AMERICANS WITH PREEXISTING CONDITIONS

TUESDAY, JANUARY 29, 2019

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 10:00 a.m., in Room 1100, Longworth House Office Building, Hon. Richard E. Neal [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

FOR IMMEDIATE RELEASE
Tuesday, January 22, 2019
FC-1

CONTACT: (202) 225-3625

Chairman Neal Announces a Hearing on Protecting Americans with Preexisting Conditions

House Ways and Means Committee Chairman Richard E. Neal today announced that the Committee will hold a hearing on Protecting Americans with Preexisting Conditions. **The hearing will take place on Tuesday, January 29, 2019, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 a.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "[Click here to provide a submission for the record.](#)" Once you have followed the on-line instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, February 12, 2019.** For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you require special accommodations, please call (202) 225-3625 in advance of the event (four business days' notice is requested). Questions regarding special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available at <http://www.waysandmeans.house.gov/>

Chairman NEAL. The Ways and Means Committee will now come to order. I want to thank everyone for their presence here today for the Ways and Means Committee's first policy hearing in the 116th Congress. A warm welcome to the new Members of the Committee on both sides of the aisle. I am honored this morning to be the 67th Chairman of the House Ways and Means Committee. We take this position, history, and prestige of the Committee all quite seriously.

I look forward to considering policies that will have a positive impact on the future of our Nation and all American families. Today we will discuss an issue that affects nearly every American family: Preexisting conditions and their impact on healthcare coverage. Over 130,000 Americans have a preexisting condition, and protecting them goes to the core of safeguarding healthcare for all Americans.

What insurance companies consider to be preexisting conditions can be anything from asthma to cancer to even pregnancy. Before the Affordable Care Act, which is the current law of the land, Americans faced significant hardship when trying to purchase adequate healthcare coverage. Insurance companies could refuse coverage altogether, charge excessive fees, and place dollar limits on the amount of care that Americans might receive. Insurers could even discriminate against patients with common healthcare issues such as diabetes or high blood pressure.

When the ACA became law, new safeguards went into place to put a stop to these practices. Our healthcare system's protections really matter for American families' peace of mind, and certainly for their pocketbooks.

My colleagues on the other side from time to time have offered a different view. Despite their repeated claims to support the protections for healthcare for people with preexisting conditions, their actions have directly contradicted the statements. They are currently leading ongoing efforts to undermine or eliminate the current law's protections for Americans with preexisting conditions. This is the wrong course of action.

The Trump administration's efforts to chip away at the law and 18 Republican attorneys general who are actively trying to sabotage the law through the courts understand what they can't do legislatively they will attempt to do judicially. As one of the first actions in the 116th Congress, my colleagues and I are moved to intervene in the GOP lawsuit and defend the current law's preexisting conditions safeguards.

I am pleased to join attorneys general from Massachusetts and other Democratic attorneys general who are defending consumers in fighting for Americans with preexisting conditions. Let me be

clear: The ongoing effort to sabotage the healthcare system is having a direct impact on the finances of Americans across the country, and it is creating uncertainty for one-fifth of the U.S. economy. Four million Americans have lost health insurance since President Trump took office. That is 4 million Americans who previously had insurance and now must pay their medical costs fully out-of-pocket or delay needed medical care. And earlier this month, this Administration took action to reduce the tax credits by \$900 million while raising the out-of-pocket maximums by an additional \$400 per family.

I want to take a minute to share a story about one of my constituents who has been personally impacted by the preexisting condition protection. Michael Finn is 48 years old and a State representative from West Springfield, Massachusetts. He was diagnosed with type 2 diabetes 2 years ago when he was 46. He was a borderline diabetic for at least 10 years before that, even though his condition went undiagnosed.

Mike is married with three children under the age of 10, and he is grateful to the ACA for allowing him to keep receiving treatment, medication, and care, even though he has a preexisting condition. His wife is a stay-at-home mother, and Mike is the sole breadwinner in the household. If he were unable to work or unable to receive insurance assistance to help cover healthcare costs, he and his family don't know what they would do.

We need to embrace policies that protect people like Mike. The law is currently clear. But there is an opportunity to build upon it and stop the ongoing sabotage. I have seen in Massachusetts that we can work together across party lines to make sure Americans have coverage and to protect families from financial ruin. Recall that 100 percent of the children in Massachusetts are covered and 97 percent of the adults. We need more of that reflection here in Congress, and I hope this hearing will be the beginning of that process.

I am pleased our witnesses could join us today to share their professional and personal experiences and thoughts on how protections for people with preexisting conditions are essential. Our witnesses know that these safeguards can be the difference between getting needed medical assistance and foregoing necessary treatments or the difference between accessing affordable care and losing a lifetime of savings just to stay alive.

These protections mean the world to people, and they are the law of the land. I am glad we will have an opportunity this morning to discuss them.

And, with that, let me recognize the Ranking Member, Mr. Brady, for his opening statement. Mr. Brady for 5 minutes.

Mr. BRADY. Thank you, Chairman Neal, for convening this important hearing today.

Without question, while America's health system boasts remarkable innovation and highly trained professionals, it faces many challenges, the greatest among them: The high cost.

Americans agree. In a recent Gallup Poll, almost 70 percent of Americans say healthcare has major problems, and nearly that many say rising insurance premiums are their biggest concern. It is clear the status quo of America's healthcare isn't working. When

Democrats pushed through a healthcare bill, written behind a closed door, filled with special interest provisions, and with no Republican support, President Obama made many unkept promises to the American people, including the reform we are proposing will provide you more stability and more security. When it comes to healthcare costs, the words “stability” and “security” are the last to come to mind.

It has been 10 years since the ACA was passed by Democrats only, and yet healthcare still remains the top worry of American workers and businesses. We have to do better. For Republicans, what we hope will happen today is an honest conversation, one on how we can create a healthcare system that is more compassionate, more convenient, and less costly.

And to begin, there are a few things that I would like to make clear. First is this: Of course, Republicans support protections for people with preexisting conditions. We included these protections in our House-approved alternative to the ACA. Section 137 of the American Healthcare Act said clearly: Nothing in this Act shall be construed as permitting healthcare insurance issuers to limit access to health coverage for individuals with preexisting conditions.

Furthermore, Republicans guaranteed there can be no lifetime limits on healthcare costs. It is important if you have a child with an expensive disease or you face one yourself. We make sure young people can stay on their parents plan until they are age 26. And then again, on day one of this Congress, Republicans offered and unanimously supported an amendment on the House floor stating our unwavering support for protecting patients with preexisting conditions. This means guaranteeing no American purchasing healthcare as an individual can be denied coverage, denied renewal, or charged more because they have a preexisting condition.

These protections, by the way, have long been guaranteed for 93 percent of the Americans who get their healthcare at work or through the government. They should be guaranteed for individuals as well. And if you remember only one thing we say today, remember this: We have to do more than protect healthcare; we have to work together to make it affordable. The ACA is failing too many Americans who face soaring costs, skyrocketing deductibles, and few choices of local doctors and hospitals. It really is time for a fresh start, this time with both parties working together creating truly affordable healthcare focused on patients, not on Washington.

This Committee advanced many bipartisan healthcare reforms last Congress that expanded health savings vehicles for families, protected the most fragile among us in Medicare, rolled back some of ObamaCare’s most egregious taxes, and looked for ways to increase innovation. So let’s work together this Congress to build on these initiatives.

I think there are many commonsense areas where we can work together, Mr. Chairman, from price transparency, to spurring innovation, lowering drug prices, addressing surprise billings, and removing the regulatory barriers to improve patient care.

The final point I would like to make is this: What Republicans don’t support, as well as the majority of Americans, is the status quo. I know many of my Democrat colleagues may want to relitigate the past today; we will be glad to because the ACA has be-

come too expensive to use for so many Americans and so many Texans. So expensive, in fact, twice as many Americans have found a way to get out of ObamaCare than those who chose it. Twice as many got out of it—out from under it because they couldn't afford it and they couldn't use it.

So what will benefit us is to focus on the future. Today let's turn a new leaf, beginning the work folks back home sent us here to do: Work together to help make healthcare less expensive and easier to use. We owe that to our families and to our businesses.

With that, thank you, Chairman Neal.

Chairman NEAL. Thank you, Mr. Brady.

And, without objection, all Members' opening statements will be made part of the record.

Let me now introduce our distinguished panel of witnesses for the opportunity to discuss many of the important questions for protecting coverage for preexisting conditions.

First, I would like to welcome Karen Pollitz, a Senior Fellow at the Kaiser Family Foundation and, for those of you with long memories, a former staffer for our longtime colleague Mr. Levin of Michigan, who recently retired from Congress.

Next is Andrew Stolfi. He is the Insurance Commissioner and Administrator from my friend Earl Blumenauer's State, Oregon. He is in the Oregon Division of Financial Regulation.

Rob Robertson from the State of Adrian Smith's, Nebraska. He is the Chief Administrator/Secretary-Treasurer of the Nebraska Farm Bureau Federation.

Keysha Brooks-Coley, Vice President of Federal Advocacy at the American Cancer Society, Cancer Action Network, will share with us why these protections are so critical for Americans living with cancer and cancer survivors.

And, finally, Andrew Blackshear, a constituent of Mr. Thompson and one of the 133 million Americans with a preexisting condition. His story highlights the dangers of short-term limited-duration healthcare plans that have been promoted by the Trump administration.

Each of your statements will be made part of the record in its entirety. I would ask that you summarize your testimony in 5 minutes or less. And to help you with that time, there is a timing light that you might take note of at your table. When you have 1 minute left, the light will switch from green to yellow and then finally to red when the 5 minutes are up.

Ms. Pollitz, please begin.

**STATEMENT OF KAREN POLLITZ, SENIOR FELLOW,
KAISER FAMILY FOUNDATION**

Ms. POLLITZ. Thank you, Mr. Chairman, and Ranking Member Brady, and Members of the Committee. Good morning.

Mr. Chairman, most people are healthy most of the time, but when we need care, it can get expensive. Figure 1 in my statement shows that each year about 20 percent of people account for 80 percent of all health spending, while the healthiest half accounts for just 3 percent of health spending. That chart is just a snapshot, though. Over time, our health status changes, and eventually, at some point, we will all get sick or hurt or pregnant and need costly

care at least for a while. So we buy health insurance in case we get sick, not in case we stay healthy.

Before the Affordable Care Act, the individual insurance market didn't always work for people once they got sick. People with pre-existing conditions could be turned down or charged more. About 27 percent of nonelderly adults each year have a condition, such as cancer, diabetes, or pregnancy, that would have made them uninsurable in this market.

Also, people healthy enough to get nongroup coverage couldn't be sure it would work for them once they got sick. Policies typically didn't cover key benefits, such as prescription drugs, mental health, or maternity care. And if people made large claims, they could find it hard to stay covered. Renewal premiums could skyrocket. Insurers also engaged in post claims underwriting, investigating a condition to see if it existed even undiagnosed before the policy, and if so, denying claims for the preexisting condition.

Premiums on average were cheaper before the ACA. But there was a lot of variation around that average. And the cheapest premiums were only available to people while they were young and healthy. The ACA made a lot of changes. It required insurers to take everybody and offer policies that cover essential health benefits at premiums that don't vary based on health status. To make that affordable, the ACA added subsidies. Last year, more than 9 million people bought nongroup policies with the help of premium tax credits.

Subsidies also stabilize the market, helping people buy regardless of health status, and they effectively absorb premium increases from year to year for people who are eligible. Of course, nearly 4 million other unsubsidized individuals were enrolled in ACA policies last year, mostly bought outside of the marketplace. And, for them, rising premiums are harder to afford and enrollment by unsubsidized individuals has been declining.

Why are premiums rising? Uncertainty is the key underlying reason. Insurers didn't know how to price for this in market when it opened. Most set premiums low and lost money in the first 3 years. Rates then increased substantially in 2017, a one-time correction, according to insurer rate filings, but then new sources of uncertainty arose.

The Trump administration ended payments to insurers for cost-sharing subsidies they are required to provide through the marketplace. Insurers responded with so-called silver loading, raising the premiums for silver plans twice as much in 2018 as for bronze and gold plans. For 2019, for the first time we saw national average premiums for the benchmark marketplace plan decline by about 1 percent. Even so, premiums this year are higher than they would have been by about 6 percent due to two new factors: Repeal of the ACA individual mandate penalty and competition from short-term policies.

Short-term policies are exempt from ACA market rules. They will deny coverage to people who are sick. They will terminate coverage for people when they get sick. And typically they covered fewer benefits. They are also cheaper, but only for healthy people. Competition by short-term plans threatens stability of the ACA risk pool. Initially that threat was limited because regulations required

the term of short-term policies to be short, less than 3 months; they weren't eligible for subsidies; and they didn't satisfy my mandate, so people who bought these to save money were at risk owing a tax penalty.

But now the mandate penalty is gone. The new Trump administration regulations allow short-term policies to last up to 12 months. And other guidance on ACA waivers now give States a path to promote the sale of these policies and even shift some Federal subsidy dollars to them.

How markets might evolve under these and other changes remains to be seen. Further steps to divide the risk pool can make cheaper options available to some people while they are healthy, but that strategy won't increase choices for people who have health conditions, and it will increase premiums for the ACA-compliant plans on which they rely.

Protections for people with preexisting conditions have become a defining feature of the ACA, and they enjoy strong public support, our polling shows, by Democrats and Republicans, and by people with preexisting conditions, and those who haven't developed them yet. Most Americans want health insurance to work for people when they get sick.

Thank you, and I am happy to take your questions.

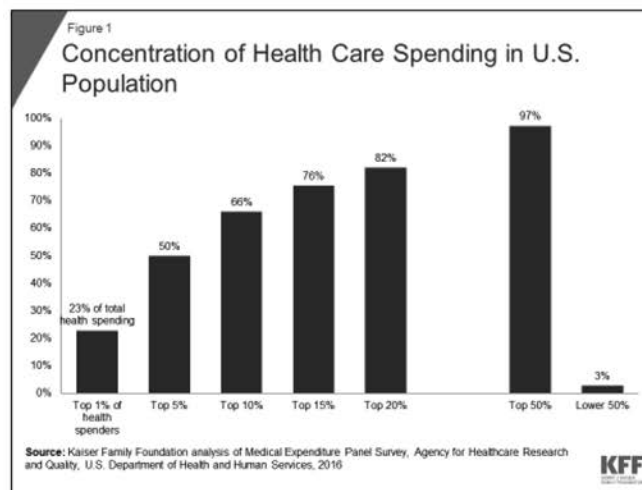
[The prepared statement of Ms. Pollitz follows:]

Good morning, Chairman Neal, Ranking Member Brady, and Members of the Committee.

Thank you for inviting me to testify about health insurance for people with pre-existing conditions. I am Karen Pollitz, a Senior Fellow at the Kaiser Family Foundation. We are a non-profit organization, serving as a non-partisan source of health policy analysis and journalism for policymakers, the media, the health policy community and the public. We not associated with Kaiser Permanente or Kaiser Industries.

Pre-existing Conditions and Health Insurance

In the most basic sense, a pre-existing condition is a health condition that a person has. Most people are healthy most of the time, but when a serious condition strikes, health care can be costly. In any given year, the sickest 1% of people account for nearly one-quarter of total population health spending, while the healthiest 50% account for just 3% of health spending. (Figure 1)



Kaiser Family Foundation has estimated that 52 million non-elderly adults (27%) have so-called “declinable” pre-existing conditions in a year.¹ These conditions – such as cancer, HIV/AIDS, diabetes, and pregnancy – are among the most costly conditions and those on which private insurers in the non-group market in most states routinely based decisions to deny applications for health insurance prior to the ACA. Using a broader definition – that includes less costly conditions such as high blood pressure, high cholesterol, and asthma – the US Department of Health and Human Services estimated 133 million non-elderly Americans have pre-existing conditions in any given year.²

Very few people could self-finance care for expensive conditions such as cancer, heart disease, or even a routine pregnancy. Instead, most non-elderly Americans rely on private health insurance to collectively finance care.

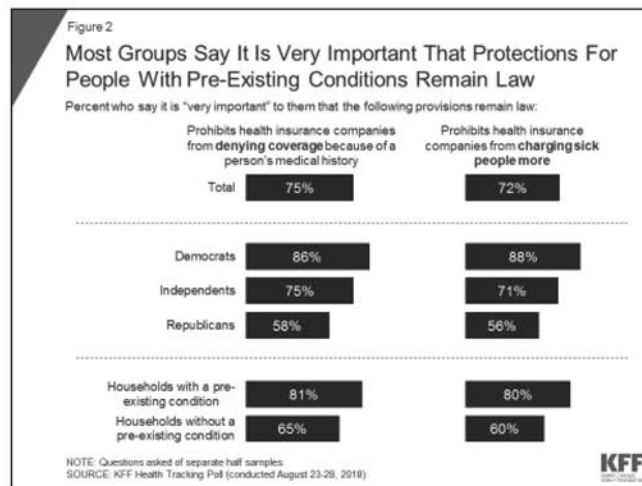
A number of provisions were included in the Affordable Care Act (ACA) to ensure that private coverage will be available and affordable, including to people when they have pre-existing conditions.

Prohibition of Medical Underwriting in the ACA

Before the ACA, insurer medical underwriting practices created barriers to getting and keeping coverage for people with pre-existing conditions, especially in the non-group insurance market. A KFF survey of private insurers prior to the ACA found that even people with mild health conditions such as hay fever could have their application denied, or their premiums surcharged, or they could be offered a policy that permanently excluded coverage for their health condition or the affected body part or system (e.g., in the case of hay fever, respiratory system.)³ By contrast, under federal law today,

- Group and individual health insurance policies must be sold on a guaranteed issue basis and must be guaranteed renewable. People cannot be turned down or have coverage cancelled based on health status.
- No private group plans or individual health insurance policies can impose pre-existing condition exclusion periods.
- Premiums for policies sold in the individual and small group market use modified community rating. Policy premiums can vary based only on four factors: family size, geography, age (up to 3:1 ratio) and tobacco use (up to 1.5:1). Premiums cannot vary based on a consumer’s health status or other factors. Insurers also must set rates based on a single risk pool.⁴

Our tracking polls find strong, bipartisan support for these provisions. (Figure 2)



Providing more accessible and comprehensive coverage to people with pre-existing conditions costs money, and the result has been higher average premiums in the non-group market, compared to premiums for non-group plans prior to the ACA.

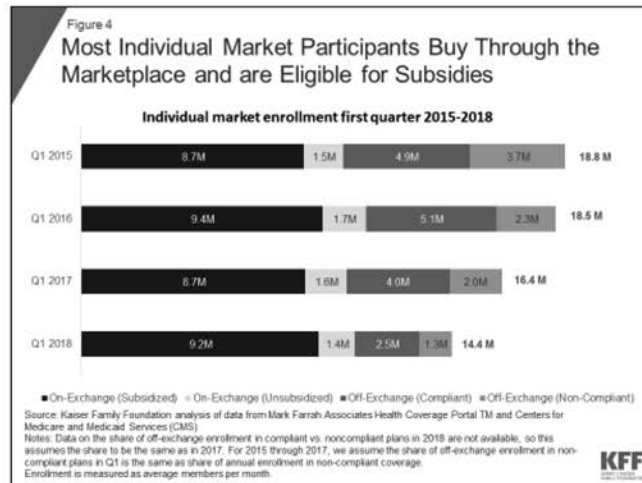
Other ACA provisions Help Stabilize the Insurance Risk Pool

In addition to the ACA market rules, other key provisions under the law also serve to encourage people to participate in coverage and to curb adverse selection.

Premium subsidies – As of June 2018, 9.2 million, or 87% of individuals enrolled in non-group policies in the marketplace received premium tax credits to make the monthly cost of coverage more affordable. Subsidies are key to stabilizing the risk pool. That is because consumers will tend to compare the cost of coverage to their expected health care costs as they make their enrollment decisions. Subsidies generally allow more people to buy health insurance, and they lower this ratio of premium costs to expected health costs for healthier individuals. Year to year, premium subsidies also shield eligible consumers from premium increases. Since the marketplaces opened, the national average premium for the benchmark silver plan has increased by about 75%, though premium tax credits absorbed this increase for subsidy-eligible individuals. (Figure 3)



This, in turn, has helped stabilize enrollment in the marketplace. The number of subsidized marketplace enrollees has held relatively steady, even while premiums have increased. However, consumers not receiving subsidies have felt the full brunt of these premium increases, and enrollment in this group has dropped significantly. (Figure 4)



Minimum coverage standards - ACA-compliant policies in the individual and small group market must cover 10 categories of essential health benefits (EHB), such as hospitalization, physician care, maternity care, mental health and substance abuse treatment, and prescription drugs. In addition, the ACA limits annual cost sharing (copays, deductibles, etc.) for essential health benefits provided in-network. These coverage standards had an important definitional effect – essentially they defined ACA-compliant policies as providing major medical coverage. Prior to the ACA, federal law had defined health insurance as any policy sold by health insurance companies, with some exceptions. Policies in the non-group market before 2014 routinely excluded or limited coverage for maternity care, mental health and substance abuse care, and prescription drugs.⁵ Since the ACA, people with serious health conditions can buy non-group policies that cover the care they need, though premiums are also higher as a result.

Also, importantly, the ACA coverage standards limit adverse selection based on benefit design. Without this standard, consumers might self-select into plans offering coverage for only the services they expect to use (e.g., only people planning to have a baby would select policies covering maternity care; only people with HIV or high medication needs would select policies covering prescription drugs), resulting in sicker people paying higher premiums than healthier people.

Individual mandate – The ACA required most Americans to have health coverage or pay a tax penalty. Congress repealed the tax penalty effective for January 1, 2019. Although the individual mandate was never a leading reason why people sought health insurance, it did create a reinforcing incentive for healthy individuals to be covered.⁶ As discussed below, with repeal of the mandate penalty, at least some healthy individuals are more likely to forego coverage, causing upward pressure on premiums.

Relaxing ACA Requirements Involves Tradeoffs

A significant number of people who buy ACA-compliant non-group health insurance – 3.9 million last year – do not receive subsidies. For them, rising premiums present serious affordability concerns. Two recent actions present these and other consumers with new options, but also have the demonstrated effect of increasing premiums for ACA-compliant plans.

Reducing the individual mandate tax penalty to zero - As part of the 2017 tax reform legislation, and following months of debate over repeal and replacement of the ACA, Congress reduced the individual mandate penalty to \$0 effective in 2019. It is likely this year that at least some individuals will forego health insurance as a result. Those most likely to do so would be individuals who struggle to pay health insurance premiums, particularly those who are not eligible for subsidies, and those who are younger and in good health, for whom doing without coverage feels less risky.

Promoting availability of short-term health insurance – Last year, the Trump administration issued regulations to allow more loosely regulated plans – short-term limited duration insurance (STLDI) – to expand and compete with ACA-compliant non-group coverage.⁷ These more loosely regulated plans offer lower premiums for some people who are not eligible for premium tax credits.

With respect to STLDI, prior regulations governing these policies had required that they could provide only short-term coverage, defined as a term of less than 3 months. The new regulations re-define short-term policies as providing coverage for a term of less than 365 days, and, with renewals – at the option of the insurer – up to 36 months. This change could make short-term policies appear to consumers to be a more comparable alternative to ACA-compliant non-group policies, even though the protection STLDI policies offer is not the same.

ACA market rules for other individual health insurance policies do not apply to STLDI, and as a result, short-term policies raise multiple barriers to coverage for people with health conditions. First, issuers of short-term policies can and will deny applicants with pre-existing conditions. Second, STLDI policies typically exclude or severely limit coverage for some ACA essential health benefits, including prescription drugs, maternity care, and mental health and substance use treatment.⁸ Third, STLDI policies exclude coverage of all benefits related to pre-existing conditions. Healthy applicants who develop health conditions once covered risk having claims denied if the insurer can establish the condition existed (even undiagnosed) prior to enrollment. Finally, because STLDI policies are not guaranteed renewable, policyholders who get sick will likely find coverage terminates without the option to renew at the end of the policy term.

These differences mean short-term policies can be offered at much lower premiums. We estimate that, on average, STLDI policy premiums are 54% lower than premiums for ACA-compliant plans.⁹ Importantly, this lower cost option is not available to people with pre-existing conditions. They can continue to rely on ACA-compliant plans, but will have to pay even higher premiums if they are not subsidy-eligible due to a worsening of the risk pool as a result of STLDI plans pulling healthier than average people out of the ACA-compliant market.

By law, STLDI policies are not considered “minimum essential coverage,” which is required to satisfy the ACA individual mandate. While the individual mandate penalty remained in effect, consumers considering short-term plans because of their lower premiums had to take into account the offsetting cost of the tax penalty. With the mandate tax penalty eliminated and under the new STLDI regulations, it is likely more people will buy short-term policies instead of ACA-compliant policies; and insurers have factored this change into their rates for ACA-compliant plans. Analysis by KFF of rate filings by non-group

market health insurers finds that 2019 premiums are, on average, 6% higher than they would otherwise be due to changes in the mandate penalty and expected expansion of short-term policies.¹⁰

Future Actions Could Affect Coverage for Pre-existing Conditions

Recent Trump Administration [guidance on ACA Section 1332 waivers](#) raises the possibility that states could take further steps to promote the sale short-term health insurance policies and even shift federal subsidy dollars from marketplace policies into these less-regulated plans.¹¹ Under Section 1332, states can apply for waivers of certain ACA requirements in order to pursue other coverage strategies. Federal law includes so-called guardrails requiring that state waivers cover at least as many people at least as affordably and comprehensively as would be the case in the absence of a waiver.

The 2018 Administration guidance changes administrative standards for measuring compliance with 1332 guardrails and gives CMS broader discretion to determine whether a state waiver meets the law's requirements. In particular, the new guidance encourages greater reliance on short-term policies as a source of coverage. It makes clear that people enrolled in such plans would still be counted as "covered" in evaluating whether the waiver program results in at least as many residents having coverage. In addition, under the new waiver guidance, states could shift at least some federal subsidy resources out of the ACA marketplace to instead provide subsidies for the purchase of ACA non-compliant plans. Reducing marketplace subsidies would make the cost of ACA-compliant plans less affordable for people who rely on them. This could prompt more people to drop marketplace coverage, increasing instability in the market.

The new waiver guidance offers states a pathway to pursue changes under the ACA similar to those that Congress debated, but could not enact, during the ACA repeal-and-replace debate in 2017. How states might respond to the new waiver guidance, and how the Trump Administration might act on any new state waiver applications remains to be seen.

Summary

In summary, the ACA substantially changed private health insurance so it would cover people with pre-existing conditions. Insurance that covers sick people and the care they need will cost more than coverage that does not. Subsidies make the cost of ACA-compliant plans more affordable, but not all consumers are eligible and, for them, affordability concerns are rising.

Relaxing ACA protections for pre-existing conditions can make cheaper coverage available to some, though at other costs. Coverage that is less expensive for people only while they are young and healthy, puts the same people at risk once they get sick. Strategies based on dividing the risk pool drive up the cost of plans that do cover people with pre-existing conditions. Our polling suggests that most Americans want health insurance to work for people when they get sick.

End Notes

¹ Kaiser Family Foundation, “Pre-existing Conditions and Medical Underwriting in the Individual Insurance Market Prior to the ACA,” December 2016.

² US Department of Health and Human Services, “Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act,” January 5, 2017.

³ Kaiser Family Foundation, “How Accessible is Individual Health Insurance for Consumers in Less-Than-Perfect Health?” June 2001.

⁴ The ACA requires insurers to determine premiums for compliant policies using a single risk pool that includes all such plans, both inside and outside of the marketplace, offered within a state. As a result, premiums for all compliant policies reflect the average expected costs of everyone in the single risk pool; this requirement spreads the cost of the most expensive individuals across the entire risk pool.

⁵ Kaiser Family Foundation, “Would States Eliminate Key Benefits if AHCA Waivers are Enacted?” June 2017.

⁶ Kaiser Family Foundation, “Poll: Survey of the Non-Group Market Finds Most Say the Individual Mandate Was Not a Major Reason They Got Coverage in 2018, And Most Plan to Continue Buying Insurance Despite Recent Repeal of the Mandate Penalty,” April 2018.

⁷ In 2018, the Administration also published regulations permitting the sale of new association health plans (AHPs), which could be offered to self-employed individuals who otherwise buy coverage in the non-group market. AHPs would not be allowed to deny applicants or charge more based on health status, and would not be allowed to impose pre-existing condition exclusion periods. AHPs would be exempted from the requirement to cover 10 essential health benefits however. To the extent consumers could choose, based on their health status, between plans offering materially different benefits, adverse selection could result, and this could drive up premiums for ACA-compliant policies in the non-group market.

⁸ Kaiser Family Foundation, “Understanding Short-Term Limited Duration Health Insurance,” April 2018.

⁹ Kaiser Family Foundation, “Why Do Short-Term Health Insurance Plans Have Lower Premiums Than Plans That Comply with the ACA?” October 2018.

¹⁰ Kaiser Family Foundation, “How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums,” October 2018.

¹¹ Kaiser Family Foundation, “New Rules for Section 1332 Waivers: Changes and Implications,” December 2018.

Chairman NEAL. Thank you, Ms. Pollitz.

Now we would like to recognize Mr. Stolfi. Would you please begin?

STATEMENT OF ANDREW R. STOLFI, INSURANCE COMMISSIONER AND ADMINISTRATOR OF THE DIVISION OF FINANCIAL REGULATION, OREGON DIVISION OF FINANCIAL REGULATION

Mr. STOLFI. Chairman Neal, Ranking Member Brady, Members of the Committee, thank you for inviting me today for this important discussion. My name is Andrew Stolfi, and I am the Insurance Commissioner and Administrator of the Oregon Division of Financial Regulation.

Since Oregon implemented the major provisions of the Affordable Care Act, more than 340,000 Oregonians have gained health insurance, and our uninsured rate has dropped from a high of more than 17 percent to about 6 percent. Today more than 3.7 million Oregonians, 94 percent of the State, are covered by health insurance, and our goal is to maintain coverage for 99 percent of adults and 100 percent of children.

Governor Brown's vision and our goal is not just a number; it is for all Oregonians to have quality, affordable healthcare, regardless of who they are or where they live. The ACA has greatly advanced this goal, and we urge this Congress to protect the gains that have been made while continuing to work toward bending the cost curve for consumers.

Oregon's health insurance market has traditionally been competitive and offered choice. We have also been a leader in implementing progressive consumer-focused health reforms. However, despite our best efforts, our uninsured rate in 2009 was higher than the national average at more than 17 percent. Oregonians seeking insurance in the individual market also experienced high rates of denials based on preexisting conditions. In 2007, the denial rate was about 30 percent.

And when an individual policy was issued, it could exclude or limit coverage in a myriad of ways. The ACA helped change all of this, particularly for those with preexisting conditions. More than 1.6 million American Oregonians with preexisting medical conditions are protected from coverage denials or limitations. Pregnant mothers know they can get the care they and their babies need. And children with developmental disabilities can get all the essential therapy they need to grow to their fullest potential.

We have individual health policies offered by at least two carriers in each of our counties and are one of the first States to implement our reinsurance program that has kept individual insurance rates about 6 percent lower than they would be without. These numbers reflect the work that has been done in Oregon to provide stability to the State's health insurance market. Unfortunately, other numbers demonstrate the harm recent Federal actions have caused.

Federal rule changes to short-term limited-duration plans and association health plans, along with zeroing out of the individual mandate penalty have raised 2019's individual health insurance rates about 7 percent. Cutting off funding for cost-sharing reduc-

tions has added another 7 percent to 2019 silver rate plans, meaning that rates in Oregon in 2019 are between 7 and 14 percent higher than they could have been without unnecessary and avoidable Federal uncertainty.

The true harm, however, would come if challenges to the ACA were successful and we lost the consumer protections it created for people with preexisting conditions. These protections require a comprehensive set of interlocking laws that work together like spokes in a wheel. For an individual with a preexisting condition, these spokes fit together like this: Guaranteed issue lets you buy a policy you need. Community rating prevents you from being charged more just because of your condition. Guaranteed renewability prevents an insurer from canceling your policy if you use its benefits. A ban on preexisting condition exclusions ensures that your policy covers the treatment you need. Preventive services can keep your problem from getting worse. Essential health benefits ensure that all the treatments you need are covered, and a ban on annual and lifetime dollar limits protects you from crippling out-of-pocket expenses when you use your essential benefits.

Oregon's experience pre-ACA shows why each of these elements are essential and work together to protect individuals with preexisting conditions. In 2009, we technically had some protections for individuals with preexisting conditions, however, within these meager protections, insurers had ample room to limit their risk exposure and control costs.

A pregnant woman could be denied coverage. Treatment for a preexisting condition could be limited. Miniscule benefit limitations could be imposed, and necessary prescription drugs were not required to be covered. For those with preexisting conditions, you were lucky if you were even given the choice to take an insurer's limited terms.

In conclusion, the ACA has helped to provide Oregonians and their families with access to comprehensive healthcare. It has greatly reduced our uninsured population, created tens of thousands of new jobs, and saved hospitals hundreds of millions a year in uncompensated care. More people are healthier than they would be without it.

Unfortunately, uncertainty at the Federal level has threatened our work and unnecessarily added cost to the system. Access to affordable healthcare is important for everyone, and it is time we stop dismantling the gains we have made and focus more on innovative solutions to control cost and maintain a stable health insurance market.

Under Governor Brown's leadership, we will continue to protect consumer's access to healthcare through the ACA. We will continue to build on our successes, fight to increase access, and search for ways to make insurance affordable for everyone.

[The prepared statement of Mr. Stolfi follows:]



United States House of Representatives
Committee on Ways and Means
Protecting Americans with Pre-Existing Conditions

Testimony of

Andrew R. Stolfi
Insurance Commissioner and Administrator
Division of Financial Regulation
Department of Consumer and Business
Services State of Oregon

January 29, 2019



Introduction

Chairman Neal, Ranking Member Brady, and members of the Ways and Means Committee, thank you for inviting me today for this important discussion. My name is Andrew Stolfi and I am the insurance commissioner and administrator for the Oregon Division of Financial Regulation.

My division is a part of the Department of Consumer and Business Services, which is Oregon's largest consumer protection and business regulatory agency. The Division of Financial Regulation protects consumers by regulating insurance, banks, credit unions, trust companies, securities, and consumer financial products and services.

Since Oregon implemented the major provisions of the Affordable Care Act (ACA), more than 350,000 Oregonians have gained health insurance. The uninsured rate in the state has dropped more than 11 percent, from a high of more than 17 percent to about 6 percent. Today, more than 3.7 million Oregonians, 94 percent, are covered by health insurance and our goal is to maintain coverage for 99 percent of adults and 100 percent of children.

Governor Brown's vision and our goal is not just a number – it is for all Oregonians to have quality, affordable health care, regardless of who they are or where they live. The ACA has greatly advanced this goal, especially for people with pre-existing health conditions, and we urge this Congress to protect the gains that have already been made while continuing to work towards bending the cost curve for consumers.

Oregon's health insurance market prior to the ACA

Oregon's health insurance market has traditionally been competitive and offered consumers choice. For example, in 2009,¹ Oregon's seven largest health insurers earned 90 percent of the premiums in the individual health market. This contrasted with many other states in which a single insurance company dominated the market.

Oregon has also been a leader in implementing progressive, consumer-focused health reforms. Health insurance rates in the individual and small group markets required division approval years before the ACA. Health insurers have also been required to file individual and group health policies, or forms, with the division and obtain approval of each form before offering it to consumers. Through its review, the division ensures that the forms include all required policy provisions and mandated benefits, and do not contain provisions that are unjust, unfair, or inequitable.

¹ For purposes of this testimony, unless otherwise noted, 2009 is being used as a baseline for pre-ACA references due to it being the last full year before ACA reforms were adopted.

Before the ACA, Oregon law also contained several consumer protections limiting an insurance company's ability to use a consumer's health status in the issuance or renewal of a policy, including:

- › **Standard health statement.** Companies selling individual policies were required to use a division-approved questionnaire to obtain the health history of an applicant. The statement limited the "look back" period to five years.²
- › **Pre-existing conditions.** Based on responses to the standard health statement, companies could decline to offer coverage due to an applicant's health history. However, if a policy had a pre-existing condition exclusion or waiver, i.e. denial of coverage for specific conditions, it could only be imposed for a specific period of time ranging up to 24 months.
- › **Rating restrictions.** Companies were prohibited from basing premium rates on an individual's health or claims experience – age was the only individual characteristic that could influence a rate and rates could only be increased once a year.
- › **Guaranteed renewability.** Companies were required to renew an individual plan as long as the individual continued to make the required premium payment, regardless of the individual's health claims during the preceding policy year.

While Oregon may have been ahead in some areas, as shown in the following table, the state's uninsured rate in 2009 was higher than the national average at more than 17 percent.

	2009	2018
Type of Coverage	Individuals (share of Oregonians)	Individuals (share of Oregonians)
Individual	193,000 (5.2%)	188,000 (4.5%)
Portability	21,000 (0.6%)	0 (0%)
Small Group	228,000 (6.1%)	175,000 (4.2%)
High Risk Pool	15,000 (0.4%)	0 (0%)
Large Group ³	1,128,000 (30.2%)	1,643,000 (39.2%)
Associations, Trusts & Other	213,000 (5.7%)	235,000 (5.6%)
Medicare	602,000 (16.1%)	831,000 (19.8%)
Medicaid	475,000 (12.7%)	980,000 (23.4%)
Uninsured	647,000 (17.3%)	279,000 (6.8%)

Fig. 1. Oregon health insurance enrollment comparison⁴

² But it was extremely broad, asking if an applicant "had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional, or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery, or hospital confinement related to any of" nearly 50 listed conditions.

³ Including fully insured and self-insured.

⁴ Enrollment numbers do not total 100 percent of Oregon's population because the numbers are rounded to the nearest thousand and come from several sources. The uninsured rate in the 2018 column reflects the rate in 2017 as the 2018 number is not available at the time of writing.

Without a comprehensive set of consumer protections such as those found in the ACA, insurers were free to limit individual market coverage, and therefore their risk exposure, using a number of methods. Examples include:

- › Annual and lifetime dollar limits to significantly restrict treatments – one insurer had a \$1,000 calendar year limit for speech therapy and, in one policy, mental health benefits were limited to a lifetime maximum of \$1,000.
- › Excluding or limiting coverage for prescription drugs. Insurers were not required to provide coverage for prescription drugs, allowing them to restrict treatment of certain conditions.
- › Exclusion of essential health benefits such as rehabilitation or offering the benefits as an add-on to those who paid extra. Other benefits such as chemical dependency and alcohol treatment, durable medical equipment (e.g. hospital beds, wheelchairs and crutches), outpatient mental health services, cardiac rehabilitation, and outpatient pulmonary rehabilitation were either excluded or extensively limited.
- › Condition-specific treatment limitations or exclusions so that a policy might cover physical, occupational, and speech therapy for stroke patients but not for children with developmental disabilities.

Oregonians experienced high rates of denials based on pre-existing conditions – a 2007 division report revealed the denial rate was about 30 percent.

For those unable to obtain a policy, the state operated a high-risk pool, the Oregon Medical Insurance Pool, which was funded by premiums as well as carrier assessments of around \$4 per member/per month. Residents who had certain identified pre-existing conditions were eligible, and the premium rates were up to 25 percent higher than individual market rates.

Oregon's health insurance market post-ACA

Although there is more work to do, the ACA has brought important benefits to Oregon, particularly for those with pre-existing conditions who previously faced high costs or coverage limitations. About 94 percent of Oregonians and 98 percent of Oregon children have health insurance coverage, with our uninsured rate dropping almost 11 percent since 2009. Approximately 115,000 Oregonians qualify annually for tax credits that, on average, reduced on-exchange premiums in 2018 by about \$315 a month. Oregon hospitals have saved millions in uncompensated care – falling from \$1.28 billion in 2013 to \$476 million in 2015 – and we added 23,000 new health care jobs from 2013 to 2016.

More than 1.6 million Oregonians with pre-existing medical conditions are protected from coverage denials or limitations. Pregnant mothers know they can get the care they 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.

Individual policies are offered by at least two carriers in each of our 36 counties, with seven carriers offering plans on the individual market and nine in the small group market. In 2019, we are even seeing expansion into new markets by two carriers. Oregon is also one of the first states to implement a reinsurance program under Section 1332 of the ACA. The Oregon Reinsurance Program leverages federal and state funds to keep individual insurance rates about 6 percent lower than they would be without.

These numbers reflect the work that has been done in Oregon to provide stability to the state's health insurance market. After a few years of adjustment, our market was maturing and stabilizing. Large individual market rate increases in 2016 (23 percent) and 2017 (27 percent) have been followed by smaller increases in 2018 (13 percent) and 2019 (7 percent). This follows a positive trend in insurer net profits, which moved from negative \$217 million in 2015 and negative \$35 million in 2016 to plus \$195 million in 2017.

Unfortunately, other numbers demonstrate the harm recent federal actions have caused Oregonians. Federal rule changes to short-term, limited-duration plans and association health plans along with zeroing out the individual mandate penalty have raised 2019 individual health insurance rates about 7 percent. Cutting off funding for cost-sharing reductions has added another 7 percent to 2019 silver plan rates, meaning individual health insurance rates in Oregon are about 7 to 14 percent higher in 2019 than they could have been without unnecessary and avoidable federal uncertainty.

Looked at another way, as the table below shows, 2019 individual health insurance rate increases for four of our seven carriers are lower than medical trend. Without the harm caused by federal uncertainty, virtually every Oregonian in the individual market would have seen rate increases in 2019 lower than medical trend.

Company	Medical trend (2019)	Additional Rate Increase Attributed to Federal Uncertainty (2018)	Additional Rate Increase Attributed to Federal Uncertainty (2019)	Final 2019 Individual Health Rates	Individual Health Enrollment Sept. 2018 ⁵
Providence	7.6%	5.1%	2.8%	9.5%	83,590
Kaiser	4.0%	2.4%	5.5%	9.4%	41,139
Moda	8.0%	2.4%	1.9%	6.3%	37,861
PacificSource	5.7%	2.4%	2.5%	-9.6%	12,513
Regence	6.5%	5.1%	2.8%	0.0%	3,925
BridgeSpan	6.5%	5.1%	2.8%	4.5%	984
Health Net	6.2%	2.4%	1.9%	10.1%	550

Fig. 2. Some components of individual health insurance rate changes in Oregon

⁵ Latest time period available at time of writing.

Protecting individuals with pre-existing conditions: Many spokes in a wheel

Pre-existing conditions can be as common as allergies or as serious as cancer and affect millions of people nationwide, including more than 1.6 million Oregonians. The ACA's consumer protections are critically important to ensuring that Americans can access the healthcare they need, regardless of health conditions they did not choose to have or develop.

Providing protection for people with pre-existing conditions requires a comprehensive set of interlocking laws that work together like spokes in a wheel – any single one would be inadequate on its own. The most important of these protections work together as follows:

- › **Community rating** prohibits an insurer from basing a premium on an individual's health status or gender. A premium may vary only based on age, tobacco use, geographic rating area and whether it is for an individual or family.
- › **Guaranteed availability** requires an insurer to accept anyone who applies for a policy, without regard to the person's health status.
- › **Guaranteed renewability** requires insurers to renew a policy at the discretion of the policyholder and regardless of claim experience during the preceding year.
- › **Ban on pre-existing condition exclusions** prevents an insurer from denying, limiting, or excluding coverage of a specific health care service on the basis of a person's health status.
- › **Annual and lifetime dollar limits** cannot be imposed on any essential health benefits, therefore protecting an individual from having insurance, but not healthcare.
- › **Preventive health services**, such as immunizations, must be provided at no cost. Preventive care helps people stay healthy, avoid or delay the onset of disease, and keep health care costs down.
- › **Essential health benefits** must be covered. Many of these benefits, such as maternity care, mental health and substance use disorder services, prescription drugs, and rehabilitative and habilitative services⁶ were either not covered or covered with significant limitations pre-ACA.

Looked at another way, for an individual with a pre-existing condition these spokes fit together like this:

Guaranteed issue lets you buy a policy you need, **community rating** prevents you from being charged more just because of your condition, **guaranteed renewability** prevents an insurer from cancelling your policy if you use its benefits, a ban on **pre-existing condition exclusions** ensures that your policy covers the treatment you need, **preventive services** can keep your problem from getting worse, **essential health benefits** ensure that all the treatments you need are covered, and a ban on **annual and lifetime dollar limits** protects you from crippling out-of-pocket expenses when you use your essential benefits.

⁶ Services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills.

Oregon's experience pre-ACA shows why each of these elements are essential and work together to protect individuals with pre-existing conditions.

In 2009, we technically had protections for individuals with pre-existing conditions. Insurers could not charge a higher premium because of your health status or claims history, were required to renew a policy (if premiums were paid) even if you got sick, could consider only five years of health history, and could not permanently limit coverage for a pre-existing condition. However, within these meager protections, insurers had ample room to limit their risk exposure and control costs.

First, individuals with pre-existing conditions, including pregnant women, could outright be denied a policy. A state high-risk pool existed if you had one of a list of specific conditions, but it cost up to 25 percent more than individual commercial health insurance, had a waiting list, and could exclude coverage of pre-existing conditions – the reason you needed the high-risk pool – for up to six months.

If an individual policy was issued, it could:

- › Limit treatment for a pre-existing condition for up to 24 months – a clearly unworkable situation for an individual with diabetes.
- › Impose miniscule limitations on benefits, e.g., lifetime limits of \$1,000 on mental health benefits and pulmonary rehabilitation, making coverage essentially meaningless for those who needed it.
- › Provide coverage of the same treatment for one disease but not another – e.g. a policy could cover speech therapy after a stroke but not for children with developmental disabilities.
- › Not include any prescription drug coverage or, when it was, include exclusions or limitations for a myriad of conditions.
- › Exclude or limit coverage for individuals with injuries from “high-risk activities” such as skiing, snowboarding, and horseback riding.

Even with these risk-controlling mechanisms, over time, a pool of individuals with the same policy could grow too unhealthy, and therefore too expensive. In response, an insurer could discontinue that policy and force all the individuals who had it to choose between a suggested new plan with the same insurer, most likely with fewer benefits and higher costs, or to submit to a new medical questionnaire to get another plan. For those with pre-existing conditions, the choice was to take an insurer's limited terms or likely live without insurance.

Conclusion

The ACA has helped provide Oregonians and their families with access to comprehensive health care. It has greatly reduced our uninsured population, created tens of thousands of new jobs, and saved hospitals hundreds of millions a year in uncompensated care. More people are healthier than they would be without it.

Unfortunately, uncertainty at the federal level has threatened our work and unnecessarily added costs to the system. Oregonians with pre-existing conditions face the greatest uncertainty if the strides we have taken since 2009 are suddenly erased, but this is not just a problem for our most vulnerable. Access to affordable healthcare is important for everyone and it is time we focus more on innovative solutions to control costs and maintain a stable health insurance market than on dismantling the gains we have made.

Under Governor Brown's leadership, we will continue to protect consumers' access to healthcare through the ACA. We will continue to build on our successes, fight to increase consumer access, and search for ways to make health insurance in Oregon more affordable for everyone.

Chairman NEAL. Thank you.

Now I would like to recognize Mr. Robertson. Please, begin.

**STATEMENT OF ROB ROBERTSON, CHIEF ADMINISTRATOR/
SECRETARY-TREASURER, NEBRASKA FARM BUREAU FED-
ERATION**

Mr. ROBERTSON. Yes, good morning, Congressman Neal, Congressman Brady, and Members of the Ways and Means Committee. I am Rob Robertson, Chief Administrator for the Nebraska Farm Bureau. We are pleased today to share with you some challenges we see in the individual health insurance markets and also some steps that Nebraska Farm Bureau took to protect those Americans with preexisting conditions.

I have dedicated my entire life to helping farmers and ranchers, and I just honestly couldn't believe what I saw during the summer of 2018. We held listening sessions with our farmer and rancher members, and they, literally, got up in tears talking about their challenges of how they are coping with the health insurance markets and the individual market. And the emotional stories were many. I mean, farmers and ranchers and spouses got up and said, you know, I am forced to work off the farm because of the high cost of health insurance.

We heard about farm and ranch families not taking out any health insurance and then having major medical bills during the year. We heard that the highest living expense for the farm is health insurance. The stories were all over the board. We heard common reports of annual premiums being \$30,000 to \$35,000 to \$36,000 a year. That is \$3,000 a month. And I am sure Congressman Adrian Smith heard similar stories throughout his travels in Nebraska as well.

But what makes matters worse is farmers and ranchers, more than any other sector or occupation in the country, are more affected by the high cost of the individual health insurance markets than any other sector because the lion's share of farmers and ranchers are self-employed. And if you are self-employed, you generally buy on the individual market where the costs are high and you are not able to be a part of a large group. This is not a partisan issue. This is not a political issue. This is an issue of hardship. And we need to fix these individual markets and try to find some ways to protect preexisting conditions at the same time.

Because of these issues with our members, the Nebraska Farm Bureau took matters into our own hands. In 2017, we began to establish an association health plan with our organization. By the fall of 2018, we implemented and started enrollment. It never would have happened without the wonderful partnership we had with the insurance carrier Medica, based out of Minneapolis, Minnesota. They partnered with us, and the plan offered a more affordable health insurance product, which on average was 25 percent less than the individual marketplace for members of our large group in our association health plan. It covers preexisting conditions. And let me repeat that: It covers all members regardless of their health status in our association health plan. And it was ACA compliant.

The plan is what our members wanted and is what we delivered. In creating the association health plan, we deeply believed it was imperative to cover preexisting conditions, and that is what we did. Let me be clear: That is not an attack on the ACA; that is a companion to the ACA by providing our members with another insurance option.

And our results: Coming out of the first year, we had almost 700 members sign up for the association health plan; they saved millions of dollars in premium costs; and then we continue to hear a lot of interest this coming year for sign-up for the next enrollment period, starting in 2019 for the 2020 year. From a policy standpoint, one of the best ways we can protect Americans with preexisting conditions is to enhance the ability of individuals to band together, pool their risk, and form large groups that are fully insured. That is what the AHP, our association health plan, did.

In our case, many of our members are self-employed. The only way we were going to be able to form this association health plan was because of the new association health plan regulation issued by the Department of Labor last summer. If it wasn't for those new regulations, we would not have an association health plan for our members.

Let me share a quick example with you on the impact this association health plan had on members. Our first enrollees out of the gate, a husband and wife who farm together near Fairbury, Nebraska, in 2018, their annual cost on the individual market was \$25,000. They are told in 2019 it was going to be \$26,000 a year. Under our plan in which they signed up, it was \$19,000. They saved \$7,000, and that is real money.

How do we get this discounted rate? You know, farmers and ranchers are now a part of a large group, rated as a large group. And when you rate as a large group, you can spread the risk out, you can lower administrative costs, and you can do a little bit more with pricing in terms of risk-adjustment factors.

My testimony provides a lot of eligibility criteria on how to be a part of our association health plan. In general, you have to be in a similar line of business to be a part of that, so we designated and targeted farmers and ranchers and agribusinesses, and it is ACA-compliant on what it covers.

Our organization represents farmers and ranchers with an average age approaching 60. We strongly support the continuation of health plans that cover preexisting conditions. The key is to provide innovative policy solutions to allow for those types of things like the association health plans to be a part of how we cover preexisting conditions. Hopefully, our plan works. And I appreciate the time from the Committee today, and I will be happy to answer any questions.

[The prepared statement of Mr. Robertson follows:]



Statement of the Nebraska Farm Bureau Federation

**TO THE UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS HEARING ON:**

“PROTECTING AMERICANS WITH PRE-EXISTING CONDITIONS”

January 29, 2019

**Presented By:
Rob Robertson
Chief Administrator/Secretary-Treasurer
Nebraska Farm Bureau Federation**

Chairman Neal, Ranking Member Brady and members of the Committee, thank you for the opportunity to speak with you today. My name is Rob Robertson, and I am the Chief Administrator/Secretary-Treasurer for the Nebraska Farm Bureau Federation (NEFB), Nebraska's largest general farm and ranch organization with over 59,000-member families. I am pleased to offer you our thoughts and inform you on the steps our organization has taken to protect those with pre-existing health conditions.

In August 2009, NEFB issued a news release expressing its concern that health insurance costs could dramatically increase for farmers and ranchers under policies similar to those Congress considered and later included in the Patient Protection and Affordable Care Act (ACA). The news release stated that "A large majority of food producers are self-employed, and many buy their own health insurance without the benefit of being part of a group." We also pointed out that farmers and ranchers would likely suffer the most with any increase in health insurance premiums associated with adoption of some of the policies found in the ACA given farmers and ranchers inability to pass increased costs onto customers, an option available to other businesses.

Today, nearly a decade after passage of the ACA, our concerns about skyrocketing health insurance premiums in the individual market and the impact on farmers and ranchers associated with the ACA have proven to be correct.

Escalating health care and health insurance costs were among the top concerns registered by farmers and ranchers who attended a series of NEFB listening sessions held across the state in the summer of 2018. Whether it was reports of health care premiums becoming the first or second highest living expense, stories of a spouse having to find off-farm work to secure employer provided health insurance, or families (young and old) dropping health care insurance all together, we heard directly from those struggling with how to deal with increasing health insurance costs. In several instances, people were in tears explaining how they wanted to help on the family farm but could not because they were forced to work in town for the sole reason of getting health insurance for their family.

While disheartening, what we heard was not surprising. In the spring of 2017, NEFB conducted a non-scientific survey of NEFB members to gather opinions on their experiences with the ACA as Nebraska eventually lost all but one insurance company in the individual market place because of concerns about the economic viability of such plans. Nearly 850 members participated in the survey. The results clearly showed that farm and ranch families were negatively impacted at a much higher level than their urban cousins in dealing with growth in premiums in the individual market. Nearly 98 percent of the farmers and ranchers surveyed overwhelmingly expressed dissatisfaction with the cost and benefits of their health insurance.

It is through this lens that NEFB began working throughout 2017 and 2018 to develop and eventually offer to our members a first of its kind Association Health Plan (AHP). This plan was provided in partnership with Medica, a health insurance company based out of Minneapolis, Minnesota. In the plan's first year of existence it has helped us offer a quality health insurance option and that has also helped lower costs for farm and ranch families who have been squeezed out of the individual market because of escalating premiums.

In creating this AHP, we deeply believed that it was imperative to cover pre-existing conditions. We wanted to offer great coverage to our farmer/rancher members. In order to attract members to the AHP, we offered health insurance that was reasonably priced and that covered pre-existing conditions. Let me be clear, we do not view our AHP as an attack on the ACA, but a companion to it that provides our member families with another health insurance option that offers them quality care at a reduced cost.

Allowing farmers and ranchers to pool together to form a large health insurance group through the AHP was the best way we could offer this product at a discounted rate from the high costs of premiums in the individual market. Without this ability to form a bona fide large employer group, our farmer and rancher members would be stuck with the high costs and limited options in the individual health insurance market if they can afford them at all.

From a policy standpoint, one of the best ways to protect Americans with pre-existing conditions is to enhance the ability of individuals to band together, pool their risks and form a large group, fully-insured plan using AHPs. In NEFB's case, it is because of the new regulations on AHPs issued by the Department of Labor that allowed us to form a large group health insurance product for farmers, ranchers and those employed in agribusiness.

Most farmers and ranchers are self-employed. The new regulations on AHPs essentially allowed the self-employed farmers and ranchers to qualify as "working owners" which meant they could be classified as both employers and employees under the ERISA requirements for AHPs. Without these new regulations on AHPs and how they treated the self-employed farmers and ranchers, we would have faced greater challenges forming NEFB's AHP and mostly likely would not be offering a plan that is ACA compliant and one that covers pre-existing conditions.

One such example of how our AHP benefits farmers and ranchers comes from a husband and wife who farm together near Fairbury in Southeast Nebraska. They have seen the cost of their health insurance continue to rise, especially over the past two years. With neither working off the farm, two grown and married children, and both being too young for Medicare, it was just the two of them looking for a cost-efficient plan.

In 2018, they paid around \$25,000 for their health insurance coverage. As they are self-employed, they are covering that entire cost themselves. Around a month before signing up for our new plan, they received a letter stating that for their 2019 enrollment, the same exact health plan was going to cost them more than \$26,000 for the year. Now enrolled in our AHP, for the same coverage through the same company, they will be paying just under \$19,000 for the year.

Outside of simply saving money on their premiums, we can also point to numerous examples of enrollees who previously went without health insurance, now entering the health insurance marketplace because of our more affordable plans. Again, our AHP provides our members with another health insurance option in a highly limited and at times unaffordable marketplace.

We believe on average, the expected premium cost of the NEFB Member Health Plan will be 25 percent less than the expected premium cost of the current individual market for farmers and ranchers. The reason is relatively simple; farmers, ranchers, and those employed in agribusiness

are now a part of a large group, which can be rated at lower costs because risks can be pooled and spread out. Also, since our group of farmers and ranchers are rated as a large group employer, there are lower administrative costs and less price defense mechanisms built into the premiums.

To be eligible for our plan, members need to be an active farmer, rancher, or involved in agribusiness as AHPs require that participants be in a similar line of business. More specifically, members of our group must adhere to the following:

- For farmers and ranchers, 50 percent of their gross income must be in production agriculture.
- For agribusinesses, 50 percent of their gross income must come from production agriculture and must provide inputs and services essential to agriculture.
- Be an NEFB member in good standing since July 1, 2018 and maintain their NEFB membership throughout the coverage period.
- Live within the selected network's service area to enroll in and remain in the plan.
- Employers, dependents, and full-time (more than 30 hours) employees only are eligible. Part-time/seasonal employees are not eligible.
- Be a member of the new Nebraska Farm Bureau Employer Insurance Consortium.

Importantly, our AHP, like other fully-insured, "large group," self-insured AHPs, covers a series of requirements including the elimination of all pre-existing condition exclusions. All of these requirements are met per ACA regulations. Also, just like all ACA compliant and individual marketplace plans, ours does not rate participants on their health status. Our AHP rates participants on only geography and age. In terms of coverage, our plan offers coverage for the following items and services:

- Outpatient and inpatient care
- Prescription drugs
- Preventive services
- Laboratory services
- Prenatal and maternity care
- Mental health and substance abuse services
- Emergency room visits
- Rehabilitation and habilitation services

While we can certainly debate the need for some federal mandates, the need for coverage of those with pre-existing conditions is not included on that list. Farmers and ranchers, like everyone else, have in the past been affected by previous limitations on pre-existing medical conditions.

Historically, farmers and ranchers largely purchased their health insurance through the individual marketplace like other entrepreneurs and small business owners. It was and continues to be relatively common for either a spouse or both members of a farm and ranch family to hold another job simply due to need for affordable health insurance coverage. Our organization's goal in supporting the NEFB AHP was to help offer a more affordable health insurance option that

also provided quality coverage, including coverage for pre-existing conditions, for our member families. With only one year under our belt and with just under 700 enrollees, we believe we have done just that, and we are looking forward to offering similar coverage again in future years.

Thank you again for this opportunity to speak with you all today, and I look forward to answering your questions.

Chairman NEAL. Thank you, Mr. Robertson.
Let the Chair recognize Ms. Brooks-Coley. Please, begin.

**STATEMENT OF KEYSHA BROOKS-COLEY, VICE PRESIDENT OF
FEDERAL ADVOCACY, AMERICAN CANCER SOCIETY, CANCER
ACTION NETWORK (ACS CAN)**

Ms. BROOKS-COLEY. Good morning, Chairman Neal, Ranking Member Brady, and Members of the Committee. I am Keysha Brooks-Coley, Vice President of Federal Advocacy for the American Cancer Society, Cancer Action Network, the nonpartisan, nonprofit advocacy affiliate of the American Cancer Society.

We appreciate the Committee holding today's hearing to examine how policymakers can build on critical patient protections in the ACA and make sure people continue to have access to quality, affordable health insurance. Nearly 16 million Americans have a history of cancer and another 1.8 million will be diagnosed with the disease this year. For these individuals, your family, friends, and many of your constituents, access to affordable health insurance is a matter of life and death.

The American Cancer Society research shows that uninsured Americans are less likely to get screened for cancer and more likely to be diagnosed at an advanced stage. Yet, prior to the ACA, a cancer diagnosis or other serious illness was often the exact reason why these individuals were uninsured. Insurance companies could deny coverage to someone simply because they had or had survived cancer. They could abruptly revoke health coverage after someone was diagnosed. They could charge exorbitantly high premiums to purchase coverage. In other words, people who needed health coverage the most could not get it.

Before the enactment of the ACA, the American Cancer Society's national call center heard from recently diagnosed cancer patients daily who were unable to get coverage because of their disease or who had lost coverage as a result of their diagnosis. It was stories like these about cancer patients from across the country that moved ACS CAN and other advocacy organizations to engage in the policy debate about access to care. Passage of the ACA significantly helped cancer patients and others with serious conditions.

People can no longer be denied coverage because of a preexisting condition. They no longer face arbitrary lifetime or annual caps on their cancer care. And more Americans are able to access meaningful health coverage, either through marketplace plans, which currently serve 10 million people, or through Medicaid expansion, which currently provides coverage to 17 million people.

These patient protections are at the core of the ACA and must be maintained. Unfortunately, recent policy changes are putting many of these most essential protections at risk, specifically the expansion of short-term health plans and the drastic reduction in navigator funding. Last year, the Administration issued a final rule to expand access to short-term limited-duration health insurance. These plans do not have to abide by key consumer protections, they can discriminate based on preexisting conditions, charge higher premiums to sick people, and exclude certain benefits based on health history. This means they could cover everything except cancer care.

Expansion of these plans does not help consumers; it puts them at increased risk. While these plans are often touted as lower cost alternatives, they are only less expensive upfront because they don't cover necessary care.

Finally, ACS CAN is concerned about the drastic reductions that had been made to navigator and enrollment education funding. Shortened enrollment periods, fewer resources for outreach and education, and less funding for consumer navigators directly impacts the number of individuals who enroll in marketplace coverage.

Beyond shoring up existing patient protections, there are also ways Congress can strengthen the ACA, many of which I detail in my written testimony, but a few I will mention now. Fixing the so-called family glitch would allow more families the opportunity to access affordable comprehensive healthcare. Eliminating the so-called subsidy cliff by creating partial subsidies for individuals with incomes above 400 percent of the Federal poverty level would also go a long way to improve affordability of coverage.

Mr. Chairman, thank you again for the opportunity to testify today. We urge the Committee to find bipartisan solutions that ensure individuals with preexisting conditions are protected from discrimination, that essential health benefits are maintained, and that coverage is made affordable for individuals.

We look forward to working with you to build upon the foundation of the ACA and strengthen healthcare coverage for millions of Americans living with a serious illness such as cancer. Thank you.

[The prepared statement of Ms. Brooks-Coley follows:]



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Statement of Keysha Brooks-Coley
Vice President of Federal Advocacy
American Cancer Society Cancer Action Network (ACS CAN)
Before the
House Ways and Means Committee Hearing
on
Protecting Americans with Pre-Existing Conditions
January 29, 2019

Good morning Chairman Neal, Ranking Member Brady and members of the Committee. I am Keysha Brooks-Coley, Vice President of Federal Advocacy for the American Cancer Society Cancer Action Network (ACS CAN). ACS CAN is the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society and supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden.

I appreciate the opportunity to testify today on behalf of cancer patients, survivors and those at risk for cancer. In 2019 nearly 1.8 million Americans are expected to be diagnosed with cancer.¹ An additional 15.5 million Americans living today have a history of cancer.² For these Americans – many of whom are your own constituents – access to affordable health insurance

¹ American Cancer Society, *Cancer Facts & Figures 2019*, available at <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf>.

² *Id.*

is truly a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.³ ACS CAN appreciates the Committee holding today's hearing to examine how policymakers can ensure that cancer patients – and other Americans with serious illnesses – continue to have access to affordable health care and how policymakers can build on the critical patient protections included in the Affordable Care Act (ACA) and prevent further erosion of these important protections.

Cancer Patients Before the Affordable Care Act

For many years, a cancer diagnosis made it nearly impossible to get or keep insurance for Americans who relied on private health plans sold in the individual and small group markets. In most states, prior to enactment of the ACA, health insurers that sold in those markets could refuse to cover an individual with a pre-existing condition like cancer; could limit and/or refuse to cover care associated with a pre-existing condition; or could charge a higher premium based on pre-existing conditions. A survey conducted before passage of the current law found that 36 percent of those who tried to purchase health insurance directly from an insurance company in the individual insurance market were turned down, charged more, or had a specific health problem excluded from their coverage.⁴

Cancer patients fortunate enough to get health care coverage through an employer often found themselves locked into their jobs out of fear that they would be unable to get affordable coverage if they left. Individuals who lost their coverage or were unable to obtain coverage faced extraordinary costs that often led to financial hardships. According to one study,

³ E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, CA: A Cancer Journal for Clinicians 58:1 (Jan./Feb. 2008), <http://www.cancer.org/cancer/news/report-links-health-insurance-status-withcancer-care>.

⁴ Doty MM, Collins SR, Nicholson JL et al. *Failure to Protect: Why the Individual Insurance Market is not a Viable Option for Most US Families*. The Commonwealth Fund, July 2009.

enactment of the ACA was a major factor in the fifty percent reduction in bankruptcy filings between 2010 and 2016.⁵

Prior to the ACA, cancer patients and others with serious illnesses could not always rely on having insurance coverage to protect them when they needed it most. This had devastating effects on health outcomes, finances and quality of life.

How the ACA Improved the Lives of Cancer Patients

Passage of the Affordable Care Act, with its many patient protections, significantly changed the landscape for cancer patients – and all Americans. In 2018, approximately 10 million Americans – many of these are persons facing serious illness – were enrolled in health care plans through the private marketplaces⁶ and 17 million through Medicaid expansion (as of 2017).⁷

Enactment of the ACA has allowed Americans with cancer and other serious conditions access to the care they need. Those with comprehensive insurance are now enjoying new protections that make health care coverage more reliable and more affordable. The approximately 102 million Americans with pre-existing conditions⁸ like cancer no longer have to worry that their illness could preclude them from comprehensive coverage. Americans who purchase insurance can depend on their plan covering essential health care benefits. Those with expensive illnesses like cancer no longer have to fear that their insurer will impose annual or lifetime limits on their coverage. Critical preventive benefits like mammograms and colon cancer screening are now available without cost-sharing. Young people finishing school or starting

⁵St. John A, How the Affordable Care Act Drove Down Personal Bankruptcy. Consumer Reports, May 2017. Available at <https://www.consumerreports.org/personal-bankruptcy/how-the-aca-drove-down-personal-bankruptcy/>

⁶ Kaiser Family Found. Marketplace Effectuated Enrollment and Financial Assistance. <https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁷ Kaiser Family Found. Medicaid Expansion Enrollment. Available at <https://www.kff.org/health-reform/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>

⁸ Mendelson D, Sloan C, Cole M, Repeal of ACA's Pre-Existing Condition Protections Could Affect Health Security of Over 100 Million People, Avalere, October 2018. Available at <https://avalere.com/press-releases/repeal-of-acas-pre-existing-condition-protections-could-affect-health-security-of-over-100-million-people>.

their careers are now able to stay on their parents' health insurance plans until the age of 26. In addition, more lower-income Americans now live in states that have expanded their Medicaid program thus expanding coverage options. The patient protections that are the cornerstone of the Affordable Care Act ensure that the insurance that Americans access provides the kind of critical coverage they need.

Policies That Could Damage ACA Patient Protections

Unfortunately, recent executive orders, legislative proposals and regulatory actions are putting some of these important protections at risk. As a result, the patient community is having to respond to policy changes that are chipping away many of the critical protections that were included in the law. Three specific proposals have been concerning to the broader patient advocacy community:

Short-term Limited-Duration Insurance: In August 2018, the administration issued a final rule to expand access to short-term, limited-duration health insurance.⁹ Originally intended as temporary bridge or gap plans, these policies have lower premiums than other plans on the market because they are exempt from many of the key requirements that provide comprehensive coverage and protect consumers from high out-of-pocket costs. For instance, rather than maintaining the protection against discriminatory pre-existing condition exclusions that make it impossible for persons with cancer to obtain insurance, short term policies in most states are permitted to use these discriminatory practices. These plans are permitted to consider an individual's health status when issuing health insurance coverage. That means an insurer can choose to deny coverage, charge higher premiums, or not cover certain benefits for individuals based on their health history.

Unlike ACA-compliant plans, short-term plans also do not have to provide coverage for Essential Health Benefits (EHBs). Individuals with cancer and cancer survivors have unique health care needs and require access to a wide range of products and services, like oncology care,

⁹ Department of Health and Human Services, Department of Labor, Department of the Treasury. Short-Term, Limited-Duration Insurance. Final Rule. 83 Fed. Reg. 38212 (Aug. 3, 2018).

chemotherapy, radiation, prescription drugs, and hospital services. Consumers who enroll in health coverage expect their plan to cover these necessary products and services. If cancer patients do not have access to cancer treatment services through their health insurance coverage, they are forced to pay out-of-pocket for their treatment, which can often be prohibitively expensive. Individuals who have been diagnosed with cancer need access to specific treatments; delaying these treatments can lead to negative health outcomes.

Ironically, many short-term policies will not cover the services needed to prevent or detect cancer – including preventive services that receive an “A” or “B” rating from the U.S. Preventive Service Task Force. Coverage of cancer screenings helps to detect some forms of cancer at earlier stages when the individual has a higher likelihood of more treatment options and a better overall health outcome. Including preventive services as standard benefits in health insurance improves overall public health and saves lives.

Short-term plans can also impose lifetime and annual limits on coverage which will directly impact cancer patients. Cancer is one of the most expensive health conditions¹⁰ and as a result cancer patients and survivors can exceed an annual or lifetime cap on covered services. According to one study, prior to the enactment of the ACA, one in ten cancer patients responding to the survey reached the limit of what their insurance plan would pay for their cancer treatment.¹¹ Short term plans are also not subject to limits on the amount of out-of-pocket costs and deductibles they can impose on enrollees for covered in-network services. One analysis of the best-selling short term plan in Georgia showed these plans had a 3-month out-of-pocket limit of \$10,000, which did not include the deductible of \$10,000, making the effective 3-month out-of-pocket maximum \$20,000.¹² Another analysis found caps on coverage for short-term plans in

¹⁰ U.S. Dep’t of Health & Human Servs., Research in Action, Issue #19: The High Concentration of U.S. Health Care Expenditures (June 2006).

¹¹ USA Today, Kaiser Family Foundation, Harvard School of Public Health. National Survey of Households Affected by Cancer. Kaiser Family Foundation, November 2006. Available at <https://www.kff.org/health-costs/poll-finding/usa-todaykaiser-family-foundationharvard-school-of-public-2/>.

¹² Palanker, D, Lucia, K, and Curran, E. *New Executive Order: Expanding Access to Short-Term Health Plans Is Bad for Consumers and the Individual Market. To the Point*, The Commonwealth Fund, October 2017. Available at <https://ccf.georgetown.edu/2017/10/13/new-executive-order-expanding-access-to-short-term-health-plans-is-bad-for-consumers-and-the-individual-market/>.

Phoenix, AZ to be as low as \$250,000.¹³ ACS CAN's Costs of Cancer report showed that it is not unusual for a cancer patient who has just been diagnosed to incur expenses exceeding these amounts – meaning in the Georgia plan a cancer patient would have to pay \$20,000 out-of-pocket, and in an Arizona plan a cancer patient would have to pay the full cost of her treatments after she reached the \$250,000 cap.¹⁴ Thus, for an individual in active cancer treatment the low caps and high out-of-pocket requirements essentially render coverage meaningless, particularly given that nearly half of all American adults report being unable to cover an emergency medical expense costing \$400 without having to borrow or sell something to do so.¹⁵

Finally, short-term plans in most states are permitted to charge older enrollees significantly higher premiums and can even choose not to provide coverage to an individual based on age alone. While cancer can be diagnosed at any age, the incidence of cancer increases with age. According to the American Cancer Society, 85 percent of all cancers in the United States are diagnosed in people 50 years of age and older.¹⁶ Prior to the enactment of the current age rating band restrictions for ACA-compliant plans, older adults faced significant problems accessing health insurance coverage, in large part because of age rating bands (compounded by the ability of issuers to use health status when setting premiums).¹⁷

Expansion of short term plans is not in the interest of consumers. These plans were originally designed as temporary bridge policies. Unfortunately, there is a real possibility that many people – attracted by lower premiums and expanded availability – will find themselves with seriously inadequate coverage and greater out of pocket costs. For people with serious conditions like cancer the lack of access to necessary treatment options and the potentially

¹³ Pollitz, K. Understanding Short-Term Limited Duration Health Insurance. Kaiser Family Foundation, February 2018. Available at <https://www.kff.org/health-reform/issue-brief/understanding-short-term-limited-duration-health-insurance/>.

¹⁴ American Cancer Society Cancer Action Network. The Costs of Cancer: Addressing Patient Costs. April 11, 2017. Available at <https://www.acscan.org/policy-resources/costs-cancer>.

¹⁵ Board of Governors of the Federal Reserve. Report on the Economic Well-Being of U.S. Households in 2015. May 2016. Available at <https://www.federalreserve.gov/2015-report-economic-well-being-us-households-201605.pdf>.

¹⁶ American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta: American Cancer Society; 2018.

¹⁷ Smolka, G, Purvis, L, & Figueiredo, C. Health Care Reform: What's at Stake for 50- to 64-Year-Olds, AARP Public Policy Institute [Insight on the Issues #124], March 2009. Available at https://assets.aarp.org/rgcenter/health/i24_hcr.pdf.

high out-of-pocket costs could be devastating. We urge Congress to enact legislation to limit and/or prohibit the availability of these products. At the very least, Congress should require that short term plans meet the same requirements as other plans in the marketplace.

Association Health Plans: In June 2018, the administration finalized a regulation that would expand access to Association Health Plans (AHPs).¹⁸ The regulation makes it easier for AHPs to be exempt from the ACA's consumer protection standards including essential health benefit requirements and restrictions against requiring very high deductibles and coinsurance. Premiums for AHP products would likely be lower than for ACA-compliant plans, not because of any AHP administrative efficiencies, but because of the ability of these plans to offer more limited benefit packages. As a result, consumers who enroll in AHPs and who are then diagnosed with a serious illness like cancer will likely find they have inadequate coverage. Younger and healthier individuals attracted to AHPs because of the lower premiums will leave older, sicker, and costlier individuals in the individual and small group products that are subject to the ACA's stricter consumer protection and other market requirements. The adverse selection spiral generated by those non-AHPs could lead other plans in the individual and small group markets to charge increasingly higher premiums, making them unsustainable. It is for these reasons that the National Association of Insurance Commissioners,¹⁹ the National Governors Association,²⁰ and the American Academy of Actuaries²¹ have also been historically opposed to AHPs.

We are also concerned about AHPs' disturbing history of fraud and financial instability. For a long time, these products were not traditionally subject to the same state insurance solvency

¹⁸ Department of Labor. Definition of "Employer" Under Section 3(5) of ERISA – Association Health Plans. Final Rule. 83 Fed. Reg. 28912 (June 21, 2018).

¹⁹ National Association of Insurance Commissioners, Consumer Alert: Association Health Plans are Bad for Consumers, available at http://www.naic.org/documents/consumer_alert_ahps.pdf.

²⁰ National Governors Association, Governors Oppose Association Health Plans, May 2004, available at https://www.nga.org/cms/home/news-room/news-releases/page_2004/col2-content/main-content-list/governors-oppose-association-hea.html.

²¹ American Academy of Actuaries Letter to John Boehner, Chairman, House Committee on Education and the Workforce, April 28, 2003, available at http://www.actuary.org/pdf/health/ahp_042803.pdf.

and licensing requirements that allowed regulators to maintain necessary oversight.²² If an AHP lacked the financial resources to pay claims, then enrollees were left with no coverage and high out-of-pocket costs. Even in cases of well-meaning AHP sponsors, insolvencies led to millions of dollars in unpaid claims.²³ ACS CAN urges the Congress to act to limit the expansion of AHPs.

Navigator and Enrollment Education Funding: Up until this year, health insurance enrollment has steadily increased. Unfortunately, recent action by the administration is jeopardizing enrollment. In 2017 HHS shortened the enrollment period for marketplace plans from 90 days to 45 days leaving consumers less time to study options and select the plan that is best for them. In addition, funding for both navigators and marketplace education and enrollment activities has been significantly reduced. Spending on outreach and marketing have shrunk to \$10 million – a 90 percent cut since 2016 – and funding for navigator programs has been cut 80 percent.²⁴ The administration is also requiring navigators to inform consumers about the new AHP and STLD coverage options – options that provide less comprehensive coverage. For individuals with a serious illness like cancer choosing the right health insurance plan is important. Navigators help cancer patients and others by providing answers to their questions. Shortened enrollment periods, fewer resources for outreach and education and less funding for consumer navigators not only creates confusion for consumers but directly impacts the number of individuals who enroll in Marketplace coverage. We urge Congress to restore full funding for navigators and for ACA enrollment and outreach activities. We also urge Congress to enact legislation that directs navigators to refrain from discussing short-term and AHP plan options with consumers if these are not appropriate options for the consumer.

²² Kofman M, Bangit E, Lucia K, *MEWAs: The Threat of Plan Insolvency and Other Challenges*, Commonwealth Fund, May 2004, available at http://www.commonwealthfund.org/usr_doc/kofman_mewas.pdf.

²³ *Id.*

²⁴ Straw T, Lueck S, Gonzales S, Cloud H, *Strong Demand Expected for Marketplace Open Enrollment, Despite Administration Actions*, Center on Budget and Policy Priorities, October 2018, available at <https://www.cbpp.org/research/health/strong-demand-expected-for-marketplace-open-enrollment-despite-administration>.

Other Improvements

There are other ways in which Congress can continue to improve the protection provided by the ACA, that we are hopeful this Committee and Congress will consider this year. Three policy changes that we would like to highlight include:

Fixing the Family Glitch: Under the ACA an individual is eligible for premium subsidies in the private market if the amount he/she would have to pay for their individual employer-sponsored coverage is more than 9.86 percent of their household income. The problem occurs when other family members are factored into the equation. Even if the employee is paying a family premium, only the amount of the individual employee's coverage is considered for purposes of calculating eligibility for subsidies. As a result, families who are paying insurance premiums in excess of 9.86 percent of their household income are ineligible for subsidies. Congress should consider fixing this family glitch so that more Americans could afford health insurance.

Prevent Changes to Essential Health Benefit Benchmarks: Section 2711 of the Public Health Services Act prohibits plans from having annual dollar limits on Essential Health Benefit (EHB) services. This prohibition applies to group health plans that do not have to comply with other EHB coverage requirements. In a proposed rule that would expand access to Health Reimbursement Arrangements,²⁵ the Tri-Agencies (Department of Health and Human Services, the Department of Labor, and the Department of the Treasury) recommended allowing employers to choose a benchmark selected by a state based on the new process adopted by HHS.²⁶ Under the guise of giving states more "flexibility," this policy change would allow states to choose a less generous benchmark – one that potentially does not represent a real plan sold in that state.

²⁵ Department of the Treasury, Department of Labor, and Department of Health and Human Services. Health Reimbursement Arrangements and other account-based group health plans. Proposed rule. Oct. 29, 2018. 83 Fed. Reg. 54420.

²⁶ Department of Health and Human Services. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019. Final Rule. Apr. 17, 2018. 83 Fed. Reg. 16930.

Allowing employers these new options for EHB standards could have serious implications for out-of-pocket spending for employees with serious and chronic illnesses like cancer. It could allow employers to choose weaker, more limited EHB standards. As a result, patients will find more services will be excluded from essential health benefits and thus plans could impose annual and lifetime limits for those services. In addition, patients could also face higher out-of-pocket costs as the annual cap on out-of-pocket expenses only applies to EHB services. Congress should consider enacting legislation to clarify that the EHB standards are meant to be robust enough to provide protections to individuals with pre-existing conditions.

Prevent the Subsidy Cliff: People who buy health insurance on the individual market may be eligible for premium subsidies. The maximum eligibility limit for subsidies is 400 percent of the federal poverty level (FPL). For an individual whose yearly income is only slightly higher than 400 percent FPL, purchasing insurance with no subsidy could be prohibitively expensive. This is a particular concern for individuals who received subsidies believing that their yearly income will be under the 400 percent FPL threshold, but find their annual income slightly above the 400 percent FPL threshold. These individuals no longer qualify for subsidies and must repay some or all of the subsidies when they file their yearly income tax.

Congress could consider eliminating the cliff and creating partial subsidies for individuals with incomes above 400 percent FPL. This would ensure that more Americans can afford their health insurance coverage.

Building on the ACA's Promise of Affordable Health Care

It is very rare that Congress enacts a major piece of legislation that doesn't require subsequent revisions and improvements. A case in point is the Medicare program. Enacted in 1965, Medicare – which enjoys overwhelming public support – continues to be fine-tuned today to ensure it meets the needs of beneficiaries. The same principle should be true for the Affordable Care Act. Rather than undoing the key consumer protections that are the cornerstone of the law we should be building on these protections.

We urge the Committee – and the Congress – to find bipartisan solutions that benefit patients. Such a process must ensure that individuals with pre-existing conditions are protected from discrimination, that essential health benefits are maintained, and that coverage is made affordable for individuals. We look forward to working with you to build upon the foundation of the ACA and strengthen health care coverage.



Chairman NEAL. Thank you, Ms. Brooks-Coley.
Mr. Blackshear, you are recognized, would you please begin.

**STATEMENT OF ANDREW BLACKSHEAR, PATIENT AND
VOLUNTEER, AMERICAN HEART ASSOCIATION**

Mr. BLACKSHEAR. Chairman Neal, Ranking Member Brady, Members of the Committee, my name is Andrew Blackshear. I have been a volunteer with the American Heart Association since 2017. Thank you for the opportunity to testify today about the lifesaving importance of quality, affordable insurance coverage for people with preexisting conditions.

I was a healthy 27-year-old in 2015 when my health took a turn for the worse. I was at home after a long night of restaurant work, and as I leaned over to untie my shoes, I felt some chest pain. The pain continued the next day, and I came down with a severe fever. My fever kept climbing over the next few days, eventually going above 103 degrees, all the way up to 103.6.

I was worried I would lose my job if I didn't get back to work. So, on my first night back, I collapsed on the floor of the restaurant in response to a fluid buildup between my heart and the pericardium, the sac that surrounds the heart, a condition that I later learned was called cardiac tamponade. The fluid buildup was making it much harder for my heart to do its job. I didn't know it at the time, but I learned later that I had contracted an infectious fungal disease while driving through California's San Joaquin Valley in August weeks before this.

The condition, known as valley fever, was caused by inhaling fungal spores that are released from the dry soil. It was likely that just by breathing the air coming through my car vents my lungs had become infected. When the spores disseminated through my lung tissue, I developed fungal pericarditis, and it almost took my life.

Treating my condition was a huge challenge. Over the next few weeks, my blood tests and symptoms only got worse. Soon I needed emergency open heart surgery to remove the fluid around my heart. While fighting for my health, I was also fighting for the care that I needed. I had purchased a short-term health insurance plan after aging out of my parents' plan when I turned 27.

Shortly after the fungal infection was diagnosed, medical bills started piling up. I knew my short-term plan had a high deductible, so during the time of my echocardiogram, I paid the \$5,000 deductible. But then I started receiving letters from the insurance company asking me for more information and demanding that I prove my heart problems weren't caused by a preexisting condition. I kept getting the same letter over and over saying the insurance company wouldn't pay my nearly \$200,000 in medical bills until I could show them that I didn't have a preexisting condition.

Still recovering from my first operation, I had to go to every doctor I had ever seen, all the way back to a pediatrician, to collect the information my insurer was demanding. The company finally agreed to pay for my care after I requested the State of California help me take them to court. When open enrollment began in November of that year, it was amazing. I enrolled in a plan, started paying my premiums, and continued to see my same doctors, but

there was a big difference. My ACA plan did what it was supposed to do: It paid for my doctors' bills instead of punishing me for being sick. No more calling around to my old doctors' offices. No more collecting and sending in paperwork to this company. And no more anxiety for my family over whether I could afford to get better.

Weeks after my first operation, I then had a tender stomach, extreme fatigue, swollen ankles, and trouble breathing. I flew to Minnesota to be seen at the Mayo Clinic and was diagnosed with constrictive pericarditis and heart failure. My left and right ventricles were failing. I underwent my second open heart surgery to remove the sac around my heart completely. This is called a pericardiectomy.

I felt so much better after the second surgery. And with comprehensive coverage, I knew I wouldn't be bankrupted because I had gotten sick. Thanks to the Affordable Care Act, today I have no medical debt and I am healthy. But I will always be without a pericardium, so having health insurance that covers a preexisting condition remains a necessity to me.

As a heart disease patient and volunteer with the Heart Association, I urge lawmakers to make sure preexisting conditions are covered. No one should face the prospect of being unable to afford the care that they need to stay alive. Thank you again for focusing on this critical issue.

[The prepared statement of Mr. Blackshear follows:]



WRITTEN TESTIMONY OF ANDREW BLACKSHEAR

Before the

House Ways and Means Committee

Hearing on

"Protecting Americans with Pre-existing Conditions"

Tuesday, January 29, 2019

Chairman Neal, Ranking Member Brady, and Members of the Committee, my name is Andrew Blackshear, and I have been a volunteer with the American Heart Association since 2017. Thank you for the opportunity to testify today about the life-saving importance of quality, affordable insurance coverage for people with pre-existing conditions.

Until a few years ago, I had never thought about what a pre-existing condition was, let alone how it would impact my ability to get health care. I was a healthy 27-year-old in 2015 when my health took a dramatic turn for the worse. I was at home after a long night of restaurant work, and as I leaned over to untie my shoes, I felt chest pain. The pain continued the next day, and I came down with a severe fever. I stayed home from work for

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a few days to get some rest, but my fever kept climbing, eventually going above 103 degrees.

I was worried I'd lose my job if I didn't get back to work. On my first night back, I collapsed on the floor of the restaurant in response to fluid buildup between the heart and pericardium, the membrane that surrounds it – a condition I later learned was called cardiac tamponade. I went to urgent care the next day and was told I had a heart murmur. An echocardiogram revealed that I had inflammation of the pericardium. Essentially, fluid had built up around my heart, making it much harder for my heart to do its job. The pain I had been feeling in my chest was coming from my heart struggling to beat while encased in excessive fluid.

I didn't know it at the time, but I learned later that I had contracted an infectious fungal disease while driving through California's San Joaquin Valley in August, weeks before. The condition, known as "Valley Fever," is caused by inhaling fungal spores that are released from the dry soil. It was likely that just by breathing the air coming through the car vents during my drive, I had infected my lungs. When the spores disseminated in my lung tissue, I developed fungal pericarditis and was left gasping for life.

Treating my condition was a huge challenge. A cardiologist first gave me ibuprofen and various other anti-inflammatory medications in the hopes of reducing the fluid. But over the next few weeks, my blood tests and symptoms only got worse. I needed emergency open-

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heart surgery. My doctors told me they would cut a "window" into my heart lining and remove the fluid, relieving the pressure on my heart and hopefully giving me my life back.

Within weeks I would need a second emergency surgery, but I was fighting for more than my health. I was also fighting to get access to the care I needed. In early 2015, I had purchased a short-term health insurance plan. My family had been encouraging me to get insurance since I turned 27 and was no longer eligible to be covered under their plan. After a minor skiing accident, I met with my family's insurance broker to explore my options. I had missed the open enrollment period for Covered California – the state's ACA insurance marketplace – so my broker suggested that I enroll in a short-term plan. He was pretty thorough, but I wasn't educated enough at my age to understand the intricacies of health insurance.

Shortly after the fungal infection was diagnosed, medical bills started pouring in. I knew my short-term plan had a high deductible, around \$5,000, so I paid it. But then I started receiving letters from the insurance company asking me for more information and demanding that I prove my heart problems weren't caused by a pre-existing condition. I kept getting the same letter, over and over, saying the insurance company wouldn't pay my medical bills until I could show I didn't have a pre-existing condition. I felt the company was just waiting for me to give up.

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But I didn't. Still recovering from my first heart operation, I had to go to every doctor I had ever seen – office to office – to collect the information my insurer was demanding so my medical care would be covered. I even had to visit a pediatrician I hadn't seen in over 15 years to request papers that turned out to be locked in a separate facility. I owed nearly \$200,000 in medical bills but my insurer was doing everything it could to avoid paying. It was as if my health was being held hostage by an insurer who was supposed to help me get better when I got sick, but instead was leaving me out in the cold. The company finally agreed to pay for my care after I requested the state of California to help me take them to court.

When open enrollment began in November of that year, it felt like Christmas. I now had a pre-existing condition, although I didn't yet know what it was. I enrolled in a plan, started paying my premiums, and continued to see my doctors. But there was one huge difference. My ACA plan did what it was supposed to do. It paid for my doctors' bills instead of punishing me for being sick. No more calling around to my old doctors' offices, no more collecting and sending in paperwork, no more anxiety over whether I could afford to get better.

Although my first surgery took some of the strain out of breathing, the relief was temporary. I never felt I had fully recovered as other symptoms began to appear. I had a tender stomach, extreme fatigue, swollen ankles and trouble breathing. I know now that these are classic symptoms of heart failure. Weeks after my first operation, I flew to Minnesota to be

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treated at the Mayo Clinic and was diagnosed with constrictive pericarditis, which was causing my left and right ventricles to fail. I underwent my second open-heart surgery to remove the sac around my heart completely.

While I was there, the incredible team of physicians diagnosed me for the first time. The Valley Fever fungus – which is officially called coccidioidomycosis – had infected my lungs and then my heart. The best part about that second surgery was feeling better, hands down. But the second-best part was knowing that I wouldn't be bankrupted just because I had gotten sick.

What happened to me under my short-term health plan is what happened to millions of people with pre-existing conditions before the ACA went into effect. Going from that experience to having coverage under an ACA plan with protections in place for people with pre-existing conditions was like night and day for me. Thanks to the Affordable Care Act, today I have no medical debt – and I'm healthy. But I will always be without a pericardium, so having health insurance that covers pre-existing conditions remains a necessity for me.

My experience with heart disease led me to join thousands of other patients, caregivers and loved ones as a volunteer with the American Heart Association. I also help out at my local John Muir cardiac conditioning center. I urge lawmakers to make sure pre-existing conditions are covered. No one should face the prospect of being unable to afford the care they need to stay alive.

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Thank you again for focusing on this critical issue. I look forward to your questions.

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Chairman NEAL. Thank you for that very important and powerful testimony, Mr. Blackshear.

We will now proceed under the 5-minute rule with questions for our witnesses. I will begin by recognizing myself for 5 minutes. But before asking the witnesses my questions, I would like at this time to yield 2 minutes to our colleague, Representative Gwen Moore, for the purpose of outlining her own experience, but most importantly, for the first time having done this publicly, for her constituency.

Ms. Moore, you are recognized for 2 minutes.

Ms. MOORE. Thank you so much, Mr. Chairman. And I am so glad to be here. And when I say that I am glad to be here, I mean I am glad to be here. Literally, instead of yielding me time, you could be delivering kind words at my memorial service.

In the spring of 2018, I joined an exclusive club of millions of Americans with the cursed C-disease: Cancer. A disaster that guarantees discrimination in the insurance marketplace; for many, a death sentence. Specifically, I have been diagnosed with small cell lymphocytic lymphoma, a manageable cancer with proper surveillance and treatment.

Right now I am in great health with an excellent prognosis of living with this disease, but throughout the spring and summer of 2018, I spent a lot of time on a gratitude tour of being grateful for medical research, having insurance, and, most importantly, thanking God for the ACA provisions. No, I am not one of the 20 million low-income people that we are going to lay down our lives to protect, but I am one of the people that, before the ACA provisions, could have been subject to medical underwriting instead of community rating, making it unaffordable, with no coverage of essential health benefits. And with all the labs that I went to and all the visits to try to pin down this diagnosis depending on early intervention, none of that could have happened if they had imposed lifetime limits on my care and imposed caps on the out-of-pocket costs, if the ACA had imposed caps on that. Worse, they could have just denied me completely because of my preexisting condition.

We have talked a lot about this costing too much or being too expensive. What does a life cost? Let me just say that I pay \$15,000 a month for medicine. Who can afford that? And what am I worth? I yield back.

Chairman NEAL. Thank you very much for that important testimony. I think your story highlights how, in considering how to strengthen and protect consumer protections for Americans with preexisting conditions, we must stand in the shoes of those facing hard decisions about their healthcare and work to make sure that they know their health insurance will be there when they need it and for what they need.

Now, let me return to the start of our questioning to the story I shared in my opening statement because each of us knows someone who had delayed getting healthcare only to be diagnosed with a chronic condition. Mike and his family benefit every day from the ACA.

Ms. Pollitz, before the ACA, what would have happened to the likelihood of Mike Finn and his family being able to get and keep an insurance plan that meets the needs of a diabetic as well as

three young children? What kind of obstacles would they have faced in trying to get meaningful affordable care?

Ms. POLLITZ. Mr. Chairman, diabetes is one of the conditions that, through our research, we demonstrated was a declinable pre-existing condition. So the individual market would not have been an option for that family or at least for the child with diabetes, with the exception of a few States before the ACA, including Massachusetts, which required coverage to be offered on a guarantee issue basis. And so that was the largest barrier to getting coverage in a nongroup market.

In other plans, before the ACA, there could be temporary pre-existing condition exclusion periods. So if you took a new job with a new health plan, there might be a waiting period as long as a year before the diabetes would be covered. Under a prior Federal law, HIPAA, people did have to get credit for prior coverage under other plans, so that when they switched jobs, they wouldn't continuously incur new preexisting waiting periods, but any break in coverage of 2 months or longer would end that protection, and then people might again face job lock or difficulty getting private insurance coverage for a preexisting condition.

Chairman NEAL. Thank you, Ms. Pollitz.

Ms. Brooks-Coley, I am sure that patients that you have represented have experience with high-risk pools, can you please share your thoughts about patient experiences with high-risk pools?

Ms. BROOKS-COLEY. Thank you, Mr. Chairman.

An individual who has cancer has—they have experienced issues with high-risk pools. Some of the concerns that patients have experienced is not having access to actual services that they need, making sure they have access to preventable screenings that we know are lifesaving. Making sure that individuals have access to actually real coverage they need that is not too expensive, and is available when they need it.

We know that high-risk pools are not always the most comprehensive coverage, especially if you have a serious illness, such as cancer, and need access to very costly treatments as well as therapies.

Chairman NEAL. Thank you.

And, with that, let me recognize the Ranking Member, Mr. Brady, for 5 minutes.

Mr. BRADY. Mr. Chairman, thank you.

And thank you to each of the witnesses for your compelling testimony. Your belief and support for preexisting conditions is one of the reasons why Republicans fully support these preexisting conditions and no lifetime caps and making sure you can't be denied coverage and making sure young people can stay on their parents' plans. All that is critical.

But we have to do more than just protect preexisting conditions; we have to make healthcare more affordable. In Texas, I cannot tell you how many of my constituents tell me they can't afford the ACA. The monthly costs are far too high. And, secondly, the out-of-pocket cost—it can be \$10,000. Who can use that healthcare insurance? And then often they can't even see their local doctor or go to the local hospital.

I am so glad that the Cancer Society is here because, in Houston, you know, maybe this is one of the reasons, you know, three Texans eligible for ObamaCare got out from under it, rejected it, for everyone that uses it. We have very few choices. Cost went down. That is the good news. But in the Houston region, for example, if you are a mom in Conroe, Texas, struck with breast cancer, if you are a father with prostate cancer, if you are someone with a blood cancer in Huntsville, we have MD Anderson Cancer Center, one of the finest cancer centers in the world. You can't go there if you're on ACA—if you have a private plan, you can. If you are on the ACA, you have to settle for less. Even if you can see MD Anderson, the best cancer doctors in the world for you, you are denied coverage under the ACA.

I am convinced we can do better to make healthcare more affordable and have access that patients need. I do believe that the Trump administration made some key moves over the last year, that have been almost a lifeline for some Americans who can't afford the Affordable Care Act. One is, for the first time, the average benchmark premium for the nearly 40 States that use Healthcare.gov, instead of doubling since ObamaCare came into place, for the first time ever, those rates decreased, including those in our State of Texas, where rates are down 2 percent. They decreased.

Second, we now have, and I am pleased to say, we are actually starting to see more insurers and more choices in our State than before because, in too many counties in America, it was take it or leave it. You take that ACA plan or nothing at all, and that is not fair.

And then, when the individual mandate penalty was repealed, I think Speaker Pelosi predicted millions of Americans would face lifesaving choices, but in truth, nearly 97 percent of those on the ACA have re-enrolled. The biggest challenge we face—one of the reasons in Oregon two out of three people eligible for ObamaCare aren't signing up—is the cost, and that is what I worry about the most.

Mr. Robertson, you were very careful in not criticizing the Affordable Care Act, and I think that is a great approach here. But what I heard you say was that these association plans and what you have developed for your members is because you can't afford the other ACA options available, and you had to find a better approach. As we think about the future of healthcare for the 7 percent of Americans we are focused on here that don't get it at work or from the government, do you consider this, what you have for your members, to be junk plans or something inferior, or something that really meets the needs of your members?

Mr. ROBERTSON. It is the latter. It really meets the needs of our members. And think about it: Everybody—most people in this room probably are part of an employer group, but if you are an individual self-employed farmer or rancher, you are not. So the association health plans allow you to form a bona fide large group, which allows you to spread out the risk. We are in this for the long term because we want to reduce costs because the cost from the ACA in the individual market, when you are there solely, is very, very high.

Mr. BRADY. You know, if I recall, was Nebraska one of the States that the ACA also created co-ops, you know, in healthcare to try to lower costs by sort of taking the public option? But if I recall, in many States, those co-ops failed and left a lot of Nebraskans and others in a real lurch. Did that contribute to the need to find something that actually works for your members?

Mr. ROBERTSON. Yeah, absolutely. Just 2 or 3 years ago there were a lot of co-ops that formed. A couple of them, they all were going great guns the first year out, and then year 2 and 3, they all went belly-up, and that left many of our Nebraskans, particularly farmers and ranchers, searching for the right policies and affordable policies, which there are hardly any.

Mr. BRADY. Thank you, Mr. Robertson.

Chairman NEAL. Thank you, Mr. Robertson.

With that, let me recognize the gentleman from Georgia, Mr. Lewis, for 5 minutes.

Mr. LEWIS. Thank you, Mr. Chairman, for holding this hearing. As I said to you, I think this is a good place to start. Healthcare is a right; it is not a privilege. And all of us—all Americans have a right to quality healthcare. I want to thank our colleague and friend, Gwen Moore, for sharing her story. It is not easy.

Mr. Blackshear, thank you for sharing your story with us. It must be difficult to come and testify in public about such a difficult and personal experience. I think you are very brave. Please, would you share more about how you felt when you learned that your insurance would not protect you?

Mr. BLACKSHEAR. Yes. Thank you for the compliments, as well. I was very worried. My whole family was worried. You know, these bills were stacking up. I knew I never had a heart problem. Everybody in my family knew I never had a heart problem. So I knew their attack wasn't justified at all, but I continued to jump through hoops until I found a way out by finding someone from the State to fight for me. Just a lot of anxiety built up in my family while I was sick over these bills.

Mr. LEWIS. But it is good that you didn't give up.

Mr. BLACKSHEAR. No, I would never give up.

Mr. LEWIS. You didn't give in.

Mr. BLACKSHEAR. No, never.

Mr. LEWIS. You kept the faith.

Mr. BLACKSHEAR. Uh-huh.

Mr. LEWIS. You kept fighting.

Mr. BLACKSHEAR. I kept fighting.

Mr. LEWIS. What would you say to others that may share your concern and conditions?

Mr. BLACKSHEAR. Yeah, to them personally, I would say: You know, if you are in that type of situation, keep fighting for what you deserve. And another thing, I don't even think we should be in a position where we have to fight in those situations.

Mr. LEWIS. Thank you, Mr. Chairman.

I yield back.

Chairman NEAL. Thank you, Mr. Lewis.

With that, let me recognize the gentleman from California for 5 minutes, Mr. Nunes.

Mr. NUNES. Thank you, Mr. Chairman.

I want to thank all the witnesses here for testifying. And I want to make sure that everyone knows that everyone up here supports protections for preexisting conditions, always have, always will. Nobody up here believes that insurance companies should be able to jerk customers around, drop their coverage, and charge more when they get sick.

It is really this long debate on ObamaCare that Democrats have consistently used protections for people with preexisting conditions as a justification for the law and the creation of two new entitlement programs. They have \$750 billion in Medicare cuts with ObamaCare, and a trillion dollars in tax increases.

ObamaCare was supposed to solve these problems but, in fact, has, in most cases, made them worse. So I understand we have a political theater here in Washington and have hearings like this, but I think we should be careful so that we are not stoking fear that someone is going to lose their insurance. We really have a responsibility to come up with a better healthcare system because ObamaCare wasn't the solution.

Republicans have put solutions on the table in the past, and we will continue to do that. I would love to work with my colleagues on finding ways to fix our healthcare system. For example, we know that the Medicare trust fund begins to go broke just after 2020. The year 2024 is what they say today; it could be even sooner than that. So we have a lot of challenges ahead of us, and hopefully we can work together. And I think what it takes first is to admit that ObamaCare was not the solution. Maybe there is a better solution, but right now, it is not the solution.

Mr. Robertson, one of the things that you have done very successfully with the Nebraska Farm Bureau is you have thought outside of the box. You have created a new program that is working in your State. Do you have some examples, without naming names, of course, but maybe give some examples of folks who have enrolled in your plan that maybe weren't able to get on the ACA, who are now getting healthcare coverage? Do you have some personal examples of this?

Mr. ROBERTSON. Yeah, I sure do. We have a member of our board of directors that did not participate in the ACA last year and signed up for the association plan this year and saved \$7,000, \$8,000, and so that is a question—they had an alternative plan, but it wasn't near ACA-compliant and didn't cover preexisting conditions. But now they are covering all of those conditions at a lower cost than what it would have been on the individual market with ACA.

So, in my mind, that is a win. Not a week went by without—or a day go by during signup where we heard stories of our members saving thousands of dollars by joining our association health plan.

Mr. NUNES. And, roughly, how many folks do you have in your plan now?

Mr. ROBERTSON. Nearly 700 members.

Mr. NUNES. Nearly 700. And they have to be Farm Bureau members.

Mr. ROBERTSON. They have to be Farm Bureau members by July 1 of that preceding year because we wanted a 6-month waiting

period because we didn't want the next hundred Farm Bureau members to need knee replacements. So that was important.

Mr. NUNES. Uh-huh. And what is the average age? You mentioned the average age in your testimony, but could you repeat that again. What is the average age of the folks that are in your plan?

Mr. ROBERTSON. We were seeking that information out from our insurance partner yesterday. I think because of some HIPAA laws, we don't have that, but we are guessing it is in the low 50s. Typically the younger producers might have been eligible for more subsidies on ACA, and so they took the subsidy ACA route rather than our association health plan route. So we think it is a little bit weighted toward the older end.

Mr. NUNES. Do you have an average price for the plan, and can you walk us through the different types of plans that you are offering?

Mr. ROBERTSON. Yeah. Prices vary for age and geography. And we had six products that were offered underneath the plan that we sponsored. And the average prices are anywhere from, we think, \$18,000 to \$25,000 a year, and, again, that sounds like a lot, but when you are paying \$36,000 a year, that is a savings. That is real-time savings.

Mr. NUNES. Well, congratulations on thinking outside of the box and coming up with plans, and I think we can learn a lot from your work, and I appreciate you being here today.

Mr. ROBERTSON. Thank you.

Mr. NUNES. Thank you, Mr. Chairman.

Chairman NEAL. I thank the gentleman. The gentleman from Texas, Mr. Doggett, is recognized for 5 minutes.

Mr. DOGGETT. Thank you. How appropriate and important it is that we are focusing on healthcare and preexisting conditions as the first formal hearing of this new and much-improved Congress. In understanding where we go forward, it is important to understand the path that has led us to today. And that path is 8 years of Republican persistence in trying to destroy the Affordable Care Act and its protection for preexisting conditions. Trying again and again and again, dozens and dozens of times, to repeal the Affordable Care Act and its protection for preexisting conditions, and failing on those efforts. Then moving to try to weaken and undermine the Affordable Care Act in any way that they possibly could.

One thing that has been missing from that path is the replace part of repeal and replace. Not once was any comprehensive alternative to the Affordable Care Act and its protection for preexisting conditions ever presented for a vote in this Committee or any other one. It is great to hear that they want to work with us, and I hope that they do, in moving to a better place and correcting some of the obvious deficiencies of the Affordable Care Act. But it would be even better had they advanced a comprehensive replacement, if they had one, for a vote and action over the course of the last 8 years.

On Inauguration Day, not even getting to the inaugural dances, President Trump decided to join their effort to destroy the Affordable Care Act, and he issued an Executive order on that day to tell all Federal agencies to do everything they could to undermine the Affordable Care Act. And the most recent example of that is what

is clearly collusion. It is collusion between an indicted Texas attorney general who sought to destroy protection in the court for pre-existing conditions and the Trump administration, which, instead of defending that protection for the Affordable Care Act, decided they would just lay down and play dead. And had it not been for the important intervention of attorneys generals from States across the country to defend the Affordable Care Act, there would have been no contest over this total capitulation by the Administration.

Republicans can tell us that they believe in preexisting conditions, but this is more than passing some sense of Congressional resolution, it is a matter of structuring a way of accessing healthcare that does protect without exorbitant premiums those many Americans, almost half of Texans, who have preexisting conditions.

Perhaps the most troubling aspect, in fact, of preexisting conditions, maybe the most overriding preexisting condition in America today, is amnesia, the political amnesia of those who have forgotten what it was like before the Affordable Care Act and how it was that those who would get a diagnosis of a serious disease would also be getting an effective diagnosis of financial ruin if there was no protection for them before the Affordable Care Act.

The Affordable Care Act is far from perfect. One of the areas that I hope our Committee will focus on is how we get an answer on the question of prescription price gouging, the need for Medicare and negotiation, and the need for more competition to reduce those costs.

But, Ms. Brooks-Coley, I would ask you one question. Across my area, I have been to so many Relay for Life events where cancer survivors come out and people from the community come out to support the American Cancer Society, and one of the statistics that I remember from those gatherings is the indication that if you don't have insurance—and, of course, in a State like mine in Texas with an indicted attorney general who keeps fighting Medicaid expansion, we have more uninsured than just about any place in the country, probably just about any place in the industrialized world—that you have a 60-percent greater chance of dying with cancer if you lack insurance than if you have access, such as through the Affordable Care Act. Is that still the case?

Ms. BROOKS-COLEY. Thank you for the question, Congressman. That actually is a 2017 statistic from our *Cancer Journal*, and it is a really important statistic that we actually cite oftentimes when we are having conversations about why patients with preexisting conditions have access to coverage.

American Cancer Society research has shown that access to coverage and your ability to have health insurance is a deciding factor, if you have a serious illness like cancer, of what your diagnosis stage would be, as far as when your cancer is found, what your treatment outcomes will be, the quality of what those treatment options will be, as well as survival rates. And speaking to your direct question, survival rates are directly linked to an individual's ability to have access to affordable, quality, and comprehensive healthcare.

Mr. DOGETT. Thank you.

Chairman NEAL. I thank the gentleman. I thank the gentleman. With that, I would like to recognize the gentleman from Florida, Mr. Buchanan, for 5 minutes of inquiry.

Mr. BUCHANAN. Thank you, Mr. Chairman, for this hearing. I also want to thank all of our witnesses.

First, I want to say that I, myself, and I know Republicans, support preexisting conditions, but I wanted to mention something else. Being someone that has been in business for 30 years, this is always my favorite time of the year, the beginning of the year. We have a new Congress. A lot of us are new on this Committee. I would challenge all of us to find a way that we can work together. These are big issues.

My big, most passionate thing I am passionate about is the rising cost of healthcare. I read in the paper, *USA Today*—and I have thrown this out before, but a year ago, it struck me so much—that 62 percent of Americans don't have a thousand dollars in the bank. They are living paycheck to paycheck. And when I thought about that, for someone that has been in business 40 years, many years before I got here, we paid for everybody's healthcare for 20 years.

And then the next 20 years, the costs continue to go up, not just in terms of ObamaCare, but in terms of the costs going up. We have to find a way to bend the curve on costs because it is bankrupting, in my mind, the middle class, and we talk a lot about the middle class.

I would just tell you I met, you know, met with a lot of people, over in Florida, anyway, about healthcare costs. One gentleman said to me that he is paying—the company is paying \$700, he is paying \$700 a month out of his pocket for a family of five, a young family, and then he has an \$8,000 deductible. So as they have children, it cost \$8,000 a year that is having to come completely out of pocket.

Another gentleman, Roberto, has an Italian restaurant, that he has had, and he was telling me that his healthcare cost is something you mentioned, \$3,000 a month. So it is clearly affecting everybody.

And my point is that cost is getting pushed to the middle class. That is why they don't have any money, you know, at the end of every week, or at the end of every month, because they are having to pay more themselves from that standpoint.

I think there has been probably some good ideas in terms of Oregon and Massachusetts. We should look for the best practices, the best ideas, and find a way to bend the cost of healthcare costs. That is what we should be doing, not playing the blame game. We are here today, let's find a way with a new Congress, to move forward and start having an impact.

I think the spending last year or this year is \$3.5 trillion that we spent on healthcare. There has to be ways we can find more efficiencies by working together. So my focus is on how do we bring the costs down?

Ms. Pollitz, let me ask you, what is your suggestion for this Committee in terms of how we can work on a bipartisan basis to start lowering the costs? What would be some of the things that you might suggest?

Ms. POLLITZ. Well, Mr. Buchanan, I work for the Kaiser Family Foundation, and we actually don't make policy recommendations, but we do provide information. We have a lot of information on our website and on our partner website, the Kaiser-Peterson Health Tracking site, that provides a lot of data on healthcare costs and where they are rising and why they are rising. And I think we would be very happy to sit down with you or any other Members and kind of review that information for you and suggest other things.

Mr. BUCHANAN. My thought is, how do we start vetting the curve on the costs?

Mr. Robertson, you mentioned—and I chaired our chamber in our area, in Sarasota, Florida, there is 2,400 members in there. Now, 80 percent of the members are 15 employees or less, exactly what you are talking about. It looks like you have about a 25 percent, 30 percent savings, through this association concept, which we weren't able to put in place in our chamber. We tried, but for whatever reasons, outside groups had more influence, but is it your sense you are going to be able to hold on to the savings that you have so far?

Mr. ROBERTSON. Yeah, we really do. I mean, it all depends on how the history looks of the whole group, of the association health plan in the first year out. We don't have experience on this group yet, but we sense we will. And as the group gets larger, which we are getting a lot of interest—more members signing up this year—as the group gets larger, just because of the fact it is larger, you can spread more of the risks and the costs out with the whole group. And so we hope that 25 percent becomes 30 percent, 35 percent reduction from the—

Mr. BUCHANAN. You mentioned that they all have preexisting condition coverage, right, as a part of that package? So you didn't drop any of that out to get to the savings?

Mr. ROBERTSON. No, no, the savings are just related to how large groups are rated, basically.

Mr. BUCHANAN. Thank you, and I yield back.

Chairman NEAL. I thank the gentleman.

With that, let me recognize the gentleman from California, Mr. Thompson, to inquire for 5 minutes.

Mr. THOMPSON. Thank you, Mr. Chairman, and thank you to all the witnesses who took time to be here today for this very important hearing.

I voted for the Affordable Care Act, a bill that was not written in the back room, a bill that was written in full public with hearings, amendments, hearing from witnesses, and I did that because I believe every American should have access to quality, affordable healthcare, including Americans with preexisting conditions. And it has worked.

In my district alone, the uninsured rate dropped from a full 10 percent, from 15.9 percent in 2013, to 5.9 percent in 2017. And that is, in large part, because folks with preexisting conditions had access to a healthcare market that they didn't before.

And you heard from my constituent, Mr. Blackshear; he was one of those people who gave an outstanding explanation of his personal situation. Every one of us have heard from constituents in

our district. Every one of us can talk about an example to this. The last time we met, I shared with this Committee the fact that my sister-in-law, who is a dental hygienist married to a young minister, couldn't afford healthcare in their State of Florida. Both were starting out in their business, and it wasn't until the ACA was passed did she have access to healthcare. And it was shortly after that, that she was diagnosed with a very serious cancer. She has undergone some pretty extreme procedures for that. She is home. She is doing well.

And the number one concern that she has is, now that she has a preexisting condition, will she be able to continue to have healthcare. She is scared to death that somehow she is going to lose that if the ACA goes away. And that is not what we should be doing. We should make sure that this is, in fact, the law of the land, because it is the ACA that made that possible.

And, Mr. Robertson, I want to thank you for your testimony and particularly the point that you made on a couple of occasions, and that is that your Farm Bureau policy is ACA-compliant. That is an important factor. Because if it weren't for that, it could very easily be another junk policy, that takes your members' premiums, and they are there for you every step of the way, unless you become injured or you become ill. So it was the ACA that provided that protection.

Mr. Blackshear, you purchased your short-term healthcare policy a few months before you fell ill. The following November you said that when open enrollment hit, you purchased a plan through Covered California, our marketplace for the ACA. Can you describe how the patient experience changed on a day-to-day basis after you purchased a plan through Covered California?

Mr. BLACKSHEAR. Yes. Basically, just the anxiety, that was the huge thing. Being sick, you know, and especially severely, in heart failure, seeing bills that aren't being paid, and I am having to run errands. It was pretty difficult. So I would say the biggest thing is just the anxiety surrounding it, you know, that wondering, I am paying my premiums, but are they going to help me out, you know.

Mr. THOMPSON. And we have heard a lot from the dais today from our colleagues on the other side who keep raising the issue of the cost of healthcare through the Affordable Care Act. Talk a little bit about what you pay and the difference between what you pay for your ACA policy and your short-term policy that didn't provide you the care that you needed.

Mr. BLACKSHEAR. With no income change, my short-term plan was \$160 to \$180 premium per month. And then surprisingly, when I got on the ACA, it went down to \$70 a month.

Mr. THOMPSON. This was after you were diagnosed with a very serious healthcare issue?

Mr. BLACKSHEAR. Yes, yes.

Mr. THOMPSON. Thank you very much.

Mr. Stolfi, you talked about your Oregon plans. In California, we recently passed legislation prohibiting these short-term, junk plans. Has Oregon done something similar?

Mr. STOLFI. Thank you, Representative, for the question. In 2017, our legislature passed a law limiting short-term plans to

what was then the Federal requirement of 3 months. It was a policy decision made at the time, and we are very happy with that decision.

Mr. THOMPSON. And all the plans that you sell are compliant with the ACA?

Not that you sell, but the State—that's sold in the State?

Mr. STOLFI. Well, the short-term plans are not required to be compliant, which is the problem with them.

Mr. THOMPSON. Thank you very much. I yield back.

Chairman NEAL. I thank the gentleman.

With that, let me recognize the gentleman from Nebraska, Mr. Smith, for 5 minutes.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman. I appreciate the opportunity to have this hearing and bring some attention to the fact that there is a lot of common agreement in terms of pre-existing conditions. Actually, what we as Republicans have proposed previously and actually voted on, and I do want the record to reflect that we did vote on an alternative that would have, I think, proven very effective to consumers to be able to have options and actually to afford health insurance.

It concerns me greatly when we see an increase in premiums to levels that are—I never even thought imaginable before we even had that vote back in 2009 and 2010.

And so, as we process this—and Mr. Buchanan certainly pointed out how important it is that we work together to find a way forward so that the American people will not be harmed, because let me be very clear, many Nebraskans have been harmed by the heavy hand of the Federal Government saying that they have been helping them, and that the government has helped in ways that many Nebraskans would tell me they have actually been harmed. So I do have some questions.

Ms. Brooks-Coley, you referenced exorbitant premiums that were paid before the ACA came about. What would you list as an example of an exorbitant premium?

Ms. BROOKS-COLEY. From the cancer perspective, one of the concerns that our patients had before the ACA, and before the important patient protections included in the law, was the fact that our patients had to oftentimes pay more for their care. Sometimes they had insurance plans that did not actually cover cancer treatment and had to pay exorbitant prices to actually access lifesaving chemotherapy, radiation, and other treatments.

So those exorbitant prices, that even if they had coverage, may not have actually covered the actual care that they needed, were extremely harmful.

If you look now at the Affordable Care Act and the patient protections and the essential health benefit requirements that are in the law, our patients don't have to worry about those costs, and they are paying their premiums and paying for the expenses that they have with the understanding, though, that they won't be hit with exorbitant costs that could impact them and their family members.

Mr. SMITH OF NEBRASKA. So a high-risk pool, you are telling me, would pay a higher premium before the ACA. Is that correct?

Ms. BROOKS-COLEY. I am sorry, Congressman.

Mr. SMITH OF NEBRASKA. A high-risk pool that would have covered preexisting conditions, even before the ACA, are you saying that those premiums would have been higher than others?

Ms. BROOKS-COLEY. I was speaking specifically to the fact that there may have been services they had to pay for out of pocket that weren't covered by those plans.

Mr. SMITH OF NEBRASKA. Okay, all right. And thank you.

I am concerned that some of the high-risk pool premiums that were around prior were higher, but now we see more people paying similar premiums, as Mr. Robertson pointed out. Even the roughly \$19,000 premium per year, that is still a lot.

Ms. BROOKS-COLEY. Right.

Mr. SMITH OF NEBRASKA. And so that is why I hope we can work together on a way forward to bring that down. Because even if there are preexisting conditions that are covered in a mandatory fashion, if the premium is out of reach for a rate-payer and they can't afford it, there is not a lot to do about that. And it is certainly unfortunate because it ultimately reduces access. I mean, we see that even folks in California who qualify for an ACA plan, only 40 percent opt for that plan. And I think we need to get to the bottom of why and how that has come to be the situation.

I think of Pam in my district, who liked her plan before all of this came about. She had a plan that she liked. It covered her pre-existing condition. She was canceled and that is unfortunate. She lost coverage through no fault of her own four times because the government said they were trying to help her, and that should be unacceptable to us as policymakers.

And certainly we want the American people to have more choices for coverage. And I am glad that the Nebraska Farm Bureau has at least given another choice to its members because we have seen choices diminish, certainly in Nebraska, since the ACA came about.

Thank you, I yield back.

Chairman NEAL. I thank the gentleman.

With that, let me recognize the gentleman from Connecticut to inquire for 5 minutes, Mr. Larson.

Mr. LARSON. I thank you, Mr. Chairman, and I thank you most of all for something that Mr. Buchanan said—this is the start of a new Congress and a commitment to have public hearings and to have them often and to go to regular order. And I would point out to my colleagues on the other side, and I often wonder when they say “ObamaCare” if they mean it in the same way that we do in terms of Obama truly caring about the people of this country. I will give them a pass and say that is what I think they mean on this and not the derisive nature that oftentimes—that it takes.

What we are going to need here on this Committee is the kind of format that Mr. Neal has indicated this Committee is going to be dedicated to, and that is to have public hearings as we did during the Affordable Care Act, and make sure that everybody has an opportunity to go back and forth.

Our colleagues on the other side, it doesn't seem that there is much disagreement between us with preexisting conditions. We should, therefore, all be able to reach a conclusion rather quickly.

I want to ask the panelists real quickly. All of you as you have sat here today, you all agree that there should be no limit, that

anyone who has a preexisting condition ought to be able to get an insurance policy, correct? Is there anyone who would disagree?

Does anyone disagree, of our panelists, with what Mr. Lewis had to say, that because of the nature of health insurance—Mr. Robertson, you have seen it up front with farmers. All of you have experienced it in one form or another. Should it be a right? Can I see a show of hands? Should it be a right, yes? You all believe that it should be a right, as Mr. Lewis has pointed out.

What we have here is an infrastructure problem, and what we find in Congress when we have an infrastructure problem, even though currently our national infrastructure, Mr. Blumenauer would tell you, has a D-minus rating by engineers, et cetera; I would say our overall health infrastructure—and by that, I mean our own personal health and well-being—is an infrastructure problem.

And in both cases, what Congress has to do is come together and talk about what is necessary to improve that infrastructure. And it is not roads and bridges in this case, but it is arteries and disease and preexisting conditions. But like all of these, they come at a cost. And so while Congress may strongly agree about the need, when it comes to paying for it, that is where the disagreements come in. And that is the bottom line here.

Mr. Robertson, you have talked about pooling resources and everybody coming together. What a great thing. A colleague of ours here, Brian Higgins, has come up with an idea, and I want to quickly ask you this. What about if we were to have 50-year-olds be able to buy into a Medicare system? A Medicare system that the Kaiser Family Foundation said that if a 60-year-old bought into the plan, it would be 40 percent less than the Affordable Care Act gold plan. Is that something you could agree with?

Mr. ROBERTSON. Well, it depends. I mean, there is a lot of value to pool individuals together.

Mr. LARSON. Precisely. And—

Mr. ROBERTSON. But if you don't address the cost side of that equation—

Mr. LARSON. Sure. But let's say if it was age 50 years old, again, and you could buy into a program which would make it revenue neutral but would look at the older end of the people that you cover from, say, 50 to 64, they would get a break, and the Medicare group would be much younger, as well. Also, the younger group would become 27 to 49, driving, as you know, insurance down dramatically.

Mr. ROBERTSON. Right. Again, there is value with pooling resources, but until you address the other side of the equation on cost of providing healthcare, somebody has to pay for those plans.

Mr. LARSON. Exactly. And so what would you suggest?

Mr. ROBERTSON. There are a lot of things that I think have not been looked at yet by Congress and policymakers, but there are some—I think, some market innovation programs that can be looked at to make a health insurance system work.

Mr. LARSON. We are running out of time, but if you would submit those to us we would be happy to take a look at them.

But thank you for your testimony. I want to thank all the panelists. I yield back.

Chairman NEAL. I thank the gentleman, and let me recognize the gentleman from Texas, Mr. Marchant, to inquire for 5 minutes.

Mr. MARCHANT. Thank you, Chairman Neal. Congratulations on your Chairmanship. I am looking forward to working with you and with our leader, Mr. Brady, on finding some solutions that will positively affect my constituency. I want to echo Mr. Brady's statements and make sure that my constituents back home know that I support protecting access for all patients with preexisting conditions.

We all agree that protecting these individuals is necessary, and I will look forward to working on policy solutions that address the uncertainty that surrounds these individuals. Sadly, current law is riddled with problems that make it a litigator's dream and a patient's nightmare.

So I will ask the panel—and I have heard each of your stories and what you do. I would like to ask you a very specific question, though, and if it doesn't apply to you, just say, it doesn't apply to me and I don't have an answer for you. But what law or laws would you propose Congress pass that the President could sign, that would give individuals with preexisting conditions the certainty that they need when it comes time to utilize their coverage?

Ms. Pollitz.

Ms. POLLITZ. I am sorry? The certainty to utilize their coverage?

Mr. MARCHANT. Yep.

Ms. POLLITZ. I am not sure what you mean by that.

Mr. MARCHANT. Make a claim, have it paid.

Ms. POLLITZ. Getting the claim paid?

Mr. MARCHANT. Yes, ma'am.

Ms. POLLITZ. I mean, the ACA does require that people have access to insurance regardless of their preexisting conditions. It does require that insurance provide essential benefits, at least in the individual and small group market, and it provides subsidies to make all of that work.

Mr. MARCHANT. So you would propose no new law to change what is on the books now?

Ms. POLLITZ. I wouldn't propose laws one way or the other. I am just saying there is that law. As I think the Members have discussed today, not everybody gets coverage under the ACA. Particularly, it is difficult for people who don't qualify for subsidies.

There are other limits. We haven't talked too much today, for example, about—well, actually, I think Mr. Brady brought up network adequacy, and whether the plans that are there for people then cover a sufficient number and distribution of doctors and hospitals. I think it is fair to say implementation of network adequacy standards under the ACA hasn't gotten very far. The Obama administration, toward the end, began to ask—

Mr. MARCHANT. But my question was about preexisting—

Ms. POLLITZ. But now the Trump administration isn't even looking at that anymore.

Mr. MARCHANT. My question is about preexisting conditions. This is the purpose of the hearing.

Mr. Stolfi.

Mr. STOLFI. Thank you, Representative. I would say that a prior Congress has already passed, and the President has already signed, a piece of legislation that protects people with preexisting conditions, the Affordable Care Act. And as far as helping those individuals further when it comes to the costs that they are faced with, and all individuals, actually, with coverage, work can be done on, as one of the panelists has mentioned, the cliff.

So individuals at and over 400 percent of the poverty level, helping those individuals get more subsidies to help. Cost-sharing reductions could be funded so that we could see rates come back down—

Mr. MARCHANT. That would be addressing preexisting conditions?

Mr. STOLFI. People with preexisting conditions and people without. So every person with insurance would benefit.

Mr. MARCHANT. Okay, thank you.

Mr. Robertson.

Mr. ROBERTSON. Well, I am here talking about the association health plans, and I think more laws and regulations to improve and reform association health plans would be very helpful to help cover preexisting conditions.

Mr. MARCHANT. Ms. Brooks-Coley.

Ms. BROOKS-COLEY. Thank you, Congressman. The American Cancer Society, Cancer Action Network supported the Affordable Care Act for that very reason, because of the patient protections that are included in the law, that made sure that patients who had serious illnesses such as cancer, and had preexisting conditions, had access to the coverage that they need.

Mr. MARCHANT. Thank you.

Mr. Blackshear.

Mr. BLACKSHEAR. With a policy question like this, I would refer you to speak with the people that I work with in the AHA.

Mr. MARCHANT. Okay. Thank you.

One of the real-life situations that some parents in my district face are children that are privately covered on their parents' insurance plans now, but their disabilities and their sickness will go much past the 27-year-old limit. And they fear that eventually, when they pass away or their coverage goes away, there is a retirement, that when they have to switch that child to Medicaid, that the preexisting condition or the level of care will not be adequate or compare to the level of care that they are getting on the private insurance. Does anyone have a comment about that?

Chairman NEAL. The gentleman's time has expired.

Mr. MARCHANT. Thank you.

Chairman NEAL. Let me recognize the gentleman from Oregon, Mr. Blumenauer, to inquire for 5 minutes.

Mr. BLUMENAUER. Thank you, Mr. Chairman. I appreciate our having this discussion today and I think it is appropriate to start out. Although I must confess that I would think my good friend from Texas, the Ranking Member, would be embarrassed to critique the Affordable Care Act process, the dozens of hearings, the work that went on, to the—I don't even know how to describe jamming through the largest transfer of wealth in American history

without a hearing, with people not knowing what was in it to this day.

When the history is written of what happened in the—in this last decade, that claim will be laughable. And I hope we can get past it.

Mr. Chairman, one of the things I think is important, two of the witnesses, Ms. Pollitz and Mr. Stolfi, pointed out that we have legislation now that reaches the requirement for preexisting conditions. The only problem in terms of gaps is that there is not adequate funding for subsidies and they are chipping away at some of the things that are going on. We have it now.

Now, notwithstanding legislation that my Republican friends passed to try to give themselves a fig leaf before the last election, what they did is not sufficient, is not as good as the Affordable Care Act. They can say that they want to do that, but it didn't speak to the interaction of all of the pieces. That is why they never passed legislation and enacted into law something to replace the Affordable Care Act. They couldn't do it and meet those standards.

Or, as the President of the United States said, healthcare is complicated. Who knew? Who knew? But the fact is, what you came up with is not as good as what we had, and if we would have been working together for the last 6 years to refine and enhance the Affordable Care Act, coverage would be better, costs would be lower, and we could move on to other areas that we agree need help.

Now, Mr. Stolfi, you have, in your testimony, impacts of what happened with the Republican Congress and the Administration that have driven up costs, not reduced them but driven them up. Do you want to point to your testimony? I think people missed that, that the things the Republicans have done and the Administration is pursuing, according to your testimony, has harmed people in my State.

Mr. STOLFI. Thank you, Representative, for the question. Yes. So we are calling it Federal uncertainty, but it is a contribution of a number of factors. It is the short-term limited duration plan changes, association health plan changes, zeroing out of the Federal mandate, the Texas lawsuit, and the loss in marketing dollars to promote open enrollment at the exchanges. All of these things have a real-life impact on people.

In Oregon, they have influenced the rates that people are paying in 2019, by increasing those rates between 7 and 14 percent over what they otherwise could have been, without this unavoidable Federal uncertainty.

Mr. BLUMENAUER. Thank you. The witnesses have pointed out, there have been some problems earlier. Getting a massive proposal in place, insurers made bids that weren't accurate, and it took them a couple of years to be able to get it right. That is not something that should be surprising for something that is dealing with this much of the economy. It will take time to get it right.

But what has happened is that, while they are working to get it right, my Republican friends and the Administration have created greater uncertainty, getting rid of the mandate and having problems in terms of cost-sharing reductions. Things that were envisioned in the bill that were part of making it work properly, unne-

essarily put this uncertainty in a business that doesn't thrive on uncertainty. They are risk adverse. They want good information.

Mr. Chairman, I appreciate our having a discussion like this today. I think as we go through, we will find areas that we don't need that make it worse. We ought to take a bill that, as enacted, is providing what people want for preexisting conditions, not chip away at it, but refine it.

Thank you, Mr. Chairman.

Chairman NEAL. I thank the gentleman for his inquiry. And now let me recognize the gentleman from New York, Mr. Reed, for 5 minutes.

Mr. Reed not being here, let me recognize Mr. Kelly for 5 minutes.

Mr. KELLY. Thank you, Mr. Chairman, and thanks for having this hearing. And to all the witnesses, thanks for taking time out of your private lives to come here.

This hearing today is about preexisting conditions and what is covered and what is not covered. But most importantly, while it is called the Patient Protection Affordable Care Act, the most obvious part of it is the "Affordable" Care Act.

I don't know how many Members sitting up at the dais today actually buy health insurance. I am still in the private sector and we do provide employer-sponsored healthcare and pensions, by the way. I think one of the biggest challenges is how do you afford to do that, especially if you are a small employer. And I think that is where we come in with the association health plans.

And I think, Mr. Robertson, that is the key to how even small employers can offer a benefit to their associates that lets them compete in an open market for talent, part of that being benefit programs.

In Pennsylvania, by the way, there is a company in Fairview, Pennsylvania, which is just outside Erie, and I represent them—there is new ownership, 13 employees. The owner wants to provide health insurance for his employees, but can't afford the rates for them.

Now he wants to join an AHP through his business association with the manufactured business association in Erie, but the Governor of Pennsylvania says "no, no, you can't join an AHP; Pennsylvania isn't providing that." And I have to tell you, we hear all this back-and-forth about what we do. We have always supported preexisting conditions. It is just flat out what we do because we believe in that.

Being an employer, I believe in that because of the people that I work with every day for mutual success. And to try to develop some type of a plan that says, "no, they don't want this," that is not true. I think what all of us want is something that is truly affordable.

Ms. Brooks-Coley, you know I am a Hyundai dealer. Hyundai Motor America Hyundai dealers have something called the Hyundai Hope on Wheels. We just finished our 20th anniversary, and through Hyundai dealers and Hyundai Motor America, have contributed \$125 million to the research for pediatric cancer. So there is nobody in America that says, "nah, they don't deserve it"; nah, we can't go down"; "too expensive." "Too expensive" is true be-

cause sometimes your heart is willing but your wallet is weak; you don't have the resources to do it.

But, Mr. Robertson, I want to get to you because there is an answer for people who want to provide healthcare. And they want to provide it for their associates. But if you are eliminated from doing that—and I think you covered it very clearly. One of the ways we develop healthcare programs is through what, age and geography, which is a little bit different than the way I would think about it. But I would think risk is probably something that should be figured in there, too.

And I am not saying people with preexisting conditions shouldn't be covered, but it has to be factored in.

Tell me, how else would a small employer be able to get the same benefits as a large group for the rates that they need to have, in order to remain competitive, and in their line of business or their competition, to find talent out there, and wanting to take care of those people?

Mr. ROBERTSON. Well, I think it is problematic for individuals or small employers. Again, it is all economics. Size matters. If you can pool a larger group, you can address the preexisting conditions, but because you are in a larger group, you can spread out the risk. And so if you are a small employer, a farmer/rancher, and if you are only yourself, it is hard to deal with the risk.

But we can address preexisting conditions if you allow the individual and small markets to pool together all their resources and risk. That is the way to do it. It is pretty simple.

Mr. KELLY. It is pretty simple, and the reason that it can be affordable is because you widen the universe of who is paying premiums.

Mr. ROBERTSON. Correct. I mean, large employers do it today. It is pretty simple. You widen the pool and you can lower administrative costs. You can lower other associated fees with that large group. Right now, we are trying to force the small and individual group to cover preexisting conditions. That is why the costs have gone up on the premiums, to where they are \$30- to \$36,000 a year for farmers and ranchers of Nebraska. We have to pool them up and——

Mr. KELLY. Let me ask you this, because we are all agreeing on the same thing, right? We want preexisting conditions covered. We want to make sure that employers can offer this.

Why would they want to exclude the association health plans? For what reason? What would be the purpose of doing that? Because basically with the Affordable Care Act, they wanted more people paying in that were actually filing claims. So it is the same principle. Why are AHPs under fire right now, with no, you are not allowed to have those? For what reason?

Mr. ROBERTSON. I don't know. I think that is the best reason to move forward, to cover preexisting conditions because you are using market forces with insurance companies to spread those risks to cover preexisting conditions. That is what needs to happen.

Mr. KELLY. And I want to encourage you to keep going. I know the farmers in Nebraska appreciate what you are doing. I have to tell you, Manufacturers Associates in Erie have over a thousand members in that plan. What a shame to have to tell those people

now, you can't participate on a level you can afford; we are going to force you into some other market. That is not what America is; that is not what we have ever been. We are about innovation. So I thank you for your time here.

Mr. Chairman, thank you, and I yield back.

Chairman NEAL. Thank you, Mr. Kelly, and with that, let me recognize the gentleman from Wisconsin, Mr. Kind, to inquire for 5 minutes.

Mr. KIND. I thank you, Mr. Chairman. I want to thank you for holding such an important hearing for our initial kickoff as a Committee, and I want to thank the witnesses for your testimony. And I am so happy to hear such wide, bipartisan support for the need to protect individuals with preexisting conditions. It is just fundamental in our healthcare system. I am glad to see that consensus developing.

Mr. Robertson, let me ask you, and listen, I am an owner of a family farm myself in a large, rural, Western Wisconsin district. We rotate corn and beans, have some beef cattle, and so I am operating in farm circles quite a bit. And I am glad to hear that you are coming up with a solution in Nebraska with these AHPs that are addressing one of the shortfalls, quite frankly, that existed under the Affordable Care Act. That is those individuals trapped in the individual marketplace that are not qualifying for premium tax credits to lower their healthcare costs. You are trying to address it right now with the AHPs.

Clearly, it is not something that is prohibited under the ACA, because the Nebraska AHP is ACA-compliant, which is all that we have been asking. The concern with the AHPs, though, is if it wasn't ACA-compliant, they would be offering junk plans that wouldn't cover very much and, therefore, offering them cheaper, and it would strip a lot of the younger, healthier people and gravitate to those plans with the more comprehensive coverage that virtually all of us ultimately need at some point in our life.

But let me ask you a couple of questions, because I am dealing with the same issue in Wisconsin. The average farmer's age in Wisconsin is 60, 61, like you said it was in Nebraska. Are you worried with the health pool that you have established with the AHP, with the average age about 60 and the fact that as we grow older, we consume more healthcare, healthcare gets more expensive, and what that is going to do with your premiums in the future, with that aging population within your health plan?

Mr. ROBERTSON. No, no, we are not. I mean, we built this plan to last for a long time, the next 5 or 10 years. And so we built it to be ACA-compliant, and we think as we grow the pool, we hope this thing becomes not just 700 members, but it becomes 3-, 4-, 5,000 Farm Bureau members.

Mr. KIND. Are you also worried about maybe the extraordinary event that might happen with some of your members, whether it is cancer or something else, with the extraordinary costs that might come with one or two individuals contracting cancer and having to deal with those expenses, what that might do with the AHP premiums in the future?

Mr. ROBERTSON. Yeah, I mean, that is always a concern because you have to have an association health plan that remains sol-

vent. And so there is that concern out there. But, again, the track records will show, with all these large employers, the larger the group, the more you can address those types of large events.

Mr. KIND. And I think there is great agreement on that point. It was just interesting, because I did encounter this article of the *World-Herald Bureau*, written by Joseph Morton, talking about the Nebraska AHP.

And, Mr. Chairman, I would ask unanimous consent to get the article included in the record at this time.

[The information follows:]

Nebraska Farm Bureau's health insurance program off to solid sta...

<https://www.omaha.com/livewellnebraska/health/nebraska-farm-b...>

https://www.omaha.com/livewellnebraska/health/nebraska-farm-bureau-s-health-insurance-program-off-to-solid/article_f72baab4-9b6e-5633-877b-7364c25518e8.html

Nebraska Farm Bureau's health insurance program off to solid start with 700 signups

By Joseph Morton / World-Herald Bureau Dec 24, 2018

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WASHINGTON — The Nebraska Farm Bureau has signed up 700 people for its new health insurance plans.

The Farm Bureau partnered with Medica to offer the plans, which have premiums roughly 25 percent cheaper than those offered through the state's Affordable Care Act exchange, not accounting for any subsidies.

Geoff Bartsh, Medica's vice president of individual and family business, said that 700 number isn't bad for a plan announced at the end of September.

"Which tells me there really was a group of farmers and ranchers who couldn't find an option that met their needs," Bartsh said.

And he said those numbers could grow significantly in the future with more time to promote the plans.

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Rep. Jeff Fortenberry, R-Neb., sought to include a provision in

the new farm bill promoting association plans like those offered by the Farm Bureau, but it was stripped out of the final version.

Rob Robertson, the Nebraska Farm Bureau's chief administrator, said the group was disappointed to see Fortenberry's language eliminated in part because it would have included seed money in the form of grants and loans to help with startup costs for such plans. The Nebraska Farm Bureau spent more than \$200,000 setting up its program, Robertson said, with much of that covering the cost of complying with the various state and federal regulations.

Robertson said the plans are saving thousands of dollars for people who weren't getting subsidies on the exchange.

The Farm Bureau's insurance offerings are treated like large group plans but are ACA-compliant. That means the premiums can be rated based on factors such as age but not health status. So there's no denying someone just because they have diabetes, for example.

"We're not cherry-picking healthy people," Robertson said.

Those who enrolled for 2019 must have joined the farm group by July 1, 2018.

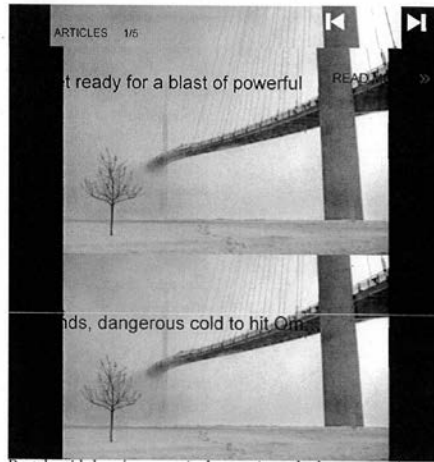
"We want to avoid adverse selection," Robertson said. "We didn't want the next 100 members of Nebraska Farm Bureau to need knee replacements."

They will take a similar approach going forward, so those signing up for 2020 will need to become a member by mid-2019.

Enrollees must also demonstrate that they are involved in agriculture. Robertson expects more of their members to sign up in the future.

Nebraska Farm Bureau's health insurance program off to solid sta...

<https://www.omaha.com/livewellnebraska/health/nebraska-farm-b...>



Bartsh said there's no particular magic to the lower premium.

"It's a matter of looking at the potential claims that are going to come through this association membership versus the claims we're seeing in the larger individual market," Bartsh said. "We had an opportunity to just assess who the potential association members would be and their health risk is lower than the remaining individual market."

There are 90,000 people on the individual market in Nebraska. Bartsh said he doesn't see an erosion in that from association plans.

"The associations in our mind are really targeting again either people who have left the market already or those people who are still in the market but don't receive a subsidy," Bartsh said. "And that's just a small overall portion."

Meanwhile, [across the river in Iowa](#), that state's Farm Bureau is offering an "underwritten health benefit plan" that is not ACA-compliant. So applicants must pass underwriting, which means they can be denied or charged more based on pre-

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existing conditions.

Iowa Farm Bureau spokeswoman Laurie Johns said in a statement that the group has seen a "steady influx of applications" but did not provide numbers.

"From the beginning, the Farm Bureau Health Plan was not designed to take the place of ACA," Johns said. "Those who qualify for tax credits (subsidies) will likely find the ACA the most affordable option for them. A significant majority of ACA enrollees receive tax credits, which greatly reduces their premium cost and makes those ACA plans a more cost-effective option."

Health policy experts have warned that association plans, particularly if not ACA-compliant, could pull younger and healthier individuals out of the exchanges and drive up premiums there.

Still, not everyone is abandoning the exchanges.

Tiffany Lechtenberg's family owns NorthView Family Farms in Spencer, Nebraska, where they raise cattle and grow commercial alfalfa along with other crops.

They had previously lauded the Farm Bureau for creating the insurance plans but ultimately opted not to join for 2019.

"We looked it over for our family and found that staying on Obamacare was less expensive for us," Lechtenberg said. "But it was nice to have an option."

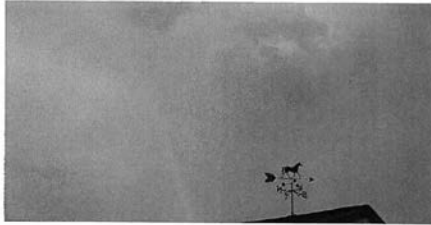
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Rain clouds and a bit of a rainbow roll over the sky in the Millard area of Omaha on Aug. 16, 2016. RYAN SODERLIN/THE WORLD-HERALD

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RYAN SODERLIN

Joseph Morton

Reporter - Politics/Washington D.C.

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Mr. KIND. But in it Mr. Jeff Bartsch, who is Medica's Vice President, who is offering the health plan for you, was asked how the initial premiums were established, and he was quoted as saying, "We had an opportunity to just assess who the potential association members would be, and their health risk is lower than the remaining individual market, and that is why you are seeing some better premiums being offered."

But he also pointed out there are over 90,000 people in health insurance exchanges under the ACA in Nebraska who are still in that pool, and the vast majority of them are receiving premium tax credits to lower their costs.

I know in Wisconsin—I don't know what it is in Nebraska—but 87 percent of the participants in the ACA health insurance exchange in Wisconsin are qualifying for these premium tax credits, substantially reducing their costs, and that is why so many have signed up for it.

But Mr. Bartsch also went on to say that the association, in our mind, is really targeting, again, either people who have left the market already, or those people who are still in the market but don't receive a premium tax credit. So that is the issue, really, the roughly 5, 6 percent of the overall population of the country. Mr. Bartsch, that is just a small overall portion of the overall population that fits that definition.

And that is one on which I hope that we could find some bipartisan agreement. How do we address that small portion of the American population stuck in the individual marketplace, not qualifying for premium tax credits?

I know Mr. Neal and others of us have offered legislation to address that by expanding these premium tax credits to cover more individuals. That is another way of addressing it.

But I am just concerned that with demographics, with an aging population, extraordinary health events, such a small pool of 700 members—you are hoping to grow that—what that might do to future premiums.

Let me finally ask you, do most of your members when they hit 65 then transfer into Medicare?

Mr. ROBERTSON. Yeah. Yeah, they do.

Mr. KIND. And Medicare is a great program, and they have to take all newcomers, whether you have a preexisting condition or not. Medicare is able to spread that risk out.

Do you have a prediction that if there was an early buy-in option to Medicare, that is budget neutral, that some of your members might find that an attractive option?

Mr. ROBERTSON. I do not. No, I am just here on the association health plans. I appreciate that—

Mr. KIND. Fair enough. Fair enough.

Mr. ROBERTSON. But on your point, on the Federal poverty level, we even saw those members who are in the 250 to 400 percent Federal poverty level—actually, our Farm Bureau plan competed with that tax credit, and we were able to pull some of those away from that premium subsidy. So that was good news we saw.

Mr. KIND. That is good. We will watch it very closely. Thank you. Thank you all.

Chairman NEAL. I thank the gentleman, and with that I would like to recognize the gentleman from Missouri, Mr. Smith. And after Mr. Smith inquires, we will move to establish precedent on the Committee, having two witnesses on our side for one on the other side. With that, Mr. Smith is recognized for 5 minutes.

Mr. SMITH OF MISSOURI. Thank you, Mr. Chairman. I look forward to working with you and the Republican leader on the important business upcoming in this Committee.

We all agree that protecting access to coverage for individuals with preexisting conditions is necessary. I look forward to working with you, Mr. Chairman, on solutions that offer certainty to our most vulnerable. That being said, the status quo is full of problems that have made many patients' nightmares become reality.

In 29 of the 30 counties I represent, Missourians only have one insurance provider on healthcare exchanges. Lack of choice has skyrocketed costs.

You know what fails to protect patients with preexisting conditions? Deductibles so high that you might technically have insurance, but it is effectively meaningless.

Lack of choice. A noncompetitive marketplace full of options that don't meet your needs.

What will fail to protect patients with preexisting conditions? Failing to address Medicare solvency before it becomes insolvent in 7 years.

We have to address costs and increase choices in our healthcare system to create a competitive marketplace, so consumers can buy insurance that works for them and meets their needs.

I want to share a letter I received from Marian and Greg from Ozark County, Missouri, in my district: "My husband Greg and I recently moved to Ozark County from Tennessee. Greg had to retire early because of a stroke that he suffered in 2015. We are currently on COBRA and are paying a thousand dollars a month for basically nothing. We discovered that our county in Missouri has only one provider for ObamaCare, and that coverage is even more expensive than our COBRA coverage.

When is Congress going to do something to correct the damage of ObamaCare? Getting rid of the mandate was great, but that is not enough. And why aren't there high-risk pools or some other options for people with preexisting conditions like my husband? We don't want to spend all of our savings on health insurance premiums, especially if we don't receive any benefit. Politicians say that people shouldn't go bankrupt from medical bills. I say that people shouldn't go bankrupt from paying ridiculously high insurance premiums."

I couldn't agree with Marian more and I hope that the Chairman will work with us to find policies to lower costs that we can advance through, not only this Committee and the House, but that can pass the Senate and earn the President's signature. I yield back.

Chairman NEAL. I thank the gentleman. With that, let me recognize the gentleman from New Jersey for 5 minutes to inquire, Mr. Pascrell.

Mr. PASCRELL. Thank you, Mr. Chairman. Doing away with the mandate and cutting subsidies, et cetera, et cetera, is just the

beginning of how you try to strangle the Affordable Care Act. Let me hope you will write some of these things down, because it seems like this is a redo of the last 6 years.

The ACA has substantially improved access to care and financial security. Between 2010 and 2017, the share of nonelderly adults with a problem paying a medical bill fell 21 percent; who didn't fill a prescription, fell 27 percent; who skipped a test or a treatment, fell 28 percent; who didn't visit a provider when they needed care, and that fell 23 percent.

Now, to bolster that, the marketplace consumers are satisfied with their coverage. That has gone from 36 percent all the way up, now it is at 82 percent in 2017. You have to look at these numbers, instead of doing redo's.

Before the ACA, women could be charged more than men just for being born female. Maternity, mental health, and substance abuse were routinely not included in insurance coverage. What are you talking about, you support preconditions? I must have missed a lot of meetings over the last 3 years. And the Administration must have missed it all.

Companies could bill consumers for every last dime with virtually no oversight. Someone said before, look at what the conditions were in 2010, which brought about this situation. If we would have done nothing, if we would have done nothing—and you are good at doing that—you criticized us and didn't come up with another plan on preconditions. You have to be kidding me.

The fact of the matter is, you voted more than 70 times to repeal the protections and take us back to the days of uncertain and discriminatory coverage. You did that.

After years of sabotaging the Affordable Care Act, your efforts have served only to make protections afforded to Americans and that law all the more popular today. Thank you.

But the repeated attempts at repealing, gutting, and otherwise sabotaging the ACA, have left us with a lot of work to do to pick up the slack. The Committee, in particular, egregiously gutted provisions of the ACA in the 2017 tax bill in December. Remember that? Remember that bill? You didn't even have the guts to run on it. You ran away from the bill. A move that is projected to cause 13 million people to lose insurance. You did it. I didn't do it. No one on this side did it. You did it.

A partisan lawsuit subsequently has tried to dismantle the entire ACA, including its protection for preexisting conditions, and taking away the few assurances we provide Americans in the healthcare marketplace. We must stabilize. No one said that the ACA was perfect. No one said that on this side. In fact, everybody on this side in the last 6 years have offered some kind of situation of amendment to make the ACA better. Because we have never had perfect legislation in this Committee or any other Committee.

I just want to ask you one quick question, Karen—Ms. Pollitz. Republicans have put forward an expansion of a short-term, limited duration plan for—it is called a junk plan—as a new option to supposedly lower costs for consumers.

Can you describe the pitfalls of high-risk pools, and have they ever worked in the past? And can you describe the problems with these junk plans?

Ms. POLLITZ. I will start with high-risk pools if I could.

Mr. PASCARELL. Sure.

Ms. POLLITZ. I actually—yes?

Chairman NEAL. You will be allowed to finish your answer if you make it succinct.

Ms. POLLITZ. Okay. So high-risk pools were a different way of going about this before the ACA in many States, including in Maryland where I live. I was actually on the board of our State high-risk pool. Insurers were allowed to turn people down because of their preexisting conditions and then the State would provide a public program, a high-risk pool that would offer alternative coverage.

That is a very expensive proposition, though. If you only offer coverage for the people who are sick, who account for most of the spending and the risk pool, that will be a very expensive program. States that had these programs, by definition, lost money on every person that they signed up. They were very, very expensive.

So States, over time, started adopting features to limit the cost of programs and to limit the number of people who could enroll. So all but one of the high-risk pools excluded coverage for the pre-existing condition, which made you eligible, for 6 to 12 months. They charge premiums higher than standard rates, and even still they lost money on average, about \$5,000 a year per person. So it is another way to do it.

There are—Medicare, for example, covers people with end stage renal disease, so there is a lot of tradition of having a public plan take some of the expensive people and make that sort of the main way of getting coverage. It is just very expensive to do it that way, and without premium financing, there has to be other taxpayer financing to make that work.

In terms of the short-term plans, that is an entirely different approach. That is sort of undoing the risk pool and saying, we can make cheaper coverage available to people while they are healthy but only while they are healthy. And you heard from Andrew what happens once you get sick in a short-term plan.

So if you believe that you buy insurance in case you get sick, then you want coverage that doesn't stop working once you stop being healthy.

Mr. PASCARELL. Thank you. Thank you, Mr. Chairman.

Chairman NEAL. I thank the gentleman for his inquiry. With that let me recognize the gentleman from Illinois, Mr. Davis, for 5 minutes to inquire.

Mr. DAVIS. Thank you, Mr. Chairman, for calling this hearing, and I also want to thank all of our witnesses for coming to share with us.

Much of my focus is on children, because children are such an important part of our population and represent so much of the future. Children living with disabilities such as autism, or ADHD, regularly need therapies or medication to ensure that they can attain and retain their maximum functioning.

Under the ACA, even though children cannot be denied coverage, they are charged higher premiums due to a preexisting condition. Sometimes therapies and medications required to address these conditions are not covered by insurance.

Ms. Pollitz, how do we ensure that treatments for children with disabilities are covered by insurance, and how well are we doing with it in the ACA?

Ms. POLLITZ. Mr. Davis, the—let's see. As you pointed out, children with disabilities can't be discriminated against, turned down, charged more, or have their preexisting condition excluded. The ACA does prior to an acute care coverage benefit. So depending on the disability and what it is, there are often limits, I think, to what private insurance would cover, which is why sometimes people end up turning to the Medicaid program which provides a much more comprehensive set of services for long-term services and supports.

And for children, because of the EPSDT benefit, the Early Preventive Screening Diagnosis Testing—I forget—it covers everything that children need, so that is the most comprehensive benefit.

In terms of two of the conditions that you mentioned, autism and ADHD—is that right?

Mr. DAVIS. Right.

Ms. POLLITZ. So that is then—the ACA is not so specific in that. So there is a standard for essential health benefits that applies in the individual and the small-group market, but those essential health benefits are categories of services. They, by and large, don't include a definition of specific services or specific conditions. States are allowed to then add more detail to the essential health benefits through the benchmark plan that they adopt.

I think most States have adopted a standard—I don't know about Oregon—to cover services and testing and diagnosis relating to autism, for example.

In other plans, including large employer plans, and particularly self-funded employer plans, at least with these two conditions that you mentioned, there is another law, the Mental Health Parity Act, which does require that plans have to cover services related to mental health conditions at the same level that they do for other medical conditions. I think—

Mr. DAVIS. Okay. Let me ask you—

Ms. POLLITZ [continuing]. Insurers can kind of have some discretion, though, about determining what counts as a mental disorder.

Mr. DAVIS. Good. Parents around the country regularly spend anywhere between \$2,000 and \$5,000 out of pocket to determine whether their child has a disability because insurance may not cover the tests required to diagnose or assess these conditions.

Is insurance required to cover the treatment associated with pre-existing conditions? Shouldn't it also cover the test or evaluations required to determine whether a child has a particular illness or situation?

Ms. POLLITZ. Again, in general, I believe insurance is required to cover diagnostic services, but insurers have discretion to determine what is medically necessary and what falls within the scope of their covered services. I am not sure if maybe in Oregon there is an example of some—

So some States are more specific, particularly with respect to autism and do require private insurance to cover diagnostic services, treatment services. But those State laws would not reach large,

self-funded, employer plans, and that may be where your constituents are finding gaps in their private coverage.

Mr. DAVIS. Thank you so much for that kind of clarity.

Thank you, Mr. Chairman. And I yield back.

Chairman NEAL. I thank the gentleman. With that, let me recognize the gentleman from South Carolina, Mr. Price, for 5 minutes.

Mr. RICE. That would be Mr. Rice, but you were close.

Chairman NEAL. Mr. Rice, I am sorry.

Mr. RICE. No problem, Mr. Chairman.

The theory of the Affordable Care Act was to provide universal coverage for people, including those who had preexisting conditions, and that we could keep the costs down by adding to the risk pool because people were basically not required to buy insurance but penalized if they didn't. And also to bring down the health insurance cost.

As you will recall, the President said, you know, if you like your plan, you can keep it, which is clearly a falsehood. When he said, if you like your doctor, you can keep him, that often proved not to be true. And when he said it would bring down the cost of health insurance, in fact, the opposite has been painfully true.

Expanding the insured base was one of the goals, and the other goal was to bring the cost down. This first chart here is of the insured base, and it clearly shows that before the Affordable Care Act, 85 percent of America was covered, either by private, employer-held insurance, which is the bottom of each bar there. The first bar is 2010; the last is 2017. But at the bottom in the blue there is employer insurance.

And then the—I am skipping the middle, the purple part is Medicaid, and then the orange is Medicare, and then the yellow is the uninsured population. So the uninsured population has shrunk some. It was 85 percent, just before the Affordable Care Act hit in 2013; now it is 91 percent.

So we have insured 6 percent more people. That is good. That is a laudable goal. We want to insure as many people as we can. But what is the cost of that? Next chart, please. So to insure those 6 percent more people, we have—this is insurance premiums. The first bar is 2013; the last is 2017. Individual market insurance premiums in 2013 were about \$225, and today they are about \$475, which, if you think about that, 85 percent of people were covered before the Affordable Care Act.

We have succeeded in covering 6 percent more people. So the cost of that, though, was those 85 percent, who were already covered, have to pay more than twice as much to pick up that incremental benefit of the 6 percent more people.

Now, there are different ways to cover those 6 percent more people. Most of those people were picked up because we expanded Medicaid in most States. And so we just basically said, here, here is your free insurance, and we picked those up. We didn't have to charge everybody else twice as much to get most of that incremental benefit.

We could have just said, we are going to expand Medicaid, forget about the rest of the Affordable Care Act, right?

Most States had other mechanisms for covering people who had preexisting conditions. My State, South Carolina, had a health insurance pool. I am curious about Oregon—and, Mr. Stolfi, I am going to pick on you, because you are the only Insurance Commissioner here. What was Oregon's mechanism for covering people with preexisting conditions? Did they have one? Did you have none?

Mr. STOLFI. Thank you, Representative. Oregon did have a high-risk pool program.

Mr. RICE. And could people be excluded from the high-risk pool?

Mr. STOLFI. There were waiting lists for the high-risk pool. There were preexisting exclusions for the first—it could be up to 6 months.

Mr. RICE. Okay. But we have open enrollment for a limited period of time in ObamaCare, so if you want to sign up in May you had a 6-month waiting period anyway, right? So that really hadn't changed.

Now, how much more was the monthly premium in Oregon for a high-risk pool, people with preexisting conditions, than for other people? Was the premium a whole lot higher? In South Carolina I know, because I had two kids that were in our high-risk pool, I had one that had a heart defect and one that had a brain defect, and the premium in South Carolina was about 30 percent higher. How much higher was it in Oregon?

Mr. STOLFI. It was capped at 125 percent of the cost.

Mr. RICE. So it was 25 percent higher, right?

Mr. STOLFI. Yes.

Mr. RICE. Okay. Well, today, I am telling you, there it is right there, everybody has to pay 230 percent more because of ObamaCare. Now, if before ObamaCare the most risky folks with preexisting conditions had to pay 125 percent and their deductibles had now gone up like five times, I mean, I looked at your plan, you had a \$750 deductible, a \$500 deductible, and a \$1,500 deductible. Now your average deductible is \$4,100.

So your people with preexisting conditions are now having to pay 230 percent more or 130 percent more instead of 25 percent more, and their deductible is five times as much. Can you really look at me with a straight face and tell me that those people are better off with ObamaCare than they were before ObamaCare? They had lower premiums. They had access to coverage. And they had much lower deductibles. Are they really better off? Do you really believe that?

Chairman NEAL. The gentleman will be allowed to finish his answer, please.

Mr. STOLFI. Thank you, Mr. Chairman. Absolutely, the people are better off now than they were before. And you touch on a point of affordability, which is a very important concept. And there is many different ways to look at affordability, and one is, you know, for the people that don't have choice. The people who have health conditions, how affordable is this coverage for them? Before the ACA, this coverage was not affordable for people. If they—

Mr. RICE. It cost half as much. It cost half as much.

Mr. STOLFI. So we have compared the price right now of an average comprehensive healthcare plan that any individual can get

now to the price that someone would pay in OMEP, and those prices are essentially the same. Actually, the OMEP policy is—

Mr. RICE. But the price you are comparing it to is 230 percent higher than it was before ObamaCare drove it up.

Mr. STOLFI. So the price differences have actually happened, and I can't dispute that. But what is very important is that we are not comparing apples to apples.

Chairman NEAL. The time of the gentleman has expired. We move to Ms. Sánchez to be recognized for 5 minutes.

Ms. SANCHEZ. Thank you, Mr. Chairman. And I want to thank all of our witnesses for joining us today.

I am extremely pleased that we are having this hearing on pre-existing conditions because it is a reminder of the measurable improvements that have been made in the lives of millions of Americans since the passage of the Affordable Care Act.

And I have personal experience with this with staff members that were employed in my district office. I know for a fact that prior to the ACA, insurance companies could deny anyone coverage for any reason, and they could also discriminate against women and charge us higher premiums simply because of our gender, because we are women. That is a practice known as gender rating, which I was proud to have championed its demise in the passage of the Affordable Care Act.

In 2009, a study by the Women's Law Center found that young, healthy women were charged 84 percent more than similarly aged males for plans that didn't even include maternity benefits. Insurance companies treated being a woman effectively as a preexisting condition. Before the ACA many with health insurance who thought they had coverage often found themselves denied coverage in their time of need. Many were shocked to find that maternity care wasn't covered under their plans or they were denied coverage entirely after a pregnancy.

But it is not just women who benefited from the Affordable Care Act. More than 130 million Americans have a preexisting condition and are now guaranteed access to coverage and quality affordable care when they need it. I am proud to have worked on and voted for the Affordable Care Act. And I am frustrated by Republican efforts, namely, efforts by this Administration, to increase costs and decrease quality. While they love to attack the ACA, what they do in response to that is create more uncertainty and drive up prices.

So I am interested, Ms. Pollitz, I have a few things that I am interested in asking you whether or not doing these things creates more certainty, and thus makes healthcare coverage more affordable because these are things that we have seen. Refusing to use appropriated money to do advertising, outreach, and hire navigators to explain enrollment processes. Do you think that creates more certainty and helps lower healthcare costs?

Ms. POLLITZ. I think that does make it harder for people to know all of our polling that we have done every year. Open enrollment shows that people don't understand the ACA still, or when the dates are. So not having advertising and consumer assistance can make it harder for people to sign up. The healthiest people are the most likely to stay out.

Ms. SÁNCHEZ. Ms. Brooks-Coley, do you think that helps create more certainty and lower healthcare costs by refusing to use money for the outreach and to hire navigators?

Ms. BROOKS-COLEY. No. From our perspective, transparency and education about plans and what type of coverage an individual can purchase is extremely important. And not having the funding used for that purpose can lead to patients not actually purchasing insurance or understanding what they are purchasing.

Ms. SANCHEZ. Okay. Ms. Pollitz—and Mr. Blackshear has personal experience with this, perhaps you would care to chime in—allowing these substandard junk plans to be sold on the market, do you think that creates certainty and lowers costs?

Ms. POLLITZ. That has been shown to increase costs. Insurer rate filings show that they expect this will cause adverse selection, and so raise the average cost of the ACA compliant plans.

Ms. SANCHEZ. Mr. Blackshear.

Mr. BLACKSHEAR. I just want to say, it literally does increase uncertainty.

Ms. SANCHEZ. Thank you. What about challenging in court critical provisions of the ACA such as penalties for those who don't get coverage or striking down the individual mandate? Ms. Pollitz.

Ms. POLLITZ. That is another source of uncertainty about the future of the ACA.

Chairman NEAL. Mr. Stolfi, would you agree with that?

Mr. STOLFI. I would agree, yes.

Ms. SANCHEZ. Thank you. Finally, Ms. Pollitz, could you explain what would happen if we rolled back the preexisting condition protections and the gender rating provisions? What would happen to those seeking coverage?

Ms. POLLITZ. Well, that would be kind of going back to what the world looked like before 2010. So that women in—certainly younger women would pay much more in premiums than younger men due to gender rating, and people with preexisting conditions or a history of them, would find it much more difficult to find coverage in the nongroup market.

Ms. SANCHEZ. I just want to state for the record in the limited time that I have, I had a staff member who worked in my district office, the mother of four children, who got cancer, and this was prior to the passage of the ACA, and they refused her care at a certain point because she had hit her cap. And so she was not able to get treatment, and sadly, she passed from cancer. That is what will happen if we roll back the protections in the Affordable Care Act.

And, again, I want to thank the Chairman, and I want to thank our witnesses.

Chairman NEAL. I thank the gentlelady. With that, let me recognize the gentleman from New York, Mr. Higgins, to inquire for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman. Prior to the enactment of Medicare in 1965, 56 percent of older Americans could not get coverage because they had the preexisting condition of old age. That is when the Medicare program was established. Today, 97 percent of older Americans have access to good quality healthcare through the Medicare program.

Preexisting conditions are basically good people that are treated differently by private insurance because they were born with a genetic mutation that causes or increases the risk of disease. Those diseases include childhood cancer, juvenile diabetes, kids born with Downs syndrome, and cystic fibrosis. Before the Affordable Care Act, almost 50 percent of adults between the ages of 50 and 64½ who tried to buy health insurance for themselves and their families were denied because of preexisting conditions.

You can't do that anymore. It is against the law because of the Affordable Care Act. My colleagues on the other side keep saying that everybody up here supports preexisting condition protections. That is not true. Everybody up here does not support preexisting condition protections. House Republicans between March of 2010 and July of 2017, more than 7 years, House Republicans voted 70 times—70 times to repeal and replace the Affordable Care Act's preexisting condition protections.

Everybody up here does not support people with preexisting conditions. Having failed 70 times, Republicans then advance their new plan. The insidious, malicious language in there said that a health insurance company had to write a policy for somebody with preexisting conditions, but that policy didn't have to cover the treatment of a family member, a kid who is struck with childhood cancer for that preexisting condition. So, no, everybody up here does not support protecting people with preexisting conditions.

Mr. BRADY. Will the gentleman yield?

Mr. HIGGINS. I will not yield. I will not yield.

Mr. BRADY. I yield back.

Mr. HIGGINS. So House Republicans couldn't pass legislation to repeal and replace. They couldn't pass their own healthcare plan because nobody supported it because nobody believed them. So then they went to the States and they said they will do what we were unable to do. Twenty States attorneys general joined a lawsuit challenging the Affordable Care Act in the preexisting condition protections in Federal court. Eleven of those States have the highest population of preexisting conditions.

So the only hope left is the White House, and the White House's Justice Department who can come in and save the day. They filed an opinion saying that they would not defend the Affordable Care Act, and that they opposed and characterized it as unconstitutional. They opposed the preexisting condition protections of the Affordable Care Act.

Nobody up here, not one person up here, supports preexisting condition protections for the American people. Not one person up here. And not one Republican out there either. You go ask the States attorneys general in those States that have joined together to fight this protection that people fundamentally need.

Here is the bottom line. The Medicare program did what private insurance companies had the opportunity to do and decided not to, because they don't make a lot of money on people who are sick. That is not who we are as a Nation. That is why we should allow people to use the leverage of the Medicare program to buy-in at their own expense so that they can get the protection of preexisting conditions now.

The private sector has had all kinds of opportunity. And the great irony in all of this is that Medicare was established as a public program, and guess what, when it was so successful, guess who wanted to get involved? Private insurance through Medicare advantage.

Look, I think the choices are pretty clear here, and I think that we will have legislation that will affirm that in clear and unambiguous language.

Mr. BRADY. Mr. Chairman, regular order—stay on the time—

Chairman NEAL. I thank the gentleman. His time has expired.

Mr. HIGGINS. We have preexisting conditions. I yield back.

Chairman NEAL. With that, subscribing and adhering to what is known as the Gibbons Rule, for some of us who have been here for a bit, we will recognize the gentleman from New York. And the Gibbons Rule simply says people are recognized in the order in which the gavel came down if they were seated. Mr. Reed.

Mr. REED. Well, I thank the Chairman for the recognition. And with great respect to my colleague from New York who just articulated one of the greatest falsehoods I have ever heard uttered in this chamber on the Ways and Means Committee, Republicans, and the gentleman, I would hope, would remind themselves that they are Members of Congress. And, as a Member of Congress, I stand here to articulate as a Republican, and as a Member of this dais on the Republican side, that we take yes for an answer.

We support the provision. The provision. Remember, the Affordable Care Act was 3,000-plus pages. And the provision that we are talking about, the protection of preexisting conditions, is something where I say to the American people and I say to this dais and I say to my colleagues on the other side of the aisle, take yes for an answer. We agree with you. This reform is good. This reform will stay as the law of the land.

And we heard the voice and the fear that was the result of the 2018 election where this issue became centerpiece in that vernacular and in that debate, that we listen to the American people as Republicans. Preexisting conditions will remain the law of the land. But we need to do better. And what I would articulate to the American people today is that there is a fundamental choice that is going to be on display for you for the next 2 years.

The fundamental choice that is carried by my colleagues on the other side of the aisle is known as something as simple as Medicare for All, single payer healthcare. What that is is government controlled, government run healthcare. We as Republicans offer you a different vision. We offer you an embrace of market pressure to bring healthcare costs down, that will also bring health insurance premiums down.

So, Mr. Blackshear, I heard your story, I heard your condition. And maybe if I could articulate something that I have seen repeatedly as I have gone across my district and across this country and talked to the American people, there is a vast misunderstanding in regard to the connection of healthcare cost and health insurance premiums.

I heard your testimony, and if I heard it correctly, you said your premiums now are about \$70 to \$80 a month. Is that correct?

Mr. BLACKSHEAR. That is correct.

Mr. REED. So that is approximately \$1,000 a year. And your horrific preexisting condition, your horrific heart condition, I read your testimony, and it articulated that you had exposure to medical costs of \$200,000, and probably those medical costs were triple that, quadruple that. It probably cost a million dollars for the care that you received.

And so do you see the issue between \$1,000 a year versus the cost of care that your horrific condition of \$200,000 plus causes? And we in the healthcare arena have to have a vehicle to take those costs, right, of \$200,000 plus for your condition, and if you are paying \$1,000 a year in premiums, how does that cover the two together?

And I think what Mr. Robertson is offering, from Nebraska, is a way to do that. Are you not, sir?

Mr. ROBERTSON. Yes.

Mr. REED. And how do you do that?

Mr. ROBERTSON. Again, by forming an association health plan you pool the individual small markets together so basically you can cover people with preexisting conditions because your risk pool is large enough to do that. That is what large employers do today.

Mr. REED. And that is what employers do. So what it is about is taking those costs, right, and trying to share them amongst everyone. But most fundamentally, I think what is lost in this debate is—did anyone here today testify to any mechanisms to bring those healthcare costs of \$200,000 down? I did not see any of your testimony talking about how to bring that \$200,000 price tag that Mr. Blackshear was exposed to down. Did I see any testimony offered by anyone in here about bringing those costs down? Did I miss it?

And the silence of the dais speaks volumes to the issue that we face. Because, Ms. Brooks-Coley, I heard your testimony, and we talked about exorbitant prices, and my colleagues question to you was about premiums. You didn't talk about the premiums, you talked about the prices, and you kind of mixed the two together. Did I hear your testimony correctly?

Ms. BROOKS-COLEY. You are referring specifically to high-risk pool premiums?

Mr. REED. He asked you about exorbitant premiums and you talked about exorbitant prices. So, to me, that was your testimony. To bring prices down is where the focus should be. And that is where agreement and common ground could be found.

With that, I yield back.

Chairman NEAL. With that, the gentlelady will be able to answer.

Ms. BROOKS-COLEY. Well, the only thing I would say is from the cancer perspective. We have concerns about the rising cost of premiums as well as the out-of-pocket costs for patients. And we agree that affordability is an issue, but you have to look at ways to address affordability without addressing and harming patient access to comprehensive coverage. You look at plans such as short-term limited duration plans and other products that aren't comprehensive, and that is where we become very concerned.

Chairman NEAL. Thank you. With that, let me recognize the gentlelady from Alabama, Ms. Sewell, to inquire for 5 minutes.

Ms. SEWELL. Thank you, Mr. Chairman. I want to commend you for having our first hearing be about preexisting conditions. As has been stated before, preexisting conditions affect over half of Americans. And as my colleague, Ms. Sánchez, said, the gender rating affected women and made being a woman a preexisting condition. I can also tell you that the ACA has not only helped us in making sure that insurance companies can no longer discriminate against Americans for preexisting conditions, but it also decreased the cost of being sick while black.

So as a black woman, I have seen the ACA work both to reduce the incidence of gender discrimination but also help to reduce some of the barriers to access that often people of color have.

My question really, I guess, is to Ms. Pollitz. Can you talk a little bit about the barriers to access to healthcare like, for example, not expanding Medicaid? There are lots of States like mine, Alabama, that did not expand Medicaid, and the premium costs have skyrocketed, not just because of, you know, the fact that not as many people are signing up for the healthcare insurance, but the fact that so many folks just can't afford the premiums and the deductibles.

Can you talk a little bit about access to healthcare and how the ACA has affected that?

Ms. POLLITZ. Sure. So about 2 million people live in—adults, below poverty, live in States that have not expanded Medicaid. So they don't have any affordable insurance options available to them.

Ms. SEWELL. And isn't it true that by decreasing the subsidies, which was one of the ways that my colleagues across the aisle sabotaged the ACA, it only exacerbates the problem?

Ms. POLLITZ. There is actually a proposal the President just released in the 2020 benefit and payment parameter rule that actually would reduce subsidies under the ACA, just by changing the formula that indexes what people have to pay and how much in subsidies they get. That is expected to save the Federal Government about a billion dollars a year, and—

Ms. SEWELL. Expanding Medicaid or creating—

Ms. POLLITZ. No, I am sorry, that is to reduce the ACA subsidies. The Administration estimates about 100,000 people would lose coverage as a result of that.

Ms. SEWELL. Well, I know that in my State we don't have—our farmers struggle oftentimes with finding affordable healthcare. In fact, there is a farmer in Nectar, Alabama, Hank Adcock, whose story I have shared in this hearing before. He is a third generation farmer, has never had health insurance until a navigator knocked on his door back in 2015. And, you know, had the navigator called it ObamaCare, he said that he probably wouldn't have gotten the health insurance. But because they said it was the Affordable Care Act and because it was an affordable subsidy that he was offered, he took health insurance.

Almost 6 months later, his hand got caught in one of those hay bailers and, you know, not only did the Affordable Care Act save his hand, it also saved his farm because he had health insurance for the first time ever. And so, you know, unlike Mr. Robertson, unlike the association plan that you discussed for your farmers, we didn't have that option in Alabama. And Alabama also did not ex-

pand Medicaid, and so, many low income workers and hardworking families are struggling just to find access. So I really wanted to talk about cutting down the costs.

Wouldn't it be better if we expanded access to coverage like you have done in Oregon through your own devices? I wanted to talk to Mr. Stolfi about how we can decrease the costs, because we have heard a lot about that. How has your State decreased the costs and at the same time expanded access?

Mr. STOLFI. Thank you, Representative. Cost is definitely one of the key issues and something that we all should be focusing our time and attention on. In Oregon, we have taken a couple of approaches—well, there are a couple of major drivers of cost. Prescription drugs are a major driver of cost, utilization is a major driver of cost. Uncoordinated care and unhealthy behavior all contribute to cost. And—

Ms. SEWELL. I am going to reclaim my time because I only have 7 seconds, just to say that your testimony—your written testimony goes into detail about that, and I refer us all to that.

I wanted to mention, Mr. Chairman, that the Black Lung Disability Trust Fund, which was established 40 years ago and pays benefits to coal miners who have had total disability, an excise tax on coal that we supported for this fund has expired, it expired last year.

And I just wanted, as a State, Alabama, who has lots of coal miners, many of whom are out on disability because of that, I would love for this Committee to have a hearing and definitely hear from them as to why it is so important that we reestablish this excise tax.

Chairman NEAL. I thank the gentlelady. I will make sure that the staff follows up with you.

With that, let me recognize the gentlelady from Washington State to inquire for 5 minutes. Ms. DelBene.

Ms. DELBENE. Thank you, Mr. Chairman. And thank you to all of our witnesses for being with us today. Ms. Pollitz, I want to make sure that it is clear what is covered by a qualified health insurance plan that is sold on the Affordable Care Act exchanges, and what could possibly be missing from a short-term limited duration plan.

And I have a constituent, a nurse in my district. She has a young son, Sammy, who has hemophilia, and her employer-sponsored insurance is very critical. But if she lost her job or could no longer work, first of all, would she qualify for a special enrollment period?

Ms. POLLITZ. In the marketplace, yes, she would.

Ms. DELBENE. Yes. And if during that special enrollment period she purchases a plan for her and her son, would all the plans sold on the ACA exchanges guarantee coverage for hemophilia?

Ms. POLLITZ. Yes.

Ms. DELBENE. And if she purchased a short-term limited duration health plan, would she be guaranteed coverage for hemophilia for her son?

Ms. POLLITZ. She would not be able to buy that policy for her son. She would be turned down.

Ms. DELBENE. She would not have coverage?

Ms. POLLITZ. Correct.

Ms. DELBENE. Yes. If a young man in my district turns 26 and can no longer stay on his parents' plan, would he also then qualify for a special enrollment period? If he has type 1 diabetes and he goes to buy coverage on the ACA exchange, would he have coverage for his diabetes?

Ms. POLLITZ. Yes, he would.

Ms. DELBENE. Would he be guaranteed coverage for his diabetes if he buys a short-term limited duration plan?

Ms. POLLITZ. He would not be able to buy one. He would be turned down.

Ms. DELBENE. So another example, say, a graphic designer who has lupus decides to quit her job and start her own small business. If she buys on the ACA exchange, is she guaranteed that her lupus would be covered by that plan?

Ms. POLLITZ. Yes.

Ms. DELBENE. And would she have that same guarantee for coverage of her lupus if she acquired a short-term limited duration plan?

Ms. POLLITZ. She would not be able to acquire a plan. She would be turned down.

Ms. DELBENE. Finally, the ACA included a provision that required all qualified health plans to spend 80 cents of every premium dollar on healthcare. If the plan spends less than that, they have to return some money to the beneficiary. Does short-term plans have that same financial protection for consumers?

Ms. POLLITZ. No, they do not, and they tend to have much lower medical loss ratios.

Ms. DELBENE. Do you have examples of what those might be?

Ms. POLLITZ. Closer to 50 or 60 percent of premium dollars are spent on claims as opposed to administration and profits and other—

Ms. DELBENE. So there is quite a stark difference between what qualified plans cover and what short-term limited duration plans cover, isn't there?

Ms. POLLITZ. That is correct.

Ms. DELBENE. Thank you so much for your feedback.

And, Mr. Chairman, I yield back.

Ms. SEWELL [presiding]. The gentlelady yields back. And the Chair recognizes Mr. Schweikert from Arizona.

Mr. SCHWEIKERT. Madam Chairwoman, you look good in that seat. All right. Let's actually walk through a couple things. First, to our witness from Kaiser, thanks to much of your staff. They were incredibly helpful to my office over the last couple of years, particularly as we worked on the invisible risk pools, and the math. I know what you do datawise is very difficult because you do a lot of your data out of survey instead of getting actual hard data from insurers and others. I am hoping over time we can find a way so you can have even crisper data.

To the gentleman on the end who also has had valley fever, you had an undifferentiated case. A couple of us actually chair a valley fever task force. Be joyful, we think in 4 to 5 years we will have a vaccine out for animals, and then a little while after that, for humans. But it has been a fixation for many of us from the desert southwest. Most people have no idea about the orphan disease,

which is this fungi, that affects so many people. So I share that with you.

I am trying to find an eloquent way to say—I am frustrated because I know everyone here is sort of speaking from their heart and their knowledge-base. Much of my life has actually been in the financing side on some of the healthcare, and how do you do the actuarial math and how do you make it work.

A year ago, we actually—not only when you look at our Republican legislation, we had in their guaranteed issue, and we can all have a conversation on the mechanisms of what is guaranteed issue and what is preexisting. They actually sort of partially overlap, but there are some structural differences.

But we also added another \$15 billion to buy down in the individual risk pool some of the actuarial toxicity, because let's face it, it is 5 percent of our population, that is a little over 50 percent of all of our healthcare spending, because there are brothers and sisters with chronic conditions.

So here is my argument to my friends on the left, the right, and anyone that might be in between. We are having the wrong conversation here. Think about what we are doing. We are talking about, well, this is preexisting, well, this isn't. Well, this is—we can do this with premiums, but we will subsidize it more over here. The quick thought experiment, pre-ACA, after ACA, Republican alternatives, this and that.

If you were to take all dollars we are spending in our society, in our country, all dollars, whether it is coming through government, whether it is coming through your insurance premium, or out of your pocket, have we done anything to actually change the cost curve? All we are really debating here is who gets to pay.

And if you actually go back over the years, you know, going back to 1986 when we had sort of guaranteed service at an emergency room, or 1996, you know, when we actually did HIPAA, which actually had lots of the guarantees and the protections or the ACA. We have just been moving around the deck chairs on the ship.

I will ask from my Democrat colleagues, from my Republican colleagues, it is time for a radical rethinking of are you willing to work with us to break down the barriers to have a cost disruption? When this is about to become your primary care physician. When the technology—when I can show you the thing that looks like a large kazoo that you blow into, it tells you if you have the flu, the handheld ultrasound. There is a revolution rolling out right now and we have lots of statutory barriers at our State levels, our Federal levels, even in the original Social Security Act, that will keep technology from rolling out, empowering us to take better care of ourselves and crash the price of healthcare. And that is the more elegant debate here.

If we can continue this sort of circular logic we are having in these debates of well, you support preexisting conditions, well, I support preexisting condition coverage. Back and forth, and it is great politics. And we are doing nothing to crash the price. It is basically your Blockbuster video moment. Is there technology rolling out that should help us crash the price?

Now, how many of the smart people sitting here at the dais could start to design plans using that technology, using these opportuni-

ties? And we are going to have to have some really difficult conversations of do we have substantial overcapacity in physical structures? Well, we have lots of reports. Kaiser has actually done a couple of them of the number of hospital beds in the Nation that are actually empty and the caring costs of those. These are difficult conversations because we love our hospitals, we love—but there is technology revolutions around us, and unless this Committee and others around us start to break down these barriers, we are going to continue in the circular logic over and over. There is a chance to do a cost disruption. Let's actually start to embrace it and do something actually good.

Thank you, Madam Chairman.

Ms. SEWELL. The Chair recognizes Ms. Chu from California.

Ms. CHU. Well, I am particularly concerned about what would happen to women's health if we did not have the ACA.

So, Ms. Pollitz, I am concerned that the actions taken by the Trump administration will fundamentally undermine one of the ACA's core tenants, the support of cost-free preventative health services. And one of the most impactful is that of the birth control benefit or the Affordable Care Act's requirement that plans must offer no cost contraception coverage.

Since the ACA went into effect, about 63 million women have access to this healthcare benefit. And I feel I must emphasize this because it so often gets wrapped up in policy debates that people don't consider birth control to be healthcare, but it is healthcare plain and simple. But if the case in Texas prevails, this benefit, like the rest of the ACA, will be eliminated.

So, Ms. Pollitz, can you discuss what the situation was for contraception coverage prior to the ACA? Were there groups who were more likely to not have access to contraception or be unable to afford it?

Ms. POLLITZ. I believe our women's health team has a brief on this, which I would be happy to look up and submit for the record. In general, the big change with ACA was to require the no-cost coverage, so no deductibles, no co-pays apply for FDA-approved methods of contraception. So that has taken down a cost barrier for many women.

Ms. CHU. Okay. Thank you for that.

Ms. Brooks-Coley, thank you for testifying today on behalf of cancer patients amongst American women. Breast cancer is the most commonly diagnosed cancer, and the second leading cause of cancer death. In 2016, 3.5 million women in the United States were living with a history of breast cancer.

So, Ms. Brooks-Coley, can you describe the provisions in the Affordable Care Act that help women detect breast cancer early when it can still be treated, and what would happen to women with breast cancer if the ACA were repealed?

Ms. BROOKS-COLEY. Thank you, Congresswoman. The Affordable Care Act made sure that women who actually are diagnosed with breast cancer have access to comprehensive coverage. One of the things that it also did for all Americans and all women was to make sure that preventative services are available to individuals for free or little cost.

We know that important preventative screenings, such as mammography and colonoscopy, can be lifesaving tools that allow an individual to actually have their cancer diagnosed early, where we know then that the diagnosis and treatment can lead to better survival rates and better survivorship.

Ms. CHU. Thank you. I am also concerned about what would happen to low income women on Medicaid if the ACA were to end.

Ms. POLLITZ. I am deeply concerned about the Medicaid population. Medicaid provides 75 percent of the funding for all family planning services, nearly half of all births, and half of all long-term care funding, which many frail elderly women on Medicaid rely on. Medicaid is a lifeline for millions of American women, and Republican actions have put this lifeline in jeopardy.

So, Ms. POLLITZ, can you please discuss what the implications would be for women in the Medicaid program if the entirety of the ACA were to be struck down?

Ms. POLLITZ. Well, the Medicaid expansion covered adult women who were not pregnant or mothers of dependent children, and who had income up to 138 percent of poverty. So the Medicaid expansion has been the engine of insurance expansion in the ACA. And if that were to go away, then millions, millions of low income women would lose coverage.

Ms. CHU. And, Mr. Stolfi, I want to ensure that women would not be left unprotected through inadequate junk plans. My State of California joined five others in limiting or prohibiting the sale of short-term limited duration plans or the junk plans, and while they may appear to have lower premiums, many consumers find themselves stranded when they don't offer coverage for some of the most expensive conditions like pregnancy.

What is some of the additional actions that States like California can do to protect consumers, especially women, from efforts to undermine the ACA?

Mr. STOLFI. Well, yes, specifically in regard to short-term plans, other States could do exactly what California has done and prohibit them. What Oregon has done also is restrict the amount of time that they can be sold. Other States have done this through regulation. We would appreciate further guidance at the Federal level reversing the Federal rule changes. Even in States where we have not taken on those changes, it has created uncertainty and added costs—unnecessary costs to our folks. So we would appreciate more certainty there.

Ms. CHU. Thank you, I yield back.

Ms. SEWELL. The Chair recognizes the gentlelady from Wisconsin, Ms. Moore.

Ms. MOORE. Thank you so much, Madam Chair. And, again, I am just really glad to be here. I just want to say to our witness from the Farm Bureau that I want to commend you for pooling together the 700 people in the association to provide them with affordable healthcare.

And while those 700 people can have some reassurances about their healthcare, the Affordable Care Act sought to do that and did do it for 20 million additional people. It was the very same concept of pooling the risk, bringing in young people like Mr. Blackshear,

who were healthy at the time, having them pay a premium so as to lower the cost for everybody.

And, as a matter of fact, before we started giving it names like the Affordable Care Act and so on, and ObamaCare, it was RomneyCare. It was the best of market ideas of the insurance industry. Get a risk pool. And it was not Medicare for All, it was the combination of a social goal of insuring as many people as possible with a market driven pathway.

So for those people who are looking for ideas, let's just go back to RomneyCare. Now, I guess the question that I have for you, Ms. Pollitz, and keeping in mind the testimony that we have heard from Mr. Robertson, if Nevada didn't have affordable care, could it be because of some of the things that this body, Congress, the Majority under the Republicans, did to undermine the affordable healthcare? I am thinking back to the \$12 billion in risk sharing that, you know, while we were trying to stand up the Affordable Care Act, there was \$12 billion that we didn't give to the insurance companies to eliminate that uncertainty.

I am thinking about not expanding Medicaid in places like Nebraska, which raised the cost of healthcare to everybody. I am thinking about reducing advertising to people. I am talking about pushing out these short-term limited duration insurance policies, which don't provide minimum care.

Cutting subsidies they did last year, how have these impacted on people to the extent that folks that are in the association health plans couldn't find good care, and what is the difference between the association healthcare and the affordable healthcare?

And I will yield to you.

Ms. POLLITZ. The changes that you—the actions that you talked about in different ways contributed to kind of an artificial increase in the cost of marketplace plans.

Ms. MOORE. And some insurers just disappearing from the marketplace all together.

Ms. POLLITZ. Correct. That is correct. So the uncertainty, as I mentioned in my oral statement, really has been kind of a common theme of changes and actions taken that have driven up marketplace premiums. Marketplace premiums in Nebraska were driven up, for example, silver loading. The benchmark plan in Nebraska is dramatic. The benchmark silver plan costs about 40 percent more than the cheapest gold plan in Nebraska, right? That is just an artificial kind of price action that the insurers had to take to back up.

So as long as people are eligible for subsidies, they don't feel that, the taxpayer picks that up. And it sounds like many of the members in Mr. Robertson's plan are not eligible for subsidies, so they would feel the full brunt of this. Just one other thing on pooling. It has just come up a couple of times, and I kind of wanted to comment on it.

The pooling itself doesn't make insurance cheaper, it just kind of spreads out the costs, it redistributes, so everybody kind of pays the same share. If you pull out a small number of people from the marketplace who are healthier than average, then that also has an upward pressure on the average—

Ms. MOORE. Thank you so much. Reclaiming my time, I just want to go back to the old axiom dating back to 1692, Gershom Bulkeley, that says that actions speak louder than words. So while we all say we are for protecting preexisting conditions, I think that the sabotage we have seen does not hearken well. Actions speak louder than words.

And if we were trying to provide healthcare to people, we would not be undermining this market-driven proposal that we have, the Affordable Care Act.

And I yield back.

Ms. SEWELL. The Chair acknowledges that votes have been called to Members. There is only one vote. We are going to continue to go. So the Chair recognizes Mr. Wenstrup from Ohio.

Mr. WENSTRUP. Thank you, Madam Chair, I appreciate it. It has been an interesting morning, obviously, and I am glad that, I think, deep down we all agree we want coverage for preexisting conditions. We have had many little history lessons today, true or otherwise. But the fact is that we as Republicans have pledged support for coverage for preexisting conditions included in our bill.

I have a family member that has a preexisting condition that will need care her entire life. We all get it. There is no part about me as a doctor—and, by the way, I came here for many reasons. I ran for office for many reasons, but in part to stand up for patients. There is no part about me as a doctor that doesn't want our fellow Americans to have access to quality affordable healthcare, all Americans.

I want Medicaid to be a better program than it is. I want all of our plans to be able to take care of people and have a way for people to get into care. And, frankly, I applaud the Obama administration because they took the issue on. It should have happened sooner. But I don't necessarily agree with the direction that it went.

And, by the way, I heard President Obama one time say he was very fond of it being called ObamaCare because it put his name with the word care every time someone said it, and I don't blame him. It is a pretty good marketing tool. And I hope the Members of this Committee will come forward with more to offer than just trying to scare Americans with the false claim that we don't want people with preexisting conditions to be covered. Is that what we are going to sit here and do for the next 2 years? I certainly hope not.

The Affordable Care Act has helped some people. That is a fact. We get that. For many, it did not. That is also a fact. I was in church in a small town in Ohio, the pastor was asking for donations to help the poor, and a woman said, "Pastor, you don't know what it is like out here right now. What I am paying for healthcare today is through the roof, and God forbid if I get sick, because I can't afford that either." And that is in part because of her deductible.

A primary care doctor in the same community quit taking insurance because if he didn't have to go through the rigamarole of insurance, he then could cut his cost. And since people are paying out-of-pocket because of their high deductible, he cut the price down and he eliminated the paperwork. That is what is happening in reality, folks. And you can talk about all this here today, but

there are flaws in the Affordable Care Act that is making it more difficult for patients to get care. And at the same time, they are budgeting with their healthcare. That is a problem when you put things off because you can't afford it because of your high deductible. And you can barely afford the premium, if you are even getting it because the premium is so high.

So, yes, they do seek some of these plans where they wouldn't take you with preexisting conditions, but then they hope they have something just in case, in case there is an unavoidable catastrophe. I would like to have all of you back here sometime to talk about incentivizing health. What do we have in our market today? What do we have in our plans today that are incentivizing health, not only for the patient but for the physician.

We talk about lifespan. We talk about how people live longer in America, although because of our drug problem that is going down, unfortunately, our lifespans. Let's focus on our health span. Ms. Pollitz, you talked about treatments. We have been great at treating things, but what have we prevented?

Think about this. Think about who gets rewarded in today's system. You know if you are the open heart surgeon that saves someone's life, yeah, we want that ability to be there, of course, and we want people to have access to that. But do we recognize any of the physicians that worked with the patient that prevented him from needing the open heart surgery? That is where we need to go, folks.

If you want to talk about a cost curve, start preventing. So I hope that we can come back and have solutions for this Committee so that maybe we can enhance things that will incentivize health in America. That is where we are going to save. That is where the cost will go down. And I want that so that we will have a robust care system for those that have something that can't be prevented. And I would hope that you all agree with me on that. This is about patients, not politics.

Let's cut the politics in this Committee and let's focus on what is best for patients and people and their families. With that, I yield back, and I hope to see you again to discuss that issue.

Ms. SEWELL. To allow Members to vote and to allow the witness to take a break, we will have a recess until 1 p.m.

[Recess.]

Chairman NEAL [presiding]. Let's reconvene the hearing. And I believe that Mr. Boyle is next to inquire. I recognize the gentleman for 5 minutes.

Mr. BOYLE. Thank you, Mr. Chairman. And just to briefly follow up on what the gentlewoman from Wisconsin was talking about in terms of the roots of the Affordable Care Act, RomneyCare, I would just point out, the first time I ever heard the concept was from a professor, he was a fellow at the Heritage Foundation named Stewart Butler, who was one of the founding fathers of this idea. The Heritage Foundation is not exactly known for its bleeding heart liberalism. And then the roots of the Affordable Care Act were originally introduced in the Senate by Bob Dole and 17 Republican Senators.

Unfortunately, when President Obama and the Democratic Congress championed it, suddenly the view on the other side changed. But having just spent or endured the last 8 years of an attempt

to repeal the Affordable Care Act, and having seen that defeated legislatively, I am very concerned that what couldn't be achieved legislatively now might be achieved judicially.

We had very recently an activist judge in Texas strike down the Affordable Care Act, even though the Supreme Court had affirmed the Affordable Care Act a number of years ago. So could you talk to me, and I will turn to Ms. Pollitz, if you could—if the 18 States attorneys general are successful ultimately in their lawsuit and higher courts affirm the lower courts' ruling and provisions of the Affordable Care Act are scrapped, what would that mean for those who currently absolutely need a policy that they have gotten from the Affordable Care Act to live or have certain protections in their already existing private plan that came about because of the Affordable Care Act, such as the one on preexisting conditions?

Ms. POLLITZ. Well, so that would roll the clock back to pre-2010. The Federal law prohibition on discrimination against pre-existing conditions would go away. In a number of States that prohibition has been enacted in State law, so at least for people in State-regulated policies that would continue, but the Federal subsidies would also go away, and that is what really helps keep the market stable.

States that tried, before the ACA, to prohibit discrimination based on preexisting conditions without subsidies found that there were adverse selection and there were rate spiral problems. And then other provisions covering kids to 26, the Medicaid expansion for poor adults, and the prevention trust fund, the FDA authority to license biosimilars, the ACA ended up including a wide number of provisions that really affect all Americans.

Mr. BOYLE. And I am glad that you point that out because often coverage of the ACA just focuses on the marketplace and doesn't focus on those other provisions. One that you spoke about, I just wanted to key in on the Medicaid expansion. That was one of the best bangs for our buck, so to speak, in terms of expanding coverage to those who didn't have it.

Now, because of the U.S. Supreme Court decision, States had the ability to opt-in or opt-out, so we haven't been able to get Medicaid expansion throughout the country. If, ultimately, the Affordable Care Act were done away with, what would happen to those who got their healthcare through the Medicaid expansion since that was one of the biggest boons for us?

Ms. POLLITZ. Right. So States—let's see. States—well, first of all, States would lose the Federal money.

Mr. BOYLE. Which is currently 100 percent or has it dropped to 90 percent?

Ms. POLLITZ. It is on its way to 90 percent. It is below 100 percent now and it will be at 90 percent next year. So billions of dollars in Federal dollars would go away. But under Federal law, Medicaid was a categorical program. And Federal matching was only for poor people in certain categories, you know, children, pregnant women and so forth. So millions of people would lose coverage if that Federal law change were to go away.

Mr. BOYLE. And when we talk about millions of people, it is not just the overall number, we are talking primarily about the working poor.

Ms. POLLITZ. Yes.

Mr. BOYLE. We are not talking about people who are sitting at home and doing nothing. These are often people with full time jobs that make a little bit too much money to qualify for traditional Medicaid, but not nearly enough to afford healthcare.

Ms. POLLITZ. Right. And actually for working poor adults, even—well, if they weren't working and they didn't earn anything, they weren't eligible for Medicaid before. But most of the expansion population, as you pointed out, they are working people. They are in minimum wage jobs and they are earning less than 138 percent of the poverty level, and they would lose coverage.

Mr. BOYLE. I yield back. Thank you, Mr. Chairman.

Chairman NEAL. I thank the gentleman. And, with that, I would like to recognize Mr. Kildee for the purpose of inquiry for 5 minutes.

Mr. KILDEE. Thank you, Mr. Chairman, for recognizing me and for holding this very important hearing. This is obviously a subject that is one of the subjects that drew me, and I know a lot of the newer Members to this Committee. This is obviously quite critical, and the decisions we make have real impacts on real people.

Like a lot of families, like a lot of people, like a lot of the people that I represent, preexisting conditions and their impact on the ability to receive healthcare is really personal to me. Like a lot of the families I represent, like a lot of people around this country, I have close family members that have pretty significant pre-existing conditions.

Twenty-one years ago my wife was diagnosed with multiple sclerosis. Thank God she has been able to receive good care, but I can't tell you how many times we have had the conversation about what our lives would be like if we were like so many other people in this country that have had to try to deal with these life-changing experiences, like Mr. Blackshear has gone through, without having the benefit of health insurance, and without having the assurance that condition will not somehow prevent them from receiving important care.

Like my wife, I have a daughter who is 26 years old, who is a type 1 diabetic, who was diagnosed when she was 7 years old. I can't tell you again how many times my wife and I had this conversation about what will happen when our daughter is gone from the nest. Will she ever be able to have a future? It is not just about being able to get healthcare.

So actually having the certainty that you can have aspirations, you can dream about your own future, that you can plan to be a productive and important part of society, that paw that hangs over people without that assurance affects our society in ways that I think we often don't even measure.

So any time there is a threat or an effort to undermine that very elegant guarantee that is embedded in the Affordable Care Act, we have to take notice. And assurances and pleading from folks on the other side who, on one hand, assure us that they want to protect those assurances, but support Federal litigation that would essentially take that away, is a threat to people like me and the people that I represent who have that same set of circumstances.

So family members that are able to purchase healthcare at an affordable price, regardless of their circumstances, is pretty important. And I wonder, starting perhaps with Ms. Pollitz, if you could tell us what options would exist for people with preexisting conditions in terms of plan availability and cost—I know this may be somewhat redundant, but it is important to put this down—what options would be available if the Administration's efforts to undermine the ACA were to succeed? Where could they go?

Ms. POLLITZ. Before the ACA, Mr. Kildee, job lock was an issue, so people would maybe take a job or stay in a job that they would rather leave because of the health benefits. A friend of mine jokingly coined the term “slob lock” to relate to people who maybe stayed in marriages for the health insurance or got married for health insurance.

For young adults—it sounds like our kids are about the same age—young adults had the highest rate of uninsurance before the ACA because their birthday gift or their graduation gift was losing eligibility for their parents' policy, for Medicaid. And if they couldn't afford coverage—often they couldn't because they weren't making a lot of money yet—then they would be uninsured. And certainly if they had a preexisting condition, like the ones you talked about, they would be uninsurable. So it is materially different now.

Mr. KILDEE. Thank you.

Mr. Stolfi, would you comment?

Mr. STOLFI. Thank you, Representative. I can add two points to that. The first—and we saw this prior to the ACA—if you were lucky enough to get an individual health plan, that pool of people, as they got older, they got sicker; insurance companies could decide that they no longer wanted to carry that block of people, that pool of people, and could discontinue an entire policy, therefore, presenting someone who might have developed health conditions with the option of taking another policy that insurer offered, which would surely have less benefits and more cost, or taking their chances to go through medical underwriting again, when, if they have developed a condition, it would surely be denied.

And another thing that happened quite a bit before the ACA, there was a lot of uncompensated care. Hospital systems in Oregon had hundreds of millions of dollars more uncompensated care, which drives up the cost for everyone else.

Mr. KILDEE. Again, I thank you for your presence here. I thank the Chairman for arranging this hearing. It is an important moment, and I yield back the balance of my time.

Chairman NEAL. I thank the gentleman.

The gentleman from Texas, Mr. Arrington, is recognized to inquire for 5 minutes.

Mr. ARRINGTON. Thank you, Mr. Chairman.

And to the Ranking Member, it is an honor to serve with you, and it is a great opportunity for rural America to have a seat at the table where a lot of the big problems that we face as a country are being worked out.

And in rural west Texas, I can tell you, the way we solve things is we start by agreeing on a set of facts. And then we agree on what success is; we define it so that we are all clear when we have

achieved it. Otherwise, we wander in the wilderness. Because this issue is so highly charged and has been politicized and demagogued on both sides, let's, Ms. Pollitz, agree on some facts.

One fact may be that Kaiser is not bringing policy advice and recommendations. You are, no doubt, an organization that has expertise in healthcare policy information and analysis. Is that—

Ms. POLLITZ. We try, yes.

Mr. ARRINGTON. Would that be a true statement?

Ms. POLLITZ. Yes.

Mr. ARRINGTON. Would you agree that in the implementation and over the last several years of the ObamaCare ACA implementation, that the cost of care has gone up significantly? I use the word "exponential," but—because premiums have doubled across the country. Would you say that because of the implementation and during the implementation, costs have gone up significantly, yes or no? Just yes or no, have costs gone up in healthcare since the implementation of ObamaCare?

Ms. POLLITZ. Healthcare costs have gone up—

Mr. ARRINGTON. Yes. Okay.

Ms. POLLITZ [continuing]. Although—

Mr. ARRINGTON. Second, has choice been reduced? My understanding is 50 percent of the counties where my fellow Americans live only have one insurer. Has their choice in being covered by an insurance company and with a certain plan, has that been reduced since the implementation of ObamaCare, yes or no?

Ms. POLLITZ. I don't believe so.

Mr. ARRINGTON. Okay. Now let's talk about this notion that Republicans somehow don't support the provisions in the ACA that protect people with preexisting conditions. Did your organization review and analyze the American Health Care Act? That is the Republican reform bill that passed last year out of the House but failed in the Senate.

Ms. POLLITZ. Yes, we did.

Mr. ARRINGTON. And are you aware that we protected the ObamaCare provision regarding people with preexisting conditions and, in fact, sort of belted suspenders; we put a rule of construction in play that says: Nothing in this Act shall be construed as permitting health insurance insurers to limit access to health coverage for individuals with preexisting conditions. Were you aware of that?

Ms. POLLITZ. I was aware of that—

Mr. ARRINGTON. Okay, so, yes.

Were you aware of that, Mr. Stolfi, that Republicans protected that provision of the ACA, because we believed it was important?

Mr. STOLFI. I was aware of that language.

Mr. ARRINGTON. Yeah, were you aware of that, Mr. Robertson?

Mr. ROBERTSON. Yes.

Mr. ARRINGTON. Were you aware of that?

Ms. BROOKS-COLEY. Yes.

Mr. ARRINGTON. Were you aware of that?

You are all aware of it. So this could be a really short hearing, Mr. Chairman. We are all in favor of preexisting conditions.

Now let's get on to the real business of solving the problem, and in order to do that, like I said, you have to define what success is.

Mr. Stolfi, is there a difference between being covered by health insurance and having access to affordable care? Is there a difference?

Mr. STOLFI. There is a—

Mr. ARRINGTON. Yes or no?

Mr. STOLFI. Between having insurance and healthcare? Yes.

Mr. ARRINGTON. Okay. Does everybody on the panel agree with that, that there is a difference between being covered, or having a health insurance card and having access to affordable care? So would the real definition of success for this Committee and your sort of advice to us, as people representing our fellow Americans, be that we focus on how we make healthcare affordable for the American people, especially our working and middle-income families? Would you agree? Just nod yes if you do.

So, Commissioner Stolfi, let me ask you a few questions about your State in particular. You said that there were 300,000 new, newly insured people since the ACA's implementation, correct?

Mr. STOLFI. About 350,000.

Mr. ARRINGTON. How many of those got care through the exchange, of the 300,000, versus Medicaid expansion?

Mr. STOLFI. The majority of the additional—

Mr. ARRINGTON. The Medicaid expansion. All right. I am not going to try to play games with you here. I am just going to state the fact—and you can confirm or deny—that 400,000 people in your State, citizens, fellow—what do you say?

Mr. STOLFI. Oregonians.

Mr. ARRINGTON [continuing]. Oregonians were qualified and eligible for the exchange. And two-thirds of the 400,000 decided not to get ObamaCare through the exchange. They decided to pay the fine rather than to get care on the exchange. Is that correct?

Mr. STOLFI. I am not certain of those numbers, no, sir.

Mr. ARRINGTON. I yield back, Mr. Chairman.

Chairman NEAL. I thank the gentleman. I would say in reference to the gentleman's point, the Chair never assumed that this would be a short meeting.

With that, let me recognize the gentleman from Virginia to inquire, Mr. Beyer.

Mr. BEYER. Mr. Chairman, thank you very much. Mr. Chairman, I would like to point out that I have been running the family business for 45 years, and our healthcare premiums were going up 15 percent per year before ObamaCare. And if you do the math, that means a doubling in 5 years. A part of what ObamaCare was designed to address was the fact that premiums were going up very quickly before. In fact, ours did not go up any faster after ObamaCare than before, despite the fact that coverage was so much greater.

Mr. Chairman, without objection, I have four letters I would like to submit for the record and just briefly describe them.

Chairman NEAL. Without objection.

[The information follows:]

Congress of the United States
Washington, DC 20515

November 1, 2017

The Honorable Paul Ryan
 Office of the Speaker
 H-232 The Capitol
 Washington, DC 20515

~~VIRGIL COWELL~~

Dear Speaker Ryan:

We are deeply concerned about the President's decision to end the cost-sharing reductions (CSRs) and the devastating financial impact it will have on small businesses, working families, and the innovator economy. We ask that you commit to fund the CSRs and eliminate this barrier to innovation.

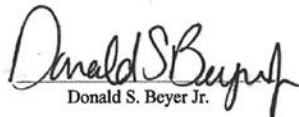
As you know, CSRs make health insurance more affordable by reducing cost sharing and out-of-pocket expenses like co-payments and deductibles in the non-group or individual market. In 2016, CSRs alleviated the cost of medical expenses for over 6.4 million enrollees. Now that President Trump has ended the Administration's payment of the CSRs, absent a subsequent appropriation of funds or other action by Congress, we could see devastating impacts on our innovator economy.

We know that failure to fund CSRs will drive up premiums as insurers cover the cost and that some insurers will be forced out of the non-group market as a result. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) anticipate that most insurance commissioners would permit insurers to substantially increase premiums in the marketplaces. This will primarily hurt millions of middle-class individuals, like the small businesses and self-employed individuals in our districts, who earn too much to qualify for premium assistance and will bear the full brunt of any rate increase. According to the Brookings Institution, uncertainty about these payments is perhaps the biggest threat to stability in the individual market. CBO and the JCT also estimate that this action increases the federal deficit, on net, by \$194 billion from 2017 through 2026.

According to Kaiser Family Foundation, roughly one in five non-group marketplace consumers are small business owners or self-employed individuals. The Treasury Department identified non-group marketplace coverage as an important source of health insurance coverage for small business owners and the self-employed, noting that it provides insurance for a large share of self-employed individuals, particularly for middle-income workers. The UC Berkeley Center for Labor Research and Education highlights how the CSR eligible plans enabled small business owners and self-employed individuals to more easily obtain affordable health insurance and pursue entrepreneurial goals, also indicating that options like eliminating CSRs would disproportionately hurt self-employed and small businesses of less than 50 employees.

We are hearing from entrepreneurs, small business owners, and self-employed individuals who are being disproportionately impacted by the President's decision. We ask that you support our innovator economy and mitigate this financial burden by fulfilling cost sharing reduction payments.

Sincerely,

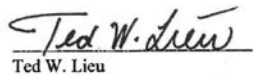

Donald S. Beyer Jr.

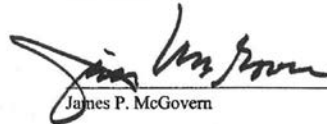

Sean Patrick Maloney


Tom O'Halleran

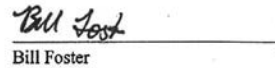

Jackie Speier


Ro Khanna


Ted W. Lieu

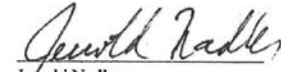

James P. McGovern



Jamie Raskin


Bill Foster

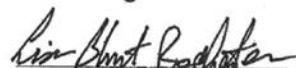

Terri Sewell

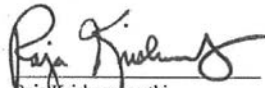

Alan Lowenthal

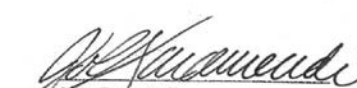

Jerrold Nadler

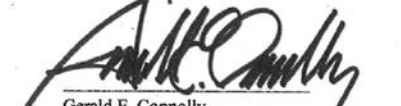

Gwen S. Moore


Denny Heck


Lisa Blunt Rochester



Raja Krishnamoorthi


John Garamendi

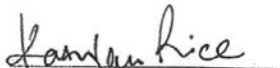

Gerald E. Connolly



Eddie Bernice Johnson


Ann McLane Kuster

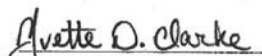

Rick Larsen

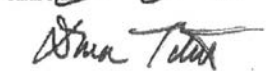

James R. Langevin

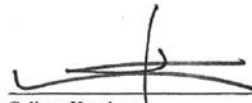

Kathleen M. Rice

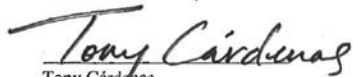

Seth Moulton

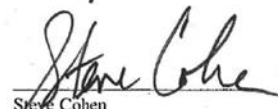

Raul Ruiz



Yvette D. Clarke


Dina Titus

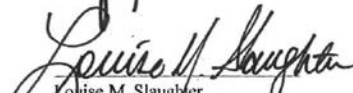

 Colleen Hanabusa



 Tony Cárdenas

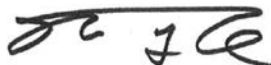

 Steve Cohen



 David N. Cicilline



 Jimmy Panetta


 Louise M. Slaughter

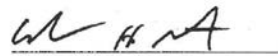

 Jacky Rosen


 Cedric L. Richmond


 Nanette Diaz Barragán


 Joaquín Castro


 Mike Doyle

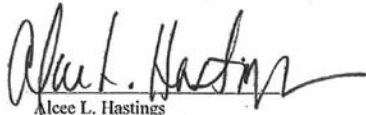

 Eleanor Holmes Norton

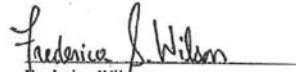

 Donald M. Payne, Jr.

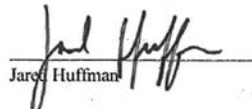

 Filemon Vela


 Mark DeSaulnier


 Scott H. Peters


Alcee L. Hastings


Frederica Wilson


Jared Huffman

Congress of the United States
Washington, DC 20515

May 31, 2018

President Donald J. Trump
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20006

Dear Mr. President:

We are deeply concerned by your Administration's actions, which both trigger higher health insurance premiums as well as undermine access to high-quality, affordable health care for millions of hard-working Americans. The reporting of early filings by health insurers shows that healthcare premiums will rise sharply next year. Their justifications reveal that your Administration's actions are to blame.

This was foreseeable. Your administration ended cost-sharing reduction (CSR) payments, which help reduce out-of-pocket costs like co-pays and deductibles for low-income exchange enrollees. When it was announced, *The New York Times* reported that it could send "insurance premiums soaring" and *The Wall Street Journal* reported that "[s]ome consumers who get health insurance through the Affordable Care Act exchanges next year will face sharp premium increases and have fewer insurer options." There was concern that eliminating CSR payments would expose the government to lawsuits from insurers looking to recoup their lost costs. There was also concern that insurers would cost-shift lost revenue to non-CSR eligible individuals in the near term, hurting the self-employed, and those in the innovator and gig economies. While some states have found viable work-arounds to help keep coverage more affordable, your reckless actions have created additional uncertainty in the marketplaces. Insurers are increasing costs to cover the added risk.

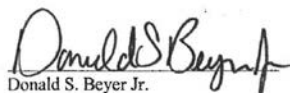
You signed H.R. 1, a tax bill that functionally eliminated a provision in the Affordable Care Act (ACA) which required Americans to purchase health insurance. According to the nonpartisan Congressional Budget Office, that is the primary cause of a projected 15 percent increase in premiums in 2019 and will lead to 5 million more uninsured Americans. The wellbeing of the health insurance market depends upon the pool of participants. This move deliberately disincentivizes healthy individuals from participating, thereby leaving pools with a more concentrated mix of sicker and more expensive participants.

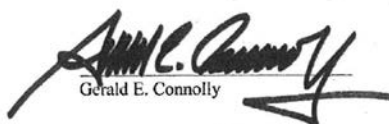
Your Administration proposed rules to modify the requirements for the sale of short-term and association health plans, which would allow insurers to sell products that do not constitute true "insurance." While these products would appear cheaper to consumers, they would do so at a significant cost, by covering fewer benefits and ensuring fewer patient protections, such as coverage of pre-existing medical conditions. This is a backdoor to undermining the health of the pools in the high-quality ACA insurance exchanges. Insurers might decide to leave these markets altogether if the customers become too unhealthy and therefore too expensive.

These efforts are sabotaging our healthcare system. As predicted, early state filings from Virginia and Maryland demonstrate significant premium hikes. In Virginia, for example, one plan option will rise by 64 percent. As justification for these significant hikes, insurers have expressly indicated that the cause lies primarily with the Trump administration, citing "elimination of the Individual Mandate penalties," "discontinuance of funding for Cost-Sharing Reduction (CSR) payments by the federal government," and "anticipated changes to regulations regarding Short Term Medical and Association Health Plans that will impact the Affordable Care Act risk pool." Sabotaging the ACA is bad for middle class families and individuals living with pre-existing conditions. They bear the brunt of annual premium increases and will be shut out of the secondary markets as their vital protections are rolled back.

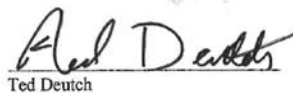
We ask that you stop your destructive campaign to sabotage the Affordable Care Act. Americans want access to high-quality, affordable health insurance. Please take efforts to undo this sabotage, and work with Congress to increase access and affordability for quality health insurance.


Sincerely,


Donald S. Beyer Jr.


Gerald E. Connolly


Mark Takano

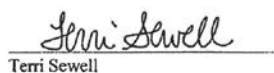

Ted Deutch


Jamie Raskin


Grace F. Napolitano


Eleanor Holmes Norton


Earl Blumenauer


Terri Sewell

Michelle Lujan Grisham
Michelle Lujan Grisham

Donald M. Payne, Jr.
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Debbie Wasserman Schultz
Debbie Wasserman Schultz

A. Donald McEachin
A. Donald McEachin

Mark Pocan
Mark Pocan

Alma S. Adams, Ph.D.
Alma S. Adams, Ph.D.

Jose E. Serrano
Jose E. Serrano

Frederica S. Wilson
Frederica S. Wilson

Nanette Diaz Barragan
Nanette Diaz Barragan

G.K. Butterfield
G.K. Butterfield

Betty McCollum
Betty McCollum

Marcy Kaptur
Marcy Kaptur


Suzanne Bonamici
Suzanne Bonamici

Andre Carson
Andre Carson


Darren Soto
Darren Soto

Pramila Jayapal
Pramila Jayapal

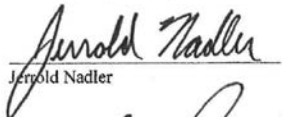

Adriano Espaillat

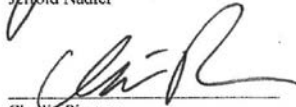

Steve Cohen


Ro Khanna


John Yarmuth



Eddie Bernice Johnson

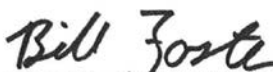

Jerrold Nadler


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Alan Lowenthal



Peter A. DeFazio


Anthony G. Brown


Bill Foster


David E. Price


Colleen Hanabusa


Emanuel Cleaver, II


Ed Perlmutter

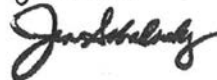

Gwen Moore



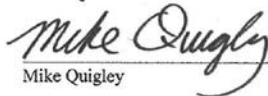
Scott H. Peters



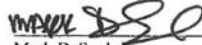
Yvette D. Clarke



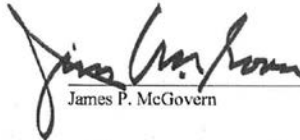
Jan Schakowsky



Mike Quigley



Mark DeSaulnier



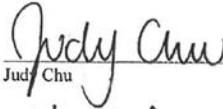
James P. McGovern



Hakeem Jeffries



Lucille Roybal-Allard



Judy Chu



Karen Bass



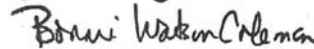
Marcia L. Fudge



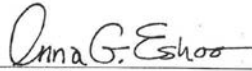
David N. Cicilline



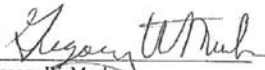
Zoe Lofgren



Bonnie Watson Coleman



Anna G. Eshoo

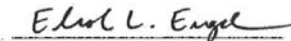


Gregory W. Meeks

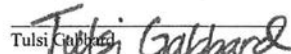

Alcee L. Hastings


Jimmy Gomez


Barbara Lee


Eliot L. Engel


Robert C. "Bobby" Scott


Tulsi Gabbard
M.C.


Lisa Blunt Rochester

Congress of the United States
Washington, DC 20515

October 30, 2018


The Honorable Donald J. Trump
President
The White House
1600 Pennsylvania Avenue NW
Washington, D.C. 20500

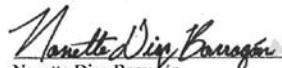
Dear President Trump:

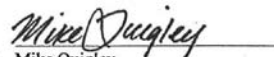
You recently tweeted, "All Republicans support people with pre-existing conditions, and if they don't, they will after I speak to them. I am in total support." Congressional leadership has made similar arguments. Senate Majority Leader Mitch McConnell said, "There's nobody in the Senate that I'm familiar with who is not in favor of coverage of preexisting conditions."^[1]

However, these words do not match the actions of your administration. Your Department of Justice has not only refused to intervene in a lawsuit brought by state attorneys general that would nullify preexisting conditions protections if successful, but also argued in a brief that guaranteeing coverage to people with health conditions and charging them the same rates should be struck down.^[2] Will you match your words to your administration's actions and order the Justice Department to intervene in *Texas, et al v. U.S., et al* to defend protections for pre-existing conditions? Will you repudiate the brief arguing for the elimination of pre-existing conditions protections?


Sincerely,

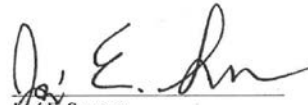

Donald S. Beyer Jr.
MEMBER OF CONGRESS

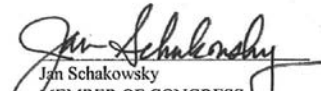

Nanette Diaz Barragan
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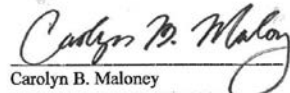

Mike Quigley
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Grace F. Napolitano
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Judy Chu
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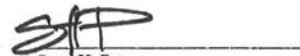

Jose E. Serrano
MEMBER OF CONGRESS

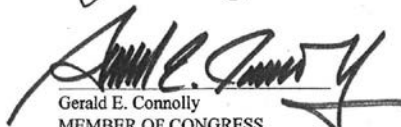

Jan Schakowsky
MEMBER OF CONGRESS

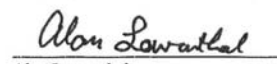

Carolyn B. Maloney
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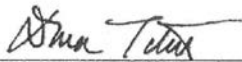

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Zoe Lofgren
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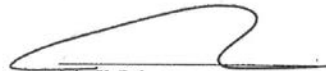

Scott H. Peters
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Gerald E. Connolly
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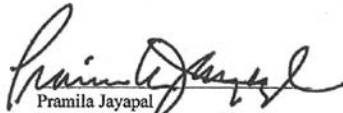

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Pramila Jayapal
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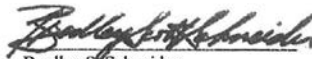
Peter DeFazio
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Norma Torres
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Nydia Velázquez
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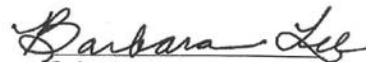
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Mark DeSaulnier
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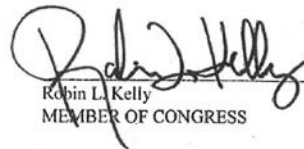
Jacky Rosen
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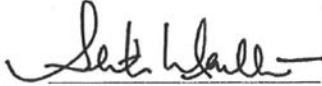
Barbara Lee
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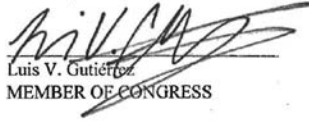
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Seth Moulton
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Luis V. Gutiérrez
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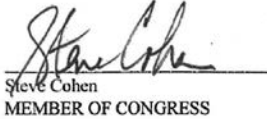
Terri Sewell
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André Carson
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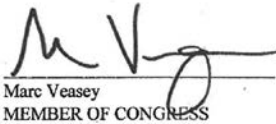
Bennie Thompson
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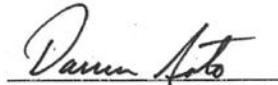
Steve Cohen
MEMBER OF CONGRESS



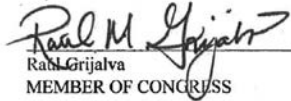
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Marc Veasey
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Raul Grijalva
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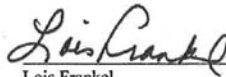
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Frederica Wilson
MEMBER OF CONGRESS



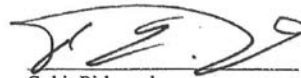
Al Lawson
MEMBER OF CONGRESS



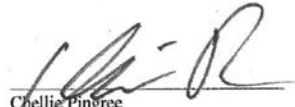
Lois Frankel
MEMBER OF CONGRESS



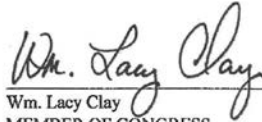
Debbie Wasserman Schultz
MEMBER OF CONGRESS



Cedric Richmond
MEMBER OF CONGRESS



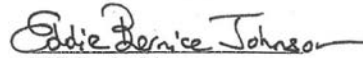
Chellie Pingree
MEMBER OF CONGRESS



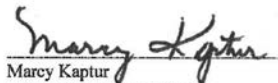
Wm. Lacy Clay
MEMBER OF CONGRESS



Stacey E. Plaskett
MEMBER OF CONGRESS



Eddie Bernice Johnson
MEMBER OF CONGRESS



Marcy Kaptur
MEMBER OF CONGRESS

^[1] https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/10/19/the-health-202-trump-says-gop-wants-to-protect-preexisting-conditions-but-a-republican-lawsuit-would-eliminate-them-if-successful/5bc8b7a71b326b7c8a8d1a68/?utm_term=.06ad7eddf4a4

^[2] <https://www.nytimes.com/2018/06/07/us/politics/trump-affordable-care-act.html?module=inline>;
<https://www.usatoday.com/story/news/politics/2018/06/07/trump-administration-not-defend-affordable-care-act/683517002/>; https://www.iustsecurity.org/wp-content/uploads/2018/06/ACA.Azar_filing.pdf

Congress of the United States
Washington, DC 20515

October 30, 2018

The Honorable Curtis T. Hill, Jr.
Office of the Indiana Attorney General
Indiana Government Center South
302 W. Washington St., 5th Floor
Indianapolis, IN 46204

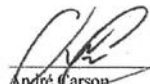
Dear Attorney General Hill:

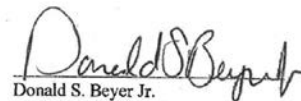
President Trump recently tweeted, "All Republicans support people with pre-existing conditions, and if they don't, they will after I speak to them. I am in total support." Senate Majority Leader Mitch McConnell said, "There's nobody in the Senate that I'm familiar with who is not in favor of coverage of preexisting conditions."ⁱ President Trump and Leader McConnell are clearly responding to the national sentiment that recognizes the importance of these protections. According to a recent Kaiser Family Foundation poll, 75 percent of Americans say it is very important prevent insurance companies from denying coverage based on a person's medical history.ⁱⁱ

According to the Department of Health and Human Services, as many as 133 million Americans under the age of 65 have a pre-existing health condition that would lead to a denial of insurance coverage, or coverage only at an exorbitant price.ⁱⁱⁱ Allowing discrimination based on pre-existing conditions will be devastating to those living with chronic health challenges like asthma, diabetes, or cancer, and drive up costs for working families, small businesses, and entrepreneurs. Given that national Republican leadership is claiming to defend pre-existing conditions protections, we expect that you will immediately drop your lawsuit which, if successful, would nullify these protections.^{iv}

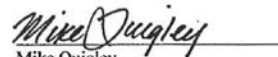
We look forward to your response.

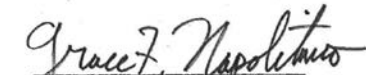
Sincerely,

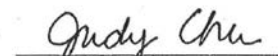

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MEMBER OF CONGRESS



Donald S. Beyer Jr.
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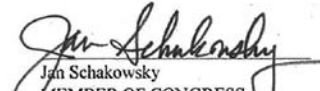

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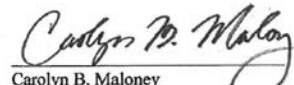

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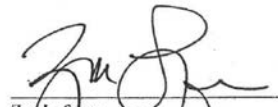

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Jose E. Serrano
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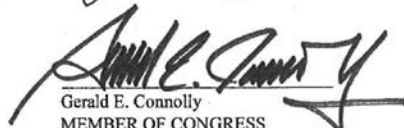

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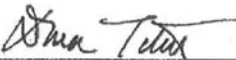

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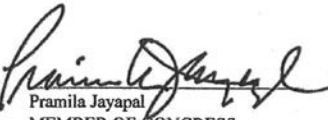

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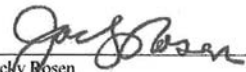

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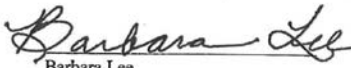

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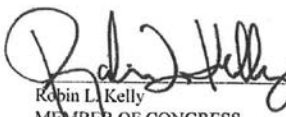

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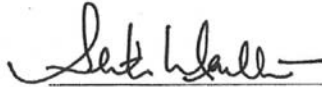

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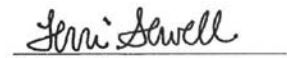

Robin L. Kelly
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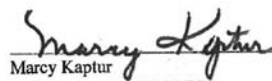
Seth Moulton
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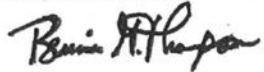
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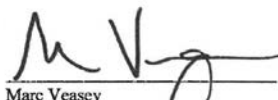
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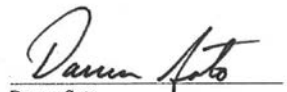
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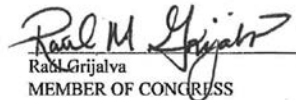
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Frederica Wilson
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Tom O'Halleran

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Debbie Wasserman Schultz

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Chellie Pingree

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Gwen Moore

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MEMBER OF CONGRESS

Stacey E. Plaskett

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MEMBER OF CONGRESS

Wm. Lacy Clay

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MEMBER OF CONGRESS

¹ https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/10/19/the-health-202-trump-says-gop-wants-to-protect-preexisting-conditions-but-a-republican-lawsuit-would-eliminate-them-if-successful/5bc8b7a71b326b7c8a8d1a68/?utm_term=.06ad7eddf4a4

² <https://www.kff.org/health-costs/press-release/poll-acas-pre-existing-condition-protections-remain-popular-with-public/>

³ <https://aspe.hhs.gov/system/files/pdf/255396/Pre-ExistingConditions.pdf>

⁴ <https://www.nytimes.com/2018/06/07/us/politics/trump-affordable-care-act.html?module=inline;>
[https://www.usatoday.com/story/news/politics/2018/06/07/trump-administration-not-defend-affordable-care-act/683517002/;](https://www.usatoday.com/story/news/politics/2018/06/07/trump-administration-not-defend-affordable-care-act/683517002/) https://www.iustsecurity.org/wp-content/uploads/2018/06/ACA-Azar_filing.pdf

Mr. BEYER. The first was—I was one of many Members of the House that wrote Speaker Ryan on November 1, 2017, about the President’s decision to end cost-sharing reductions. We have heard so much about the costs of healthcare. Ending the cost-sharing reductions, which were an integral part of ObamaCare, the Affordable Care Act, certainly increased the cost for premiums.

The second was a letter on May 31, 2018, again, from many Members of the House, to President Trump, about his signing H.R. 1 that functionally eliminated the provision that required Americans to purchase health insurance. I believe, Mr. Robertson, in your explanation of how the association has reduced costs, you said the larger the risk pool, the better.

Well, the very core of the Affordable Care Act is we have the largest risk pool possible, and that is what the mandate did. And when the Republican leadership and the President eliminated that mandate, obviously we pushed costs up for everyone. We took those low-cost young people out of the health insurance pool. That is the way insurance works, going back a thousand years.

The third letter, in two versions, October 30, 2018, both to the Attorney General and to the President, was about the Justice Department refusing to intervene in the lawsuit brought by State attorneys general that would nullify preexisting conditions protection.

If my friends on the other side are so committed to the protection of the preexisting conditions waiver, the first thing we should do is get the Department of Justice and our President to stop the lawsuit that would make it irrelevant.

All of these, by the way, Mr. Chairman, contribute to the uncertainty that pushes up premiums. Every time we mess with the Affordable Care Act and do something yet again to undermine it, we are making premiums go up.

But, Ms. Pollitz, I have a specific concern for you, because I have heard a number of times the quote that nothing in this Act shall override the ObamaCare protection for preexisting conditions. Isn’t there also a provision in the Act that allows States to apply for a waiver to get rid of the preexisting conditions?

Ms. POLLITZ. There was, yes, a provision to allow States to waive the community rating requirements so that people could be charged more based on health status.

Mr. BEYER. Isn’t that functionally the same? When you don’t waive preexisting conditions, you just make it unaffordable; is it not virtually the same thing?

Ms. POLLITZ. Well, that would have made it harder for people with preexisting conditions to afford coverage.

Mr. BEYER. Like a Mr. Blackshear or like so many of our family members that we talked about here today.

Ms. POLLITZ. Yes.

Mr. Beyer, that law also substantially changed the subsidies, turning them into flat tax credits and smaller tax credits so that they would not have had the same stabilizing effect. And to the extent that people did drop out of coverage, which CBO estimated tens of millions of people would lose coverage, that would drive up premiums for people, to the extent that people with preexisting

conditions stayed, and the tax credits would no longer protect them from that premium increase.

Mr. BEYER. It seems like most of the adjustments made in the last few years have been to increase the number of people with adverse selection being part of the insurance pool and reduce the ones that would bring the costs down.

So we talked about pregnancy as a preexisting condition. Maybe someone would like to comment on the fact that because of the Affordable Care Act and the pregnancy prevention coverage, the contraception coverage, one of the few things we can agree on here—the anti-choice versus pro-choice, a woman's reproductive rights—is that our abortion rate is the lowest it has been since *Roe v. Wade*, and that there are fewer teen pregnancies and unintended pregnancies than there have been in decades. Ms. Pollitz, as a researcher, would you agree?

Ms. POLLITZ. Yes. And access to contraceptive coverage has helped. Actually, I was not able to answer the Congresswoman's question before, but now only about 2 percent of young women end up having to pay out-of-pocket costs for a contraceptive. It was much higher before the ACA.

Mr. BEYER. And, Ms. Brooks-Coley, now that we have this waiver of preexisting conditions, the protections, have you seen any difference in cancer survival rates, when people are not thrown off insurance because they have cancer or can't get insurance?

Ms. BROOKS-COLEY. Congressman, thank you for the question. We do have evidence to show that individuals who receive a cancer diagnosis, their cancer is being detected earlier, and we know that their survival rates and treatment outcomes are better because they have access to coverage earlier than they did pre the Affordable Care Act passing.

Mr. BEYER. Thank you very much.

Mr. Chair, I yield back.

Chairman NEAL. I thank the gentleman.

The gentleman from Pennsylvania, Mr. Evans, is recognized for 5 minutes to inquire.

Mr. EVANS. Thank you, Mr. Chairman.

I would like to follow up with Mr. Arrington's statement and allow you, Ms. Pollitz and Mr. Stolfi, to respond to what I think you wanted to say, what you wanted to add in addition. That is the impression I got. So you have your opportunity, both of you, to kind of give some response in terms of protecting people with pre-existing conditions. So whoever wants to start.

Ms. POLLITZ. Well, I guess in response to the question about rising premiums versus rising costs, the national health expenditure data show that, actually, healthcare costs per capita have risen at a lower rate since the enactment of the ACA.

In the 1990s, the average annual rate of increase in per-capita healthcare costs was about 5 percent. In the 2000s, it was 6 percent, and since the ACA, it has been 4 percent. So, still rising, but at a slower rate, kind of a bend in the curve. And we see similar changes in the rate of out-of-pocket per-capita spending since the enactment of the ACA.

Mr. EVANS. Commissioner.

Mr. STOLFI. Thank you, Representative Evans. I could just add to that to follow also what Representative Beyer said about costs rising, this is not a new phenomenon. In the individual market in Oregon before the Affordable Care Act, in 2008 and 2009, we saw rate increases that were greater than the rate increases we saw in 2018 and 2019. There was 21 percent and 17 percent, if I have those numbers correct.

So this is not a new phenomenon, but also, as Representative Beyer pointed out, the products are fundamentally different. So the products that people have now, the protections that individuals have now are much more comprehensive and worth much more than they were before the Affordable Care Act.

Mr. EVANS. So, in other words, they weren't protected then?

Mr. STOLFI. Much less so than they are now.

Mr. EVANS. Okay. Mr. Chairman, being that I am new to this Committee but obviously not new to life, the President of the United States came to Philadelphia August of 2016, and this is the exact quote he said. He was specifically talking to the black community. He said: "What the hell do you have to lose?"

The reason I asked the question is, in the past 2 years, the Trump administration has drastically underfunded outreach and education initiatives. What I am interested in, could you please discuss the linkage between risk pools, outreach, and health disparities? Can you respond to that aspect?

Ms. POLLITZ. I think—we still have a continuing health disparities problem due to many factors. But it is also true that extending coverage does help to address that because it gives more people at least a ticket to healthcare. They may encounter other barriers after that, but we have seen—we have seen dramatic increases—or decreases, rather, in uninsured rates, particularly among minorities, and so that has a positive effect in improving access to care.

Mr. EVANS. So minorities have something to lose?

Ms. POLLITZ. Yes.

Mr. EVANS. Okay. Do you want to comment on that?

Mr. STOLFI. Representative Evans, I could just add that every healthcare consumer is different. Every individual has different healthcare needs, a different healthcare IQ, different biases, as one Representative noted earlier. And the best way to help each individual is to have one-on-one counseling, one-on-one education, and that costs money. And States like Oregon do spend quite a bit of money training advocates, training people to educate and help consumers. It is unfortunate when there are cuts to programs such as that.

Mr. EVANS. Mrs. Brooks-Coley, do you have any comment on that?

Ms. BROOKS-COLEY. I do. Thank you, Congressman. I would just make the comment that, from a cancer perspective, racial and ethnic minorities continue to have higher cancer rates and are less likely to be diagnosed early. So access to coverage and access to comprehensive coverage is extremely important for that population of individuals.

Mr. EVANS. I am going to go to Ms. Pollitz real quick. There was a report in 2017 coming from your organization that said changes

in insurer participation in the Affordable Care Act relating—was somewhat down. The question I want to ask you, can you explain to us how premium tax credits assist in keeping healthcare affordable and also help to stabilize the insurance risk pool?

Ms. POLLITZ. Yeah. So premium tax credits are set on a formula so that you, as an individual, pay only a certain dollar amount toward the benchmark plan. If you are at the poverty level, that is about \$20 a month. If you are at 150 percent of the poverty level, that is about \$60 a month. That is what you pay, and the difference between that and whatever the benchmark plan is, is the dollar value of your tax credit.

So, if premiums go up \$100 next year and I am at 150 percent of poverty, I paid \$60 for the benchmark plan last year; I pay \$60 for the benchmark plan this year.

The tax credits also help to really cure a lot of adverse selection. Normally, especially a low-income person, I would have to really ask some hard questions. Can I afford the \$60? I need a car payment. I am healthy. Maybe I will skip the insurance because I need to spend the money somewhere else. So the subsidies help people when they sort of evaluate the expected cost of care and the cost of insurance. They help kind of bring that calculation in line, so that people are much more likely to sign up and stay signed up as long as they are protected from the full cost of insurance.

Chairman NEAL. We thank the witness.

With that, let me recognize the gentleman from Georgia to inquire, Mr. Ferguson, for 5 minutes.

Mr. FERGUSON. Thank you, Mr. Chairman, and I am very grateful to be having this hearing. Let me say to each of you: Thank you for taking time out of your busy schedules and your personal lives to come here and talk about this important topic.

I think it is important that we set that we are doing exactly what we are doing today, which is to set the record straight on pre-existing conditions, our past positions, our current positions, and our future positions. And one of the things I think that—a Rubicon that we have crossed in this country is that we all recognize—Republicans and Democrats, Independents; it does not matter—we all believe that our fellow Americans should be covered.

I don't think there is an argument there, and I think that every one of us believes that in our heart. I think a lot of the argument is about how do we do that. Okay? I think to simply say that "if you are against the Affordable Care Act, that you are against pre-existing conditions" is not being intellectually honest, particularly with the American people.

You can be for preexisting conditions and be against the Affordable Care Act for other reasons, and that is pretty much the position I am in.

Listen, as a former healthcare provider, I used to fight this battle with insurance companies when I would have a patient that would come in with a preexisting condition, that they said would not be covered, yet they were willing to spend countless dollars on another condition that was created by, in fact, this existing condition. It made absolutely no sense. And we had to go to battle for our patients on a regular basis. And this is in the pre-ACA days.

So there have been a lot of comments about what we had before didn't work. True. What we have now is not working because one of the challenges that we have had is that we have seen real costs rise to everyday Americans.

You know, you made the comment, Ms. Pollitz, that rates are rising at a lower—at a slower rate. Healthcare——

Ms. POLLITZ. Healthcare costs, not premiums, yeah.

Mr. FERGUSON. So, you know, if you would like to come down to the Third District of Georgia and stand on stage and make that comment, I will let you do it by yourself. Because you might have some stuff other than words thrown at you. And my point in saying that is, I think that in many parts of the country, that is not the case. I mean, we have constituents that have seen premiums go from \$600 a month with a \$1,000 deductible to \$2,400 a month with a \$6,000 deductible.

I have a single mom, a former patient of mine, with two teenage girls, that simply cannot afford to go to the doctor on her insurance plan.

So I think the thing that we want to get out of all of this today and I think the real honest conversation that we have is, number one, recognize that we all believe that our fellow Americans, and particularly those that are most vulnerable, should have access to affordable care, and they should have access to affordable insurance. I think it is wrong to state otherwise.

I also think that we need to come together, as a Congress and as a Nation, to discuss how to drive down the actual cost of care. One of the things that I worry about greatly, in all of this, and one of the unintended consequences, or maybe the intended consequence, of the ACA is that you are now seeing a very rapid, vertical integration of the healthcare delivery space. You look at the different players that are in that market, and they are all joining hands. And it is becoming fewer and fewer players in the marketplace, and there is less competition.

One of the things that I am excited that Mr. Robertson has brought is a competitive idea that gives the consumer a different choice. So to say that we can't have competition in the marketplace or we won't be able to cover our most vulnerable, I think, is wrong. I think we are a talented enough group of Americans that we can figure out how to do that.

And let's be honest about the fact that we all believe in care for our most vulnerable and those with preexisting conditions. But we can all band together to fight to drive down the rising costs of healthcare and health insurance so that people can actually take better care of themselves and their families.

And, with that, Mr. Chairman, I yield back.

Chairman NEAL. I thank the gentleman. I thank the gentleman for his inquiry.

With that, let me recognize the gentleman from Illinois to inquire for 5 minutes, my friend, Mr. Schneider.

Mr. SCHNEIDER. Thank you, Mr. Chairman, and I want to thank the witnesses first for being here today and sharing your perspectives and insights but also for your patience. I know it has been a long day, but it is a critically important issue.

And I think what we have been talking about on this panel and what others have said, but it is worth repeating, is we all need to be striving—in the richest country in the world, everyone in this country should have quality affordable care, where they are, where they live, when they need it. And healthcare is not something—I heard in a different meeting this morning, someone made the comment about Congress, as we try to tackle long-term problems, working in 2-year cycles, and it is difficult.

Healthcare is not just a long-term issue; it is a lifetime issue for each and every one of us. And it starts at birth, but it is something we deal with our entire life.

And one of the things we have seen is that since the Affordable Care Act—Ms. Pollitz, you touched on this—the cost of healthcare, of delivery, has not risen at the same rate it was before then.

And, with that, Mr. Chairman, I would like to submit for the record a report from the Commonwealth Fund, highlighting how ACA reforms have moved to paying for value and beginning to address the healthcare costs.

Chairman NEAL. Without objection, so ordered.

[The information follows:]



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The Affordable Care Act's Payment and Delivery System Reforms: A Progress Report at Five Years

Melinda Abrams, Rachel Nuzum, Mark Zezza, Jamie Ryan,
Jordan Kiszla, and Stuart Guterman

Abstract In addition to its expansion and reform of health insurance coverage, the Affordable Care Act (ACA) contains numerous provisions intended to resolve underlying problems in how health care is delivered and paid for in the United States. These provisions focus on three broad areas: testing new delivery models and spreading successful ones, encouraging the shift toward payment based on the value of care provided, and developing resources for systemwide improvement. This brief describes these reforms and, where possible, documents their initial impact at the ACA's five-year mark. While it is still far too early to offer any kind of definitive assessment of the law's transformation-seeking reforms, it is clear that the ACA has spurred activity in both the public and private sectors, and is contributing to momentum in states and localities across the U.S. to improve the value obtained for our health care dollars.

OVERVIEW

In addition to its more familiar health insurance coverage reforms, the Affordable Care Act (ACA) contains numerous provisions that directly target how health care is organized, delivered, and paid for in the United States. These provisions take aim at the well-known shortcomings of the U.S. health system, from the inefficiency and high cost of our predominantly fee-for-service system to the extreme variability in the quality of care patients receive from region to region.

Building on existing reform models in the private and public sectors, the law takes multiple, complementary approaches to addressing the health system's longstanding problems. These center on:

- testing new models of health care delivery
- shifting from a reimbursement system based on the *volume* of services provided to one based on the *value* of care
- investing in resources for systemwide improvement.

With the Affordable Care Act now five years old, this brief reviews these approaches and reports on the early impact of specific reforms and initiatives for which reliable data are available. Because many of these provisions are still in the early stages of implementation and testing, it is difficult, if not impossible, to make any definitive assessment of their impact. Nevertheless, it is useful at the five-year mark to review some of the law's delivery and payment reforms in some detail and reflect on the experience of patients, providers, and payers as these profound changes unfold.

NEW MODELS FOR DELIVERING HEALTH CARE

Transformation in health care delivery is a complex undertaking. Moving away from fee-for-service payment and the fragmented care it creates will take resources, experimentation, and time. A single approach will not work for all providers, in all states, or in all markets. The Affordable Care Act includes provisions that encourage the spread of several care models, but two approaches in particular hold promise for improving the effectiveness and efficiency of care delivery: accountable care organizations and patient-centered medical homes.

Accountable Care Organizations

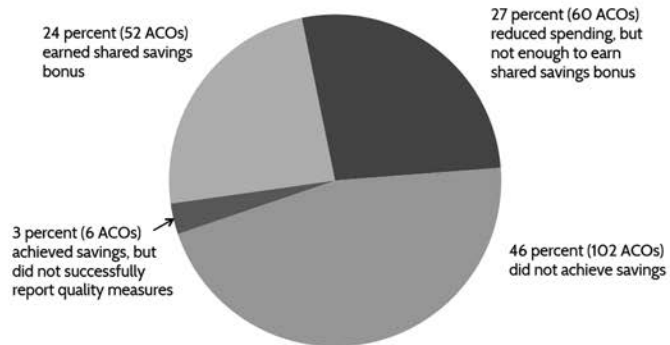
An accountable care organization (ACO) is an entity formed by health care providers—from primary care physicians and specialists to hospitals and postacute care facilities—that agree to collectively take responsibility for the quality and total costs of care for a population of patients. Beginning in 2012, the ACA established the Medicare Shared Savings Program to encourage the development of ACOs. If participating ACOs meet quality benchmarks and keep spending for their attributed patients below budget, they receive half the savings that result, with the rest going to the Centers for Medicare and Medicaid Services (CMS), which administers the program. To keep a larger share of the savings (up to 60 percent), ACOs can choose to participate in a “two-sided risk” model, whereby they must repay a share of losses if health care spending for attributed patients exceeds the budget target.

In 2015, there are more than 400 Shared Savings ACOs serving nearly 7.2 million beneficiaries, or 14 percent of the Medicare population. While these participation numbers have exceeded expectations, results from the program's first year of operation, 2013, were mixed. Of the 220 Shared Savings ACOs that year, only 52 were able to meet quality-of-care benchmarks and keep spending below budget targets; these ACOs generated \$700 million in total savings and roughly \$315 million in shared-savings bonuses (Exhibit 1).¹ Another 60 ACOs kept spending under their targets but either did not fulfill their requirements to measure the quality of care delivered to patients or did not reduce spending enough to meet the minimum criteria to share in savings.

ACOs in the Shared Savings Program showed some improvement on most of the 33 quality measures—from diabetes care to depression screening—compared with other Medicare providers (Exhibit 2). However, these organizations were eligible to share in savings for simply reporting data on all measures, regardless of actual performance. Beginning in 2014, Shared Savings ACOs were required to meet minimum quality standards to qualify for a share in any savings, though performance data are not yet available.

The majority of the participating ACOs have opted for one-sided risk, which means they can share in savings produced but are not subject to paying a share of the losses incurred if spending exceeds targets. A key question for CMS officials is how they can sustain participation in the future while encouraging and supporting providers to assume greater financial risk. A global budget covering

**Exhibit 1. Medicare Shared Savings Program:
Year 1 Performance of Participating Accountable Care Organizations (2013)**



220 Medicare Shared Savings Program ACOs

Source: Centers for Medicare and Medicaid Services, www.cms.gov.

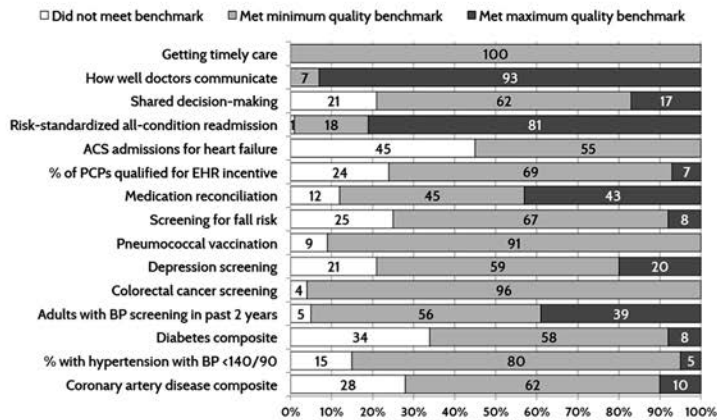
all patients is one potentially important strategy for encouraging clinicians to deliver care in innovative ways, invest in value-producing services that are generally not currently reimbursable (such as taking time to email or educate patients), and devote resources to infrastructure enhancements (such as information technology systems) that improve coordination with other providers.

However, most providers across the country have limited experience in managing care to a budget and limited capacity to coordinate care with other providers. Hence, many are not ready to take on the extra financial risk. For providers equipped to test more advanced payment models and stringent quality thresholds, CMS has launched the much smaller Pioneer ACO program, which is administered by the newly created Center for Medicare and Medicaid Innovation. Known as the CMS Innovation Center, this agency has the authority to test and nationally expand new models that are proven to reduce health care costs while maintaining or improving quality of care. The idea is that lessons learned from the Pioneer ACOs can be incorporated into the Shared Savings Program.

In the second year, 11 of 23 Pioneer ACO participants earned financial bonuses totaling \$68 million, while three ACOs faced penalties of roughly \$7 million. The Pioneer ACO that generated the most savings was Montefiore Medical Center, a safety-net system located in The Bronx, New York (read more about Montefiore's experience [here](#)). Although Pioneer participants are considered among the most advanced ACOs, some have had difficulty meeting financial targets, and 13 have dropped out of the program as of March 2015, with most switching to the Shared Savings model.

In recognition of the challenges providers face to be successful Medicare ACOs, CMS is allowing providers to take it slow by adopting the one-sided risk model for at least three years and by getting credit for simply reporting on quality measures in the first year. (See Exhibit 5 on page 8.) In addition, low-cost loans are being made available to help spread the model to smaller provider

Exhibit 2. Percentage of Accountable Care Organizations in the Medicare Shared Savings Program Meeting Select Quality Benchmarks (2013)



organizations and those in rural areas with limited start-up capital; in fact, one rural organization, Rio Grande Valley ACO, had achieved one of the highest levels of savings as of 2014. ACOs that have proved successful from the start tend to make investments in information technology systems, data analytic tools, and the necessary staff to identify high-risk patients and closely monitor their care.

Medicare's ACO programs are likely to evolve with the accumulation of experience. An important marker of impact to watch will be whether ACOs' investments improve outcomes for patient populations beyond Medicare.

Primary Care Transformation Through Implementation of Medical Homes

Although primary care is fundamental to a well-functioning health system, the U.S. has undervalued and underinvested in it for decades. The neglect of primary care is largely a byproduct of the prevailing fee-for-service reimbursement approach: providers have inherent financial incentives to favor higher-priced procedures over care management and other cost-saving services. As a result, the care U.S. patients receive is often poorly coordinated and expensive.

On the flip side, there is considerable evidence that comprehensive, coordinated, and well-targeted primary care can improve outcomes and reduce per-patient costs. These characteristics are embodied in the patient-centered medical home, a model of care that emphasizes more comprehensive care coordination, care teams, patient engagement, and population health management.

A number of the ACA's reforms seek to transform primary care by way of the medical home model, through programs and initiatives involving private physician practices, community health centers, and even home-based care providers. The ACA also is helping health systems and states to experiment with ways to improve the quality of primary care, spread promising models, and integrate primary care more seamlessly with other health care services, such as behavioral health and long-term

care services (see appendix for a summary of several primary care-related provisions in the law). Below we present recent findings from two of the CMS Innovation Center's large-scale, multipayer primary care initiatives that seek to change the face of primary care in the U.S. (Exhibit 3).

Comprehensive Primary Care Initiative. This national initiative involving 29 payers (excluding CMS), nearly 500 providers, and some 2.5 million patients is testing a new way to deliver

Exhibit 3. Select CMS Innovation Center Initiatives on Primary Care Transformation

	Comprehensive Primary Care Initiative	Multi-Payer Advanced Primary Care Practice Demonstration	FQHC Medical Home Demonstration	Independence at Home	Total
Patients	2,534,506	2,225,537	Total n/a; 207,000 Medicare beneficiaries	8,300	4,768,343
Providers	2,494	3,837	2,700	347	9,378
Multiple payers?	Yes	Yes	No	No	2/4 initiatives
Total payments to date	\$153.2M	\$99.2M	\$41.7M	Have not issued payments	\$294.1M
Early results	In year 1, initiative generated nearly enough savings to cover \$20 care management fee paid, although not enough for net savings. Across all seven regions, emergency department visits decreased by 3% and hospital admissions by 2%. Quality results mixed.	Generated \$4.5 million in savings across eight states.	73% of 492 participating health centers achieved Level 3 Patient-Centered Medical Home recognition based on standards set by National Committee for Quality Assurance, short of 90% goal set in 2011.	No results yet	

and pay for care that is designed to improve access, coordination, and chronic disease management while engaging patients and their caregivers. The program offers participating physician practices enhanced payment, technical assistance, and ongoing feedback on performance. Evaluation results show that in the initiative's first year, spanning October 2012 to September 2013, the practices generated enough savings to cover most of the \$20 per-member, per-month care management fee paid on average by CMS (although not enough to produce net savings overall). While there was considerable variation in performance among the seven participating U.S. regions, across all markets emergency department visits decreased by 3 percent and hospital admissions by 2 percent after year 1. Significant effects on quality were few.²

Multi-Payer Advanced Primary Care Practice Demonstration. Medicare has joined eight state-sponsored pilot programs involving Medicaid and private insurers to test the impact of per-member, per-month fees paid to primary care sites for providing medical home services.³ In the demonstration's first full year of operation, 2012, more than 3,800 providers in 700 practices serving 2.2 million patients participated. Recent evaluation results estimate \$4.5 million in savings generated in year 1, translating to a return on investment of \$1.35 for every \$1 Medicare paid out. In Vermont

and Michigan, growth in Medicare fee-for-service health care spending significantly slowed as hospital inpatient care expenditures fell. There is less evidence, however, that the state initiatives were able to reduce hospitalizations, readmissions, and emergency department visits.⁴

A major theme emerging from these efforts to transform primary care is the critical role of technical and financial support in building the capacity of physician practices to function as medical homes. Each of the ACA-supported transformation initiatives includes some level of support for practices to address common challenges. These include: collecting, reporting, and using data in a timely fashion for care management and quality improvement; changing the practice culture to enable effective teamwork; and obtaining information about patients from settings outside the practice.

In general, federal investments have stimulated unprecedented collaboration and dialogue among payers, both private and public, and providers on how to reorganize primary care at the local level to achieve the aims of reform. Still, Medicare, despite collaborating more actively with primary care providers and other payers since the ACA's passage, needs to identify ways to share data more quickly with local partners and communicate programmatic changes clearly.

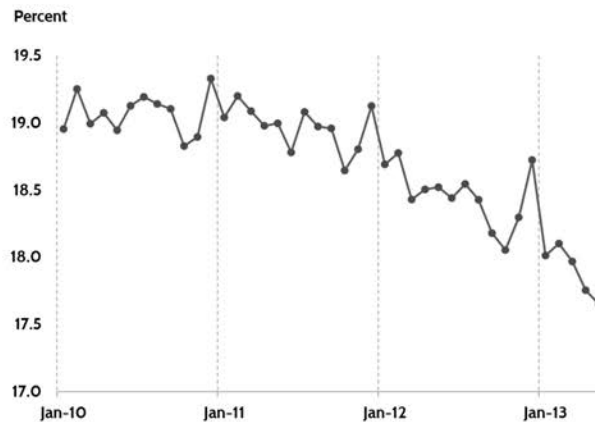
REFORMING PROVIDER PAYMENT

The Affordable Care Act included many payment reform provisions aimed at promoting the development and spread of innovative payment methods to facilitate the adoption of effective care delivery models. The earliest of the ACA's provisions related to provider reimbursement have slowed growth in fee-for-service payment levels. The intention was to provide some budget relief, particularly for the Medicare Trust Fund, and to send a clear signal to providers that they will need to adapt quickly to incentives that reward appropriate, high-quality care and good patient outcomes.

For example, reflecting the anticipated reduction in uncompensated care from increased insurance coverage, the ACA lowered annual increases in Medicare payment rates for hospitals and other facilities and explicitly set an expectation for providers to become more efficient over time. The law also reduced overpayments to private plans administering Medicare benefits through the Medicare Advantage program, bringing these payments more in line with traditional Medicare costs, and linked, as of 2012, plan payments to performance ratings and made the results public.⁵ Today, even with these lower payments, increasing numbers of beneficiaries are enrolling in private plans, with many choosing higher-performing plans.⁶

Other ACA provisions target quality problems that lead to inefficiencies and jeopardize patient health. For example, the law imposes financial penalties on hospitals with high rates of hospital-acquired conditions and readmissions, an effort that has likely contributed to the recent reduction in associated adverse medical events (Exhibit 4). The new value-based purchasing program for hospitals, meanwhile, fosters greater accountability for performance by dispensing bonuses and penalties tied to publicly reported quality measures; similar programs for physicians are being implemented in phases, starting in 2015, with a full rollout to all fee-for-service providers in 2017.

The ACA provisions also seek longer-term, systemic change in how health care is organized and delivered. In addition to the accountable care programs and medical home initiatives discussed above, the ACO is also testing a payment approach known as bundled payment, a single reimbursement for all the services required for a given medical condition or procedure. This means that physician, hospital, or postacute services can all be covered under a single payment, which should incentivize the various providers involved in a given patient's care to work better together. Nearly

Exhibit 4. Change in All-Cause 30-Day Hospital Readmission Rates

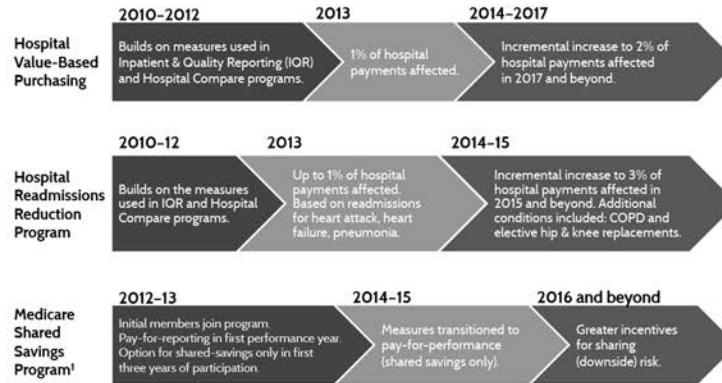
Source: Patrick Conway, Office of Information Products and Data Analytics, Centers for Medicare and Medicaid Services.

7,000 postacute care providers, hospitals, and physician organizations have signed up to participate in bundled-payment demonstrations, which represent a further step away from payment for individual services and toward shared accountability for quality and costs.

Most of the new payment models are still in their early phases, and evidence of their impact is far from definitive. Many initiatives have adopted an incremental approach to financial accountability, often starting with pay-for-reporting or bonus-only options (Exhibit 5). The gradual approach recognizes that the type of structural change required to be successful under risk-based payment systems takes time, a concern repeatedly voiced by providers.

The pace of change is about to pick up, however. Earlier this year, the U.S. Secretary of Health and Human Services (HHS) announced a goal to have at least 90 percent of traditional Medicare payments linked to some form of ACO, medical home, bundled payment, or other value-related approach by 2018.⁷ A private-sector consortium has set a similar goal for its member businesses.⁸ In fact, an important effect of the ACA is how it has opened up new channels of communication between providers and CMS about the design and implementation of new payment and delivery models. The CMMI Innovation Awards program, for example, encourages health care organizations to propose new care delivery and payment initiatives for piloting. And provider involvement in the design of the law's ACO and bundled-payment provisions enabled CMS to create programs that have attracted large numbers of participants. CMS and providers are now sharing much more data to monitor and gauge program performance. While implementation of these new programs has not been without delays and hiccups, the culture change occurring across the health care sector may soon make greater strides possible.

Exhibit 5. Accelerating Implementation of Key Payment Reform Provisions



¹ Builds on Physician Group Practice demonstration. Pioneer and Advanced Payment ACOs also launched through the Center for Medicare and Medicaid Innovation in 2012 with more-sophisticated provider organizations.

Exhibit 6. CMS Innovation Center's Focus Areas and Selected Initiatives

Accountable Care <ul style="list-style-type: none"> Pioneer ACOs Advance Payment ACOs 	Initiatives Focused on the Medicaid and CHIP Population <ul style="list-style-type: none"> Medicaid Emergency Psychiatric Demonstration Medicaid Innovation Accelerator Program Strong Start for Mothers and Newborns Medicaid Incentives for Prevention of Chronic Diseases
Bundled Payment for Care Improvement <ul style="list-style-type: none"> Model 1: Retrospective Acute Care Model 2: Retrospective Acute and Postacute Care Episode Model 3: Retrospective Postacute Care Model 4: Prospective Acute Care 	Initiatives Focused on Medicare-Medicaid Enrollees <ul style="list-style-type: none"> Financial Alignment Initiative Initiative to Reduce Avoidable Hospitalization Among Nursing Facility Residents
Primary Care Transformation <ul style="list-style-type: none"> Comprehensive Primary Care Initiative Advanced Primary Care Practice Demonstration (Federally Qualified Health Centers) Independence at Home Demonstration Multi-Payer Advanced Primary Care Practice Demonstration 	Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models <ul style="list-style-type: none"> Health Care Innovation Awards State Innovation Models Initiative
Initiatives to Speed the Adoption of Best Practices <ul style="list-style-type: none"> Innovation Advisors Program Partnership for Patients 	

RESOURCES FOR SYSTEMWIDE IMPROVEMENT

The Affordable Care Act created a number of new resources to establish a foundation for accelerated public- and private-sector innovation in health care delivery. These institutes and agencies, described briefly below, appear to be contributing to growing momentum in the U.S. to reconfigure how care is delivered and paid for. (See *Appendix A. Selected Health Care Payment and Delivery System Reform Provisions of the Affordable Care Act.*)

Center for Medicare and Medicaid Innovation. As mentioned earlier, CMMI, also known as the CMS Innovation Center, was established to identify, test, and spread new payment and service delivery models to reduce expenditures while maintaining or improving quality of care for beneficiaries of Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). The U.S. Secretary of Health and Human Services has been granted authority to expand innovations if evidence shows actual cost reductions or improvements in outcomes. When the ACA was enacted, the Congressional Budget Office estimated that the Innovation Center, with its \$10 billion of direct funding over 10 years, would save \$1.3 billion between 2010 and 2019. Since 2010, the center has launched an array of initiatives that together reach more than 2.5 million patients and 60,000 clinicians across the 50 states (Exhibit 6).⁹ (See sidebar on next page.)

Patient-Centered Outcomes Research Institute. Supported through appropriations from general fund revenues and fees assessed on Medicare, private health insurance, and self-insured plans, PCORI funds research on clinical treatments and their outcomes with respect to quality of life, daily functioning, and long-term survival.¹⁰ It also is charged with improving the quality, relevance, and translation of the evidence itself, helping to ensure that research results are useful to frontline clinicians. As of April 2015, PCORI has awarded 399 research projects in 39 states, totaling nearly \$855 million across five priority areas.¹¹ While preliminary feedback shows that the institute has engaged patients and other stakeholders in developing research questions and reviewing proposals, there are as yet no results available to document the impact of funded projects on patients or providers.

Medicare-Medicaid Coordination Office. The Duals Office, as it is commonly referred to, was created by the ACA to increase coordination between Medicare and Medicaid, which together serve the more than 10.7 million low-income individuals with disabilities who are jointly enrolled in both programs.¹² This population generally has more extensive health care needs than other beneficiaries and accounts for a disproportionate share of health spending in both programs. The Duals Office has launched demonstrations to integrate care for these individuals in 18 states through two initiatives: one to reduce avoidable hospitalizations among nursing home residents, and another to test new models to better align the financing of Medicare- and Medicaid-covered services. As of July 2014, CMS had finalized memoranda of understanding with 12 states to implement 13 demonstrations to change the financing arrangements among CMS, the states, and providers serving this population. Although states have submitted plans to evaluate their respective demonstrations, data on beneficiaries' experience with care or on cost and quality effects are not yet available.

National Strategy for Quality Improvement in Health Care. Designed to align health care improvement efforts across federal, state, and local agencies and the private sector, NQS aims to ensure providers and government are working toward the same goal: healthier communities and lower overall health care costs. According to the U.S. Department of Health and Human Services, work undertaken in at least one NQS priority area—patient safety—has had a significant impact on hospital-based care: between 2010 and 2013, incidents of harm experienced by hospital patients

THE STATE INNOVATION MODELS INITIATIVE

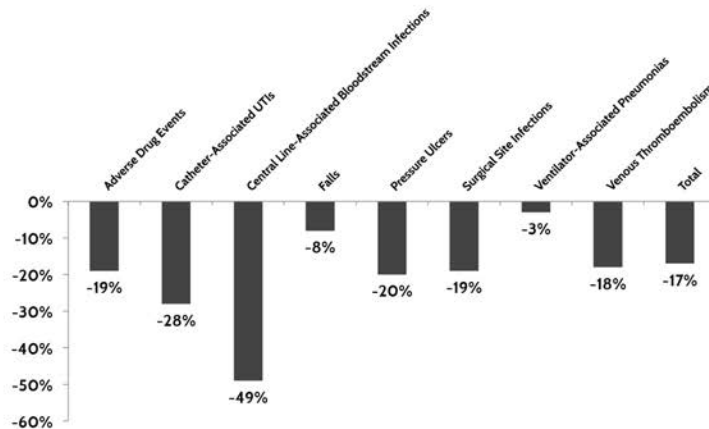
Recognizing the critical role that states play in providing, purchasing, and regulating health care services, the CMS Innovation Center established the State Innovation Models Initiative (SIM) to help states achieve better health outcomes at lower cost. SIM grants provide federal dollars and technical assistance for a wide range of health system transformation efforts. Thirty-nine states have received SIM grants for design, pretesting, or testing activities.

Connecticut	Iowa	Oregon
<p>Awarded design grant in 2013 and testing grant in 2014. Will develop Medicaid Quality Improvement Shared Savings Program for providers, engage in practice transformation initiatives for primary care, and focus on workforce development projects and programs.</p> <p>SIM design process helped Connecticut cultivate commitment to value-based payment across payers and accelerated trend toward organization of providers into ACO-like entities. Design process also sparked interest among federally qualified health centers in alternative payment methodologies, which state aims to develop with SIM testing grant.</p>	<p>Awarded design grant in 2013 and testing grant in 2014. Iowa seeks to: 1) expand coverage of its shared-savings ACO model to the entire Medicaid population; 2) align with other payers through standard quality and performance measurement; and 3) build community care teams and enhanced use of health information technology and exchange. ACO services will include behavioral health and long-term care.</p> <p>Iowa also is addressing social determinants of health through community integration efforts and development of incentives for healthy behaviors.</p>	<p>Awarded testing grant in 2013, which provided assistance for establishment of regional coordinated care organizations (CCOs) that oversee physical, behavioral, and ultimately dental care under a global budget (reform program launched previously under Section 1115 waiver).</p> <p>SIM funding enabled creation of Oregon Health Authority's Transformation Center, which supports CCOs by providing technical assistance, best practices, and other support to providers to embrace the state's reform model.</p> <p>In 2013, Oregon achieved: decreased emergency department visits and spending; increased primary care utilization and spending; higher rates of child developmental screening during first 36 months of life; fewer hospitalizations for chronic conditions; and greater adoption of electronic health records. All CCOs improved on some measures and 11 of 15 met all their improvement targets. Oregon regularly updates progress on its website.</p>

Source: National Association of State Medicaid Directors, "Perspectives on Innovation: A State Medicaid Approach to Evaluation," March 30, 2015, <http://medicaiddirectors.org/node/1172>.

nationwide decreased 17 percent, and potentially as many as 50,000 deaths were avoided, and 1.3 million fewer patients experienced harm from hospital-acquired medical conditions (Exhibit 7).¹³ These improvements are estimated to have saved \$12 billion in health care costs.

Exhibit 7. Change in Rates for Hospital-Acquired Conditions, 2010–13



Source: Agency for Healthcare Research and Quality, *Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms: Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted from 2010 to 2013*, Dec. 2014.

Prevention and Public Health Fund. This fund provides sustained national investment in preventive care and public health. Through 2015, it has awarded more than \$5 billion to local community efforts.¹⁴ Among other things, the fund supports diabetes prevention, immunization programs, tobacco use prevention, and heart disease and stroke prevention. Community Transformation Grants provide resources to state and local governmental agencies and local organizations to address chronic disease; grantees must reduce rates of obesity, tobacco-related death and disability, heart disease, or stroke by 5 percent within five years. Over \$370 million has been awarded—20 percent to rural areas—benefiting nearly 130 million Americans.¹⁵

CONCLUSION

Five years after passage of the Affordable Care Act—and fewer years from the time many delivery system reforms got off the ground—a full measure of the law's national impact is premature. It is clear, however, that the ACA has spurred activity in both the public and private sectors, contributing to the accelerated pace of state and local innovations across the country. There is widespread agreement that fee-for-service health care should no longer be the norm, and that fundamental shifts are needed to produce affordable, high-quality, value-based care.

The ACA has provided a platform and a commitment to testing new approaches to how health care is delivered and paid for, as well as recognition that there is no single solution. Experimentation and innovation, by definition, involve missteps, particularly in these nascent stages of transformation. Whether the payment and delivery system reforms currently being tested have the desired impact will depend on the nation's ability to continuously test new approaches, correct course when necessary, and apply lessons learned. Seen in this light, promising and discouraging results alike should be examined critically along the way.

NOTES

- ¹ <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/News.html>.
- ² E. Taylor, S. Dale, D. Peikes et al., *Evaluation of the Comprehensive Primary Care Initiative: First Annual Report* (Princeton, N.J.: Mathematica Policy Research, Jan 2015).
- ³ The eight states are: Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont.
- ⁴ N. McCall, S. Haber, M. Van Hasselt et al., *Evaluation of the Multi-Payer Advanced Primary Care Practice Demonstration: First Annual Report* (Research Triangle Park, N.C.: RTI International, Jan. 2015).
- ⁵ B. Biles, G. Casillas, G. Arnold, and S. Guterman, *The Impact of Health Reform on the Medicare Advantage Program: Realigning Payment with Performance* (New York: The Commonwealth Fund, Oct. 2012).
- ⁶ Centers for Medicare and Medicaid Services, "Medicare Advantage Enrollment at All-Time High; Premiums Remain Affordable," press release, Sept. 18, 2014, <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2014-Press-releases-items/2014-09-18.html>.
- ⁷ S. M. Burwell, "Setting Value-Based Payment Goals—HHS Efforts to Improve U.S. Health Care," *New England Journal of Medicine*, published online Jan. 26, 2015, <http://www.nejm.org/doi/pdf/10.1056/NEJMp1500445>.
- ⁸ <http://www.hctf.org/>.
- ⁹ Center for Medicare and Medicaid Innovation, Report to Congress (Washington, D.C.: Centers for Medicare and Medicaid Services, Dec. 2014), <http://innovation.cms.gov/Files/reports/RTC-12-2014.pdf>.
- ¹⁰ An estimated \$3.5 billion is expected to flow to PCORI from 2013 through 2019. PCORI announcement, Feb. 5, 2015.
- ¹¹ PCORI fact sheet, <http://www.pcori.org/sites/default/files/PCORI-About-PCORI.pdf>.
- ¹² Medicare–Medicaid Coordination Office, *Data Analysis Brief: Medicare–Medicaid Dual Enrollment from 2006 Through 2013* (Washington, D.C.: Centers for Medicare and Medicaid Services, Dec. 2014), <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DualEnrollment20062013.pdf>.
- ¹³ Agency for Healthcare Research and Quality, *Efforts to Improve Patient Safety Result in 1.3 Million Fewer Patient Harms: Interim Update on 2013 Annual Hospital-Acquired Condition Rate and Estimates of Cost Savings and Deaths Averted from 2010 to 2013* (Rockville, Md.: AHRQ, Dec. 2014).
- ¹⁴ The federal investment in these community-based activities through 2021 is estimated at \$10.5 billion. National Association of County and City Health Officials, "Public Health and Prevention Provisions of the Affordable Care Act," <http://www.naccho.org/advocacy/upload/PH-and-Prevention-Provisions-in-the-ACA-Revised.pdf>.
- ¹⁵ U.S. Department of Health and Human Services, "Prevention and Public Health Fund," <http://www.hhs.gov/open/prevention/index.html>.

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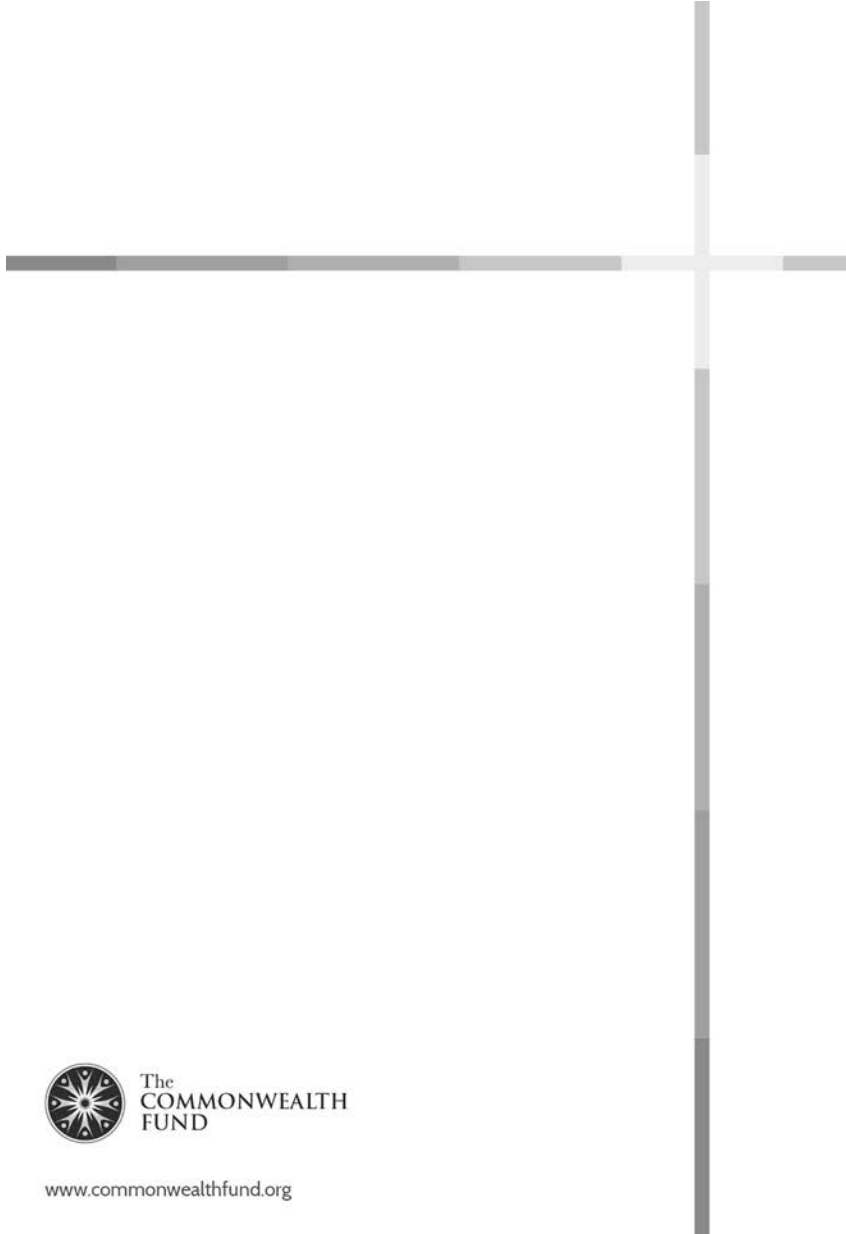
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Mr. SCHNEIDER. Thank you. And we are here today; it is a critically important topic, talking about protection for people with preexisting conditions. And as I have sat here today listening, but also over the course of the year, meeting with people, I am reminded of many young people I have met. I think of Jared Cooper, who was diagnosed at a young age with type 1 diabetes and has become a champion, and all the other kids I have met with diabetes, a lifetime condition, that, with treatment, hopefully they will be able to have a full and productive life.

A young woman, Kendall, who I met when she was in seventh grade, was diagnosed when she was 2 years old with leukemia, and—it was a burden on the family, but she survived, and will always be a cancer survivor. But when I met her—and I saw her recently. She is now in ninth grade. This is a young woman who is on the soccer team, was a swimmer. She is living the life we hope for all of our children, reaching her full potential.

I met a young woman yesterday, Brie, who was brave enough to share with me her experience of dealing with learning disabilities, combined with ADHD, which can be a preexisting condition that would affect her outcomes, but with the proper treatment, she is going to have all the opportunities we all want for our children.

And it is not just young people. Mr. Blackshear, thank you for sharing your story and bravely sharing your story. I can only imagine what you went through, and it starts with just a drive through the desert. You know, you wake up the next day, and your life is changed forever. But that diagnosis shouldn't be a sentence of financial challenge. It should be something that you have the opportunity to consistently pursue—and it looks like you might want to say something.

Mr. BLACKSHEAR. I was just going to say: I agree.

Mr. SCHNEIDER. But it is not just that, and these are things, I think all of us have experience with preexisting conditions. My sister is a thyroid cancer survivor, the mother of three young children, and doing quite well, but she will be dealing with healthcare issues her entire life. My cousin is a breast cancer survivor. My great nephew was born 2 months prematurely; he will soon celebrate his second birthday.

These are all things about our healthcare system that make the world possible for us to appreciate. They should be open to everybody. I didn't mean to give a speech. I really wanted to get to a question, and, Ms. Pollitz, I will start with you. I just gave a list of friends, neighbors, and family with preexisting conditions. If we were to lose the protections for these people, broadly speaking, what is the impact, not just on these individuals but on our community?

Ms. POLLITZ. It would make it harder for people, as hard as it was before the ACA, to get and stay affordably covered. It would just make it harder for people. People, before the ACA, sometimes hit bottom and did without, and—so they couldn't get treatment for those conditions. Sometimes they had to rearrange their lives in extraordinary ways, move or take a job or marry or change their income or, you know, do something extraordinary in order to be able to stay attached to some other coverage for which they were eligi-

ble that wouldn't discriminate based on their preexisting condition. So this makes other options possible for people.

Mr. SCHNEIDER. Thank you, and I just have a few seconds left. But, Mr. Blackshear, you were 27 when you were diagnosed with valley fever—

Mr. BLACKSHEAR. Correct.

Mr. SCHNEIDER [continuing]. Right? And you said that was a couple years ago. I think you shared with us, you have healthcare now; it is not a worry. And as you look to your future, is it something that you feel you can count on, or is it something that still hangs over your head, saying, you know, I don't know if I will have it a year or 5 years from now?

Mr. BLACKSHEAR. I really do hope I can count on it. I really do. The conversations we are having, you know, I wish we were past this, but they are very important, and I really do hope so.

Mr. SCHNEIDER. Thank you. I hope so, too. I am out of time. I will just say this: It has been 10 years we have been litigating the Affordable Care Act while healthcare has moved forward. Our job as policymakers, I would like to say—is we don't get to be ahead of the curve; we have to do everything we can to catch up and stay in pace with healthcare—but our job is to make sure, Mr. Blackshear, that you don't have to worry about this and you can achieve your dreams. Thank you and I yield back.

Mr. BLACKSHEAR. I appreciate it. Thank you.

Chairman NEAL. I thank the gentleman.

And, with that, let me recognize the gentleman from California, Mr. Panetta, to inquire for 5 minutes.

Mr. PANETTA. Thank you, Mr. Chairman. I appreciate this opportunity and appreciate this type of hearing on such an important topic as preexisting conditions. Let me also thank all of the witnesses at this point for being here and for your endurance this morning and this afternoon.

But I want to give four of you a break and actually focus on Mr. Stolfi and have a conversation with you, if that is okay. So the rest of you can either zone out or just take a little break.

I want to talk about the connections between preexisting condition protections and the ACA. Okay? I think what you are hearing today is that most of us support the protections of preexisting conditions. But I think what we need to highlight is what exactly people are doing to support it, and that it is not necessarily intellectually dishonest. What it is, is an actual contradiction. What it is, is an actual inconsistency, which I think is something that all of us, as representatives of the people, try to avoid, being inconsistent. We want to be consistent.

But it seems that in some of my colleagues' support for a couple things, there is some inconsistency. And starting with the *Texas v. Azar* case, a case that was filed to strike down all of the ACA, in that you had 20 Republican attorneys general who basically wanted to repeal the individual mandate as part of the tax law, is what they were arguing because it was zeroed out in such that the mandate was no longer constitutional.

And then, on top of that, you had our Administration, this Administration, through the Department of Justice, file a separate brief during that case in which they decided not to defend the con-

stitutionality of the individual mandate, and they agreed that certain provisions of the ACA—guaranteed issue, community rating, the ban on preexisting condition exclusions, and discrimination based on health status—are inseverable, are inseverable, from that mandate.

Now, to me, supporting the DOJ brief, supporting that case by the 20 Republican AGs, seems inconsistent with saying you are then for preexisting condition protections. Am I correct?

Mr. STOLFI. I would agree that it would be inconsistent to support protecting people with preexisting conditions and the Texas lawsuit at the same time.

Mr. PANETTA. And why is that?

Mr. STOLFI. Well, the Texas lawsuit itself is seeking to invalidate and dismantle the entire Affordable Care Act.

Mr. PANETTA. And that includes protection of preexisting conditions?

Mr. STOLFI. Absolutely.

Mr. PANETTA. Now, what we are also seeing recently is certain States are trying to create their own laws, saying: We protect preexisting conditions.

And I will use Wisconsin as an example. But what they are doing, though, in trying to protect preexisting conditions, how is that possible—how is that possible without the ACA? Can you explain that?

Mr. STOLFI. Well, for one very big reason it would be rather difficult without the ACA, because the ACA, one of the essential elements of it are the subsidies it provides to individuals to afford the insurance that they need to have.

Mr. PANETTA. Would it also create unbalanced risk pools?

Mr. STOLFI. Without the ACA, yes.

Mr. PANETTA. And would it also—I mean, it is basically—it wouldn't ensure that certain procedures are covered as well, correct?

Mr. STOLFI. That would be likely, yes.

Mr. PANETTA. And what about the exclusions on annual or lifetime caps?

Mr. STOLFI. Those would go away in most States, yes.

Mr. PANETTA. Exactly. So it would be pretty hard to support preexisting conditions without supporting the Affordable Care Act, correct?

Mr. STOLFI. It would be difficult, yes.

Mr. PANETTA. Thank you, Mr. Stolfi.

I yield back. Thank you, Mr. Chairman.

Chairman NEAL. I thank the gentleman.

Once again acknowledging the Gibbons rule. When the gavel came down, Mr. Suozzi had been seated, so we will move to him for 5 minutes for inquiry.

Mr. Suozzi.

Mr. SUOZZI. Thank you, Mr. Chairman. I first want to thank you for holding this hearing and thank you again for making clear to the Ways and Means Committee that you are going to be spending a lot of time on hearings looking at the facts of different issues. I think it is a great practice that you are making sure we return to. I saw Mr. Reed privately a few moments ago. I was hoping he

would be here so I could say publicly that I want to congratulate him because he stated in his very strong comments earlier, that he gets it now. He finally gets the fact—and the Republicans that he associates with—they get it, that preexisting conditions must be protected. They heard the message. It only took years. It only took 70 votes. It only took hundreds of millions of dollars of campaign commercials. It only took billions of dollars of free air time debating these issues. But they finally get the fact that we must protect preexisting conditions. I think that is an excellent, excellent result.

Ms. POLLITZ, I know you said earlier that you don't advocate for policy; you just focus on the facts and what is out there, the data. So I wanted to just confirm some things with you. Of the 330 million people in America, 160 million to 175 million are covered by their private employer for their health insurance.

Ms. POLLITZ. Correct.

Mr. SUOZZI. And about 75 million by Medicaid; 45 million by Medicare; and 30 million remain uninsured, 4 million people more than it was before this Administration took office. Is that correct?

Ms. POLLITZ. I don't know that the number of uninsured has risen quite 4 million in the last 2 years, but it has started to tick up again.

Mr. SUOZZI. Do you have any idea of what that number would be, of how many it has gone up by? It is okay. You don't—

Ms. POLLITZ. I will have to submit a number for you.

Mr. SUOZZI. And there are about 23 million people that are covered in the individual marketplace?

Ms. POLLITZ. Not that many. It is closer to 15 million that are in the individual marketplace.

Mr. SUOZZI. Okay.

Ms. POLLITZ. I am sorry. In the individual market, most of them in the marketplace.

Mr. SUOZZI. Is it 15 million?

Ms. POLLITZ. Total, for the individual market, yes.

Mr. SUOZZI. So most of the stories that we hear about insurers pulling out of the market and about premiums going up dramatically, are most of those stories specifically related to the individual market?

Ms. POLLITZ. Yes.

Mr. SUOZZI. So most of the dissatisfaction with what is going on in the marketplace is directly related to the individual market?

Ms. POLLITZ. Correct. And that rise in premiums that was on the chart before, that is just for the individual market. We don't see that same volatility in the cost of employer plans.

Mr. SUOZZI. So you are referring to Mr. Rice's questioning earlier when he had the charts up, about—he said only 6.6 percent more people were covered. That happens to be 20 million people, which is an awful lot of people whose lives are much more improved now that they have access to healthcare, and it is a humongous number of people, especially if you are one of those 20 million people.

Ms. POLLITZ. Yes.

Mr. SUOZZI. But when he talked about the rising of the rates in the individual market, much of those rate increases would have existed anyway because rates were going up before the Affordable

Care Act. Of course, they were affected by the Affordable Care Act as well, but weren't rates going up anyway?

Ms. POLLITZ. They were, but the rates weren't the same for everybody. So people, as long as they were healthy, could kind of move to another plan, resubmit to medical underwriting, maybe get another cheap rate. But as soon as you got sick, either your rates would go through the roof or you would get locked out of that market altogether.

Mr. SUOZZI. So one of the things that we have discussed here today is that the Administration has been pushing these short-term plans. And these short-term plans are, in fact, cheaper for the people who are buying these short-term plans, but one of the reasons they are cheaper is they don't cover preexisting conditions. Is that correct?

Ms. POLLITZ. That is correct.

Mr. SUOZZI. So one of the points that we are trying to make in this testimony today, or this hearing today, is that preexisting conditions, when they are not covered, may provide you with cheaper rates, but the people who have preexisting conditions are very seriously hurt by that and can't afford themselves those particular plans?

Ms. POLLITZ. That is right.

Mr. SUOZZI. And I just wanted to clarify one thing that you—I think it was you that said it earlier. You said that we have seen premiums increase over the past year, but we estimate that about 6 percent of the increases are due to, one, the repeal of the individual mandate, and, two, the okaying of short-term plans.

Ms. POLLITZ. Actually, we saw the 2019 premiums go down a little bit this year, by 1 percent, but if not for those two other factors, the repeal of the mandate and the expansion of short-term plans, we would have seen them go down another 6 percent. So insurers tell us in their rate filing that even though they kind of overshot the mark last year when they corrected and so they are kind of lowering their rates, they are not going as low as they would have otherwise because they are still worried about this other source of uncertainty.

Mr. SUOZZI. Thank you very much. I yield back my time.

Chairman NEAL. I thank the gentleman.

Let me recognize the gentlelady from the State of Florida, Mrs. Murphy, to inquire for 5 minutes.

Mrs. MURPHY. Thank you, Mr. Chairman, and thank you to the witnesses for your testimonies.

Along with Congressman Buchanan, I am one of the two Members on this Committee who represents Florida, and according to the Kaiser Family Foundation, there are an estimated 3.1 million people in Florida under the age of 65 who have a preexisting health condition, such as cancer or diabetes or heart disease. And I can sit here thinking to myself that I know at least one family member or friend who has some kind of preexisting condition, and I imagine that my constituents probably could do that as well.

And, in fact, according to Kaiser, nearly 3 in 10 nonelderly adults in my Orlando-area district have a preexisting condition. That is one of the most of any major metropolitan area in all of Florida. It would have been very difficult, and maybe even impossible, for

these constituents of mine to have obtained health insurance on the individual market prior to the passage of the Affordable Care Act in 2010 because of the way that the insurance companies screened applicants for coverage.

And the ACA, in addition to empowering States to expand Medicaid to more people and creating federally supported health insurance marketplaces for individuals and families, established robust protections for Americans with preexisting conditions within those marketplaces. Specifically, the law guaranteed access to insurance regardless of health status. It prohibited insurance companies from varying premiums based on people's health and required coverage of certain essential benefits that are important to a healthy life.

And thanks to these consumer protections and to the availability of the Federal financial assistance for lower income individuals, there are now 1.7 million Floridians enrolled in a marketplace plan. That is far more than any other State.

And, in other words, you know, despite the misguided decision not to expand Medicaid, Florida has benefited a great deal from the Affordable Care Act. The State and its citizens stand to lose a great deal if the law is repealed by Congress, struck down by the Federal courts, or undermined by regulators at the Department of Health and Human Services.

Nonelderly adults with preexisting conditions could once again be denied coverage or charged an excessive amount for coverage. And while my colleagues on the other side of the aisle claim that they support protecting people with preexisting conditions, it is my understanding that few, if any, of the patient advocacy groups supported their various efforts to repeal and replace the Affordable Care Act.

If their proposals were even adequate at providing patient protections, why would the patient groups that purport to help, oppose them? My colleagues on the other side can say they support people with preexisting conditions all they want, but the reality is that they continue to support efforts to undermine these protections that Americans want. And I think it is well past time that they matched their words with actions.

So my question is for Ms. Pollitz. At the risk of asking you to repeat what you have already said many times today, can you explain in just very simple terms what the recent legislative, administrative, and judicial efforts to weaken the Affordable Care Act would mean for people with preexisting conditions in Florida and other States? And can you really argue with a straight face that—or can anyone really argue with a straight face that my constituents would be in a better position now if these efforts were successful?

Ms. POLLITZ. The recent changes—I won't go through them all—have had the effect of increasing premiums artificially, for individual health insurance through the marketplace. When people are eligible for subsidies, they are protected from that. So it is the taxpayers of Florida who pay for that, not the insurance enrollees. But there are millions of people throughout the United States who aren't eligible for subsidies: They earn too much. They are in the family glitch that Keysha talked about. There are other reasons why they are not eligible. And they bear the full burden. So to the

extent that they start to fall out of the marketplace, it is more likely that the healthier people will let go first, that the people who know they are using the coverage will hang on as hard as they can, find ways to hang in there, and that kind of drives up the cost more because it just means the average cost, the morbidity of the risk pool, increases.

So far the subsidies are kind of the stabilizing factor. They are kind of keeping it all together. They are keeping most of the people kind of covered in the marketplace. But at the margins, people with preexisting conditions are—they are having to pay more for ACA coverage because they are not protected by the subsidies, and at some point, they may not be able to do that.

Mrs. MURPHY. Thank you. I yield back.

Chairman NEAL. I thank the gentle lady.

I recognize the gentleman from California to inquire for 5 minutes, Mr. Gomez.

Mr. GOMEZ. Mr. Chairman, thank you so much for organizing this important hearing. Healthcare is a very personal issue. For me, it was growing up without health insurance, spending 7 days in the hospital, when I was a kid, with pneumonia and almost bankrupting my family. Preexisting conditions don't just apply to seniors. They also apply to little kids.

This individual I want to talk about was about the same age as me when I had pneumonia when she was diagnosed with a congenital heart disease. Her name is Micah. And I had the privilege of meeting her. She is amazing. She introduced herself as, first, a Girl Scout—that is very important—a figure skating aficionado, and a little lobbyist, because she was making her voice heard about the Affordable Care Act and what kind of impact it had on her life.

She might be just a kid, but her and her friends are really fighting to make sure the Affordable Care Act is in place. She has already had two open-heart surgeries and will need a third in the future. And without the ACA, she could lose her healthcare due to a serious preexisting condition.

And it doesn't only—although they might be young, they are very aware of how their healthcare, their health, impacts their entire family. Because from that moment on, I knew that if I went outside to play, when I was a little kid, if I got hurt, you know, it would have a big impact on my family because we didn't have healthcare coverage.

Micah and 130 million people with preexisting conditions deserve no less than to have an honest conversation about the Affordable Care Act.

The other side of the aisle, I have been listening to them, and I must admit, I have been getting kind of, a little bit furious, a little hot under the collar here, because it is just—all I could think about is whatever—they don't understand that the Affordable Care Act works together, as all of you know, right? Every piece of it. When it comes to the subsidies, outreach, getting the risk pools, the marketplaces, the expanding of Medicaid, it all works together.

And when you don't fight for all of it, but you are saying you are for protecting people with preexisting conditions, it is not—people who make that argument, I don't believe, are sincere. You know,

the words I come up with when I hear those arguments are hogwash, rubbish, blarney, and just plain nonsense.

You know, if you weren't at a hearing and somebody was making that argument, let's say, at your kitchen table, right, what would you say to them, that, "Oh, yeah, I am for preexisting conditions, but I am not for subsidies; I am not for anything else in the Affordable Care Act"? I would love to hear what you would say.

Ms. Brooks-Coley, what would you say?

Ms. BROOKS-COLEY. From the cancer perspective, we represent a population of people who, before the Affordable Care Act, could not access coverage. Oftentimes, they were individuals who actually couldn't even get a plan even though they had a serious illness such as cancer. So, from our perspective, the entire ACA and that infrastructure is what has led to patients with serious illness, like cancer, having access to coverage and I agree with you that the patient protections, of course, which are center of the law and important to us from the serious illness perspective, but the entire law does work together to make sure people have better access.

Mr. GOMEZ. Mr. Stolfi, what would you say?

Mr. STOLFI. Thank you, Representative Gomez. I mean, to be honest, I think one of the most challenging things about this is how complex the issues are. And it is one of the reasons why this hearing is so important today, to talk in great detail and to make sure everyone fully understands what it means and all of the things that go into protecting people with preexisting conditions.

I mean, I am going to walk away today with, you know, a belief that there is a much greater understanding today, about what that is. And I think if I were sitting around the table with someone, I would spend quite a bit of time talking about some rather intricate, somewhat boring, insurance concepts in order to make sure they fully understood why every single part of it is important.

Mr. GOMEZ. And I appreciate that. And sometimes in life you just have to call out people for saying nonsense, right? And I know that they are probably sincere that they want to cover people with preexisting conditions, but we passed the Affordable Care Act to work as an overall structure. And now they are saying, after they basically ruined it, that the prices are coming up. So our job in the next Congress and moving forward is to fix what they broke.

Thank you, and I yield back.

Chairman NEAL. I thank the gentleman.

And now to recognize the gentleman from Nevada, Mr. Horsford, to inquire for 5 minutes.

Mr. HORSFORD. Thank you very much, Mr. Chairman. Former Congressman Mo Udall once said: Everything has been said, but not everyone has said it.

So as the last Member today, I am extremely thankful for this opportunity.

And thank you, Mr. Chairman. It says a lot that you made this issue of preexisting conditions and the hearing today the first priority of this Committee. So I want to thank you for that.

There are 371,000 Nevadans who would lose coverage in 2019 if the Affordable Care Act were repealed. Approximately 1.2 million Nevadans with private health coverage would lose guaranteed ac-

cess to free preventative care like immunizations and cancer screenings.

The impact of the Affordable Care Act is critical. About one in two Nevadans, 51 percent, live with a preexisting condition, including myself. Because of the ACA, insurance companies can no longer deny coverage or charge more because of a preexisting condition.

One of those Nevadans is Joe Molino, who lives in north Las Vegas, Nevada. Joe was diagnosed with a rare cancer in 2011, called chondrosarcoma of the larynx. On September 13, 2013, Joe underwent a 12-hour surgery to remove much of the tumor. He awoke with a tracheotomy, which he would have in for months.

The hole, his stoma, never healed, and he experienced a complication called tracheal stenosis, which impacted his ability to breathe. These complications kept him from going to work, and in February 2014, he was notified by his employer that his employee-sponsored healthcare would end. And he could not afford a COBRA plan on his disability payment.

Luckily, he was able to get coverage under Nevada's expanded Medicaid program, which I would note was actually approved by former Governor Brian Sandoval, the first Republican Governor in the country to adopt the Medicaid expansion in the country.

In 2016, with the help of the Medicaid expansion and the ACA health plan, he was finally able to get back to work and live a fulfilling life.

So I am committed, as my colleagues are on this side of the aisle, to do everything that I can to strengthen the Affordable Care Act. This is the central issue that the constituents in my district talked to me about over the last few years. So I am hopeful now with this new Congress that we will look at ways to build on the Affordable Care Act and make healthcare better for all Americans.

But, Ms. Pollitz, I would like to ask you, what are some of the improvements that Congress should be considering in order to improve affordability and access?

Ms. POLLITZ. Well, again, Congressman, we don't make recommendations. I think there are a number of proposals that have been discussed in the course of today's session, including expanding subsidies for some or all people who aren't eligible for them today; expanding the cost-sharing subsidies so that they are more generous; other changes to ensure that the Medicaid expansion is available in every State, instead of, you know, just the ones that have elected that so far.

So I think there have been—and, you know, there are proposals to undo the Affordable Care Act and go in another direction. You know, the Better Healthcare Act is one direction. Others are talking about expanding public programs in other ways: Medicare, Medicaid eligibility.

So I think there are a lot of options on the table, and I am glad you are working on them.

Mr. HORSFORD. We will figure it out.

Ms. POLLITZ. Thank you.

Mr. HORSFORD. Can you discuss why the end to annual and lifetime limits are important to cancer patients and other Americans facing complex healthcare needs, please?

Ms. POLLITZ. Yeah. So there aren't that many people who would reach lifetime limits, but actually an old friend of mine who was on the board of the Nebraska high-risk pool reached it because he had two daughters born prematurely with severe congenital conditions, and he hit the million dollar lifetime limit on his policy with those girls in less than a year. So it does happen. They are the most severe conditions.

Cancer sometimes can get that high. My cancer treatment was never that big, but over a lifetime, it could get there. So that protection is there for the most extreme cases and the most costly cases, and it is a lifeline for those people.

Mr. HORSFORD. Thank you very much.

Thank you, Mr. Chairman. I yield back.

Chairman NEAL. Mr. Gomez has asked for a brief interlude here for a couple of seconds.

Mr. GOMEZ. Yeah. Mr. Chairman, I forgot to mention I would like to submit for the record a statement from Ricardo Lara, California's new Insurance Commissioner, on this issue. Thank you so much.

Chairman NEAL. Without objection, so ordered.

[The information follows:]

United States House of Representatives
Committee on Ways and Means
**Protecting Americans with Pre-Existing
Conditions**



Statement from
Ricardo Lara
California Insurance Commissioner
January 29, 2019

*California Department of Insurance
300 Capitol Mall, Suite 1700
Sacramento, CA 95814
(916) 492-3500*

Passage of the Affordable Care Act (ACA) was one of the most significant legislative acts in the last fifty years. The ACA has directly improved the health and economic security of millions of Californians – both those who were uninsured prior to the passage of the ACA and those whose individual or group health insurance coverage was improved.

California decided to go "all in" with regard to implementing the Affordable Care Act. Since its passage in 2010, we have seen a dramatic decrease in the number of Californians who lack health insurance coverage. The uninsured rate went from 17.2 percent in 2013 to a new historic low of 7.2 percent in 2017.

Before the passage of the ACA, people were routinely denied health insurance coverage due to pre-existing conditions such as asthma, cancer, or heart disease. Others were sold coverage that excluded care for their pre-existing conditions. After January 1, 2014 when the guarantee issue provision of the ACA went into effect, many individuals gained affordable, comprehensive coverage. The California Department of Insurance heard from numerous people with pre-existing conditions who had previously been denied health insurance coverage and were grateful that they could now buy health insurance for the first time in years.

An estimated 5.9 million Californians have pre-existing conditions, so the repeated efforts to repeal the ACA in 2017 and 2018 caused distress and concern for the millions of people with pre-existing conditions and their families. During the time the Congress was considering repeal of the ACA, the Department and I heard from people who were very afraid that they would not be able to buy health insurance in the future and would not be able to get the medical care they need. In addition to the millions of Californians who already have pre-existing conditions, any one of us may find ourselves with a pre-existing condition in the future, and could find ourselves uninsurable in the future without the protections in the ACA. These protections are a promise we have made to the American people, one which we should never break. I will stand up against any attempts to weaken or dismantle the Affordable Care Act given what is at stake for Californians who rely upon its protections.

Chairman NEAL. Over the past decade, this dialogue has been, from time to time, pretty contentious. But today I heard a lot of Members on the other side of the aisle say they support protecting people with preexisting conditions. And I welcome this as an opportunity to move forward, and I hope that we can work together to make sure that we preserve these protections for all Americans, as they have come to rely upon them.

The witnesses today, all of you, you were exceptional. And I think that this is the sort of dialogue we could have going forward, based upon the testimony you have all offered. It was solution-based on how we can proceed in an area where people expect us to. So, I want to thank you for your testimony.

Please be advised that Members have 2 weeks to submit written questions to be answered later in writing. Those questions and answers will be made part of the formal hearing record.

And, with that, the Committee stands adjourned.

[Whereupon, at 2:14 p.m., the Committee was adjourned.]

[Submissions for the Record follow:]

The Future of Contraceptive Coverage

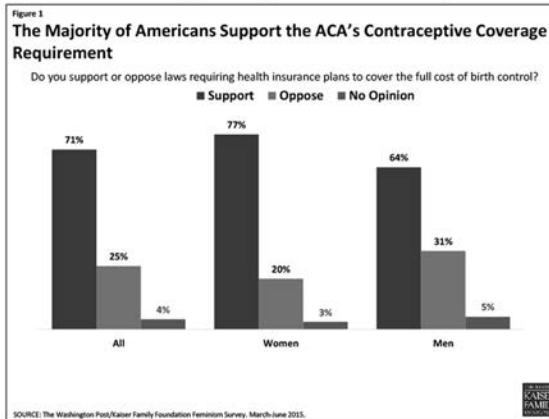
Laurie Sobel, Alina Salganicoff, and Caroline Rosenzweig

Contraceptive coverage under the Affordable Care Act (ACA) has made access to the full range of contraceptive methods affordable to millions of women. This provision is part of a set of services that has been identified by the Health Resources and Services Administration (HRSA) as [key preventive services](#) for women that are not addressed by the US Preventive Services Task Force or the CDC's Advisory Committee on Immunization Practices, entities that identified preventive services that must be covered without cost-sharing under the ACA. On December 20, 2016, HRSA issued updated coverage requirements, accepting in whole the recommendations of the Women's Preventive Services Committee, which is comprised of representatives of national groups with expertise in women's health. These updated recommendations continue to include contraceptive coverage.

Since it was first issued in 2012, this provision has been controversial. While very popular with the public, with over [77% of women and 64% of men reporting](#) support for no-cost contraceptive coverage (**Figure 1**), it has been the focus of litigation brought by religious employers, with [2 cases](#) reaching the Supreme Court. As the Trump administration transitions to the White House, it remains to be seen specifically how or whether the new Administration and 115th Congress will address this particular provision. This brief explains the current contraceptive coverage rule, the impact it has had on coverage, and the potential state of coverage if the ACA rule is eliminated either through a full ACA repeal or administrative action.

What does the contraceptive coverage rule require plans to cover?

Starting in 2012, all new private plans were required to cover, without cost-sharing, the full range of contraceptives approved by the Food and Drug Administration (FDA) as prescribed for women, counseling and services.¹ This provision applies to all non-grandfathered individual, small and large group, and self-



funded plans. Grandfathered plans do not have to comply with this requirement or the other insurance reforms in the ACA.

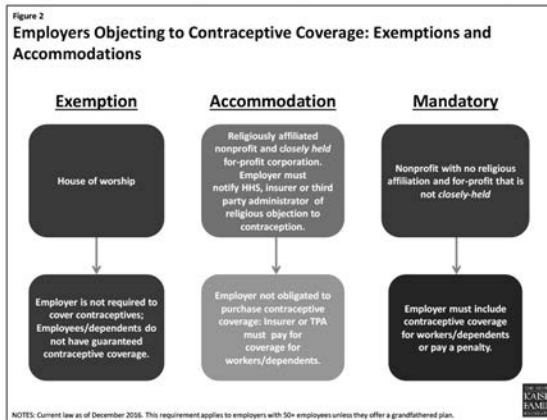
The Department of Health and Human Services (HHS) issued guidance in May 2015, which clarified that at least one form of all 18 FDA-approved methods of birth control must be covered without cost-sharing (**Table 1**). If a provider recommends a specific option or product, plans must cover it without cost-sharing as well. Insurers may use reasonable medical management, however, to limit coverage to brand-name drugs when a generic version exists, and can impose cost-sharing for equivalent branded drugs. Plans are required to have a “waiver” process for women who have a medical need for contraceptives otherwise subject to cost-sharing or not covered.² In addition, plans must cover services such as contraceptive counseling, initiation of contraceptive use, and follow-up care, including management and evaluation, as well as changes to and removal or discontinuation of contraceptive methods.

Table 1 : Minimum Contraceptive Coverage Requirements Clarified by HHS Guidance	
Contraceptive Method	Products/Options
Surgical sterilization	Also called tubal ligation
Implant sterilization	Only Essure available
Implantable Rod	Multiple
IUD – Copper	Only ParaGard available
IUD – Progestin	Multiple
Injection	Multiple
Oral contraceptives – combined	Multiple
Oral Contraceptives – progestin only	Multiple
Oral Contraceptives – extended/continuous use	Multiple
Patch	Multiple
Vaginal Ring	Only NuvaRing available
Diaphragm with Spermicide	Only Milex Omniflex available
Sponge with Spermicide	Only Today Sponge available
Cervical Cap with Spermicide	Only FemCap available
Female Condom	Multiple
Spermicide alone	Multiple
Emergency Contraception–Progestin	Multiple
Emergency Contraception– Ulipristal Acetate	Only ella available
SOURCES: FDA, <u>Birth Control Guide</u> and Departments of Labor, Health and Human Services, and Treasury, <u>FAQs about Affordable Care Act Implementation (Part XXVI)</u> .	

What are the coverage requirements for employers?

As the contraceptive coverage rules have evolved through litigation and new regulations, there are three categories of employers with differing requirements. Most employers are required to include the coverage in their plans. Houses of worship can choose to be *exempt* from the requirement if they have religious objections (**Figure 2**). This exception means that workers and dependents of exempt employers do not have coverage for either some or all FDA approved contraceptive methods, if their employer has an objection. Religiously affiliated nonprofits and closely held for-profit corporations are not eligible for an exemption, but may receive an *accommodation*. The Obama Administration originally crafted the accommodation to address the concerns of religiously-affiliated nonprofit employers, and then extended this same option to *closely held for-profit*s after the Supreme Court ruling in *Burwell v. Hobby Lobby*. The accommodation allows these employers to opt out of providing and paying for contraceptive coverage in their plans by either notifying their insurer, third party administrator, or the federal government of their objection. The insurers then are responsible for covering the costs of contraception, which assures that their workers and dependents have contraceptive coverage, and relieves the employers of the requirement to pay for it.

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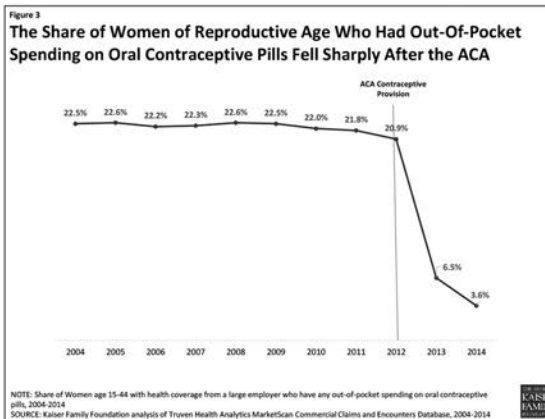
While 10% of nonprofits with 5,000 or more employees have *elected for an accommodation* without challenging the requirement, this approach, however, has not been acceptable to all nonprofits with religious objections.³ Some are seeking an “exemption” from the rule, meaning their workers would not have coverage for some or all contraceptives, rather than an accommodation, which entitles their workers to full contraceptive coverage but releases the employer from paying for it. In May 2016, the *Supreme Court remanded* *Zubik v. Burwell*, sending 7 cases brought by religious nonprofits objecting to the contraceptive coverage accommodation back to the respective Courts of Appeal. The Court *instructed* the parties to work together to “arrive at an approach going forward that accommodates petitioners’ religious exercise while at the same time ensuring that women covered by petitioners’ health plans receive full and equal health coverage, including contraceptive coverage.”⁴ In July 2016, the Departments of Health and Human Services (HHS), Labor and Treasury issued a *Request for Information* (RFI) inviting public comments on “whether there are alternative ways (other than those offered in current regulations) for eligible organizations that object to providing coverage for contraceptive services on religious grounds to obtain an accommodation, while still ensuring that women enrolled in the organization’s health plans have access to seamless coverage of the full range of Food and Drug Administration-approved contraceptives without cost sharing.” The Obama

Administration asked the courts to delay any action on the cases while they review the over 50,000 comments submitted. The next case [status reports](#) with the courts are due after the transition to the Trump Administration. It is not clear whether the Trump Administration will continue to defend these lawsuits, maintain the current regulations, or change the rules for employers with objections to contraceptive coverage. The Trump campaign supported expanding the exemption for nonprofits with religious objections, and incoming Secretary of Health and Human Services, Tom Price, stated in 2012, that he felt the contraceptive coverage requirement infringes on religious liberties.⁵⁶

How has the contraceptive coverage rule affected women?

Contraceptive use among women is widespread, with over 99% of sexually-active women using at least one method at some point during their lifetime.⁷ Contraceptives make up an estimated 30-44% of out-of-pocket health care spending for women.⁸ Since the implementation of the ACA, out-of-pocket spending on prescription drugs has decreased dramatically (**Figure 3**). The majority of this decline (63%) can be attributed to the drop in out-of-pocket expenses on the oral contraceptive pill for women.⁹ One study estimates that roughly \$1.4 billion dollars per year in out-of-pocket savings on the pill resulted from the ACA's contraceptive mandate.¹⁰ By 2013, most women had no out-of-pocket costs for their contraception, as median expenses for most contraceptive methods, including the IUD and the pill, dropped to zero.¹¹

This provision has also influenced the decisions women make in their choice of method. After implementation of the ACA contraceptive coverage requirement, women were more likely to choose any method of prescription contraceptive, with a shift towards more effective long-term methods.¹² High upfront costs of long-acting methods, such as the IUD and implant, had been a barrier to women who might otherwise prefer these more effective methods. When faced with no cost-sharing, women choose these methods more often¹³, with significant implications for the rate of unintended pregnancy and associated costs of childbirth.¹⁴



Finally, decreases in cost-sharing were associated with better adherence and more consistent use of the pill. This was especially true among users of generic pills. One study showed that even copayments as low as \$6 were associated with higher levels of discontinuation and non-adherence,¹⁵ increasing the risk of unintended pregnancy.

If the contraceptive coverage rule is modified or eliminated, are there other federal rules and state laws that affect coverage?

More than half of women in the United States are insured through an employer-sponsored plan, either as the primary beneficiary or as a spouse or dependent. In 2000, a [ruling by the Employment Equal Opportunity Commission \(EEOC\)](#) found that employers that covered preventive prescription drugs and services, but did not cover prescription contraceptives, were in violation of the Civil Rights Act.¹⁶ The EEOC reasoned that failure to cover contraception constituted sex discrimination under Title VII and the Pregnancy Discrimination Act, which prohibits discrimination against women based on their ability to get pregnant. This ruling, however, did not address the issue of cost-sharing, nor the scope of coverage.

Prior to the passage of the ACA and the contraceptive coverage requirement, the 2010 Kaiser/HRET survey of employers found that 85% of large firms covered prescription contraceptives in their largest health plans¹⁷, although they may have used cost-sharing and were not required to cover the full scope of contraceptive care, the amount of which can vary greatly by employer and type of plan. If the ACA contraceptive coverage rule is modified or eliminated, any requirement for the coverage of contraceptives without cost-sharing will fall back to the states. State laws, however, only apply to state regulated plans, not self-funded plans where 61% of covered workers are insured.¹⁸ In self-funded plans, the employer assumes the risk of providing covered services and usually contracts with a third party administrator (TPA) to manage the claims payment process. These plans are overseen by the Federal Department of Labor under the Employer Retirement Income Security Act (ERISA).

States have historically regulated insurance, and many have mandated minimum benefits for decades. Contraceptive coverage is no exception. Currently, 28 states require insurance plans to cover contraceptives, with a wide range of coverage and cost-sharing requirements, and exemptions among these mandates.¹⁹

Since the passage of the ACA, four states have strengthened and expanded the federal contraceptive coverage requirement. In 2014 California passed the [Contraceptive Coverage Equity Act of 2014](#), which requires private and Medicaid managed care plans to cover all prescribed FDA-approved contraceptives for women without cost-sharing. Maryland enacted a very similar [law](#) in 2016, and it will go into effect in January 2018. Vermont also passed a similar [law](#) (effective January 2017) that applies to all health insurance plans, as well as coverage offered through Medicaid and all other public programs offered by the State. Illinois's [law](#), (effective January 2017) requires plans to cover all contraceptive methods, including all over-the-counter methods except male condoms, without cost-sharing.

While contraceptive coverage without cost-sharing will remain intact for fully insured plans in these 4 states, regardless of what happens with the ACA rule, state laws do not have jurisdiction over self-funded plans, under which many women are insured.

Conclusion

For the first time, the ACA set federal preventive services rules, including no-cost contraceptive coverage, for all insurance plans. If the Trump Administration modifies or eliminates the ACA contraceptive coverage rule, scope of coverage will depend on where a woman lives, where she works, and her insurance plan. Millions of women could lose no-cost coverage for the full range of contraceptive methods. Insurance companies and employers will be the ones to make choices about coverage and cost-sharing. For some women, their choices will be limited, and some of the most effective and costly methods will be out of financial reach.

ENDNOTES

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- ⁴ Supreme Court of the United States, *per curiam opinion*, [Zubik v. Burwell](#), May 16, 2016, page 4
- ⁵ Charisma News. (2016). [Read the Letter Donald Trump Wrote to Catholic Leaders](#).
- ⁶ ThinkProgress. (2012). [House Republican Leader Price: 'There's Not One Woman' Who Doesn't Have Access To Birth Control](#)
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- ⁸ Nora V. Becker and Daniel Polsky. [Women Saw Large Decrease in Out-Of-Pocket Spending for Contraceptives After ACA Mandate Removed Cost Sharing](#). *Health Affairs* 34, no.7 (2015):1204-1211.
- ⁹ Kaiser Family Foundation. (2016). [Examining high prescription drug spending for people with employer sponsored health insurance](#).
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- ¹² Caroline S. Carlin, Angela R. Fertig and Bryan E. Dowd. [Affordable Care Act's Mandate Eliminating Contraceptive Cost Sharing Influenced Choices of Women with Employer Coverage](#). *Health Affairs* 35, no.9 (2016):1608-1615.
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- ¹⁴ Birgisson, N. E., Zhao, Q., Secura, G. M., Madden, T., & Peipert, J. F. (2015). [Preventing Unintended Pregnancy: The Contraceptive CHOICE Project in Review](#). *Journal of Women's Health*, 24(5), 349-353.
- ¹⁵ Lydia E. Pace, Stacie B. Dusetzina and Nancy L. Keating. [Early Impact of the Affordable Care Act On Oral Contraceptive Cost Sharing, Discontinuation, And Nonadherence](#). *Health Affairs* 35, no.9 (2016):1616-1624.
- ¹⁶ U.S. Equal Employment Opportunity Commission. December 14, 2000. [Decision- Contraception](#).
- ¹⁷ Kaiser Family Foundation. (2010). [2010 Employer Health Benefits Survey](#).
- ¹⁸ Kaiser Family Foundation and Health Research Educational Trust, [2014 Employer Health Benefits Survey](#).
- ¹⁹ Guttmacher Institute. (2016). [State Policies in Brief: Insurance Coverage of Contraceptives](#).



American Speech-Language-Hearing Association
Statement for the Record for the House Ways & Means Committee for the Hearing on
“Protecting Americans with Pre-Existing Conditions”
January 29, 2019

Chairman Neal and Ranking Member Brady: My name is Shari B. Robertson, and I am President of the American Speech-Language Hearing Association. I appreciate the opportunity to provide testimony to the Committee on the critical issue of protecting Americans who have pre-existing conditions.

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. Our members work in health care settings to habilitate and rehabilitate the language, hearing, swallowing, cognition, and communications skills for people of all ages. Access to medically necessary health care services is of importance to our members regardless of whether the condition is new or pre-existing.

Overview

The Affordable Care Act (ACA) has ushered in many consumer protections including coverage for Americans with pre-existing conditions. Approximately 130 million nonelderly Americans, including one in four children, currently live with a pre-existing condition and are potentially at risk if pre-existing protections are removed from federal law¹. The removal of this protection would roll back the clock to the pre-ACA era when insurance companies denied coverage or charged significantly higher premiums to people with pre-existing conditions. Seventy-five percent of Americans say it is “very important” to retain the ACA provision to prevent insurance companies from denying coverage based on a person’s medical history and 72% say it is “very important” to prohibit insurance companies from charging sick people more.²

Beyond pre-existing condition protections, ASHA strongly supports the continuation of essential health benefits (EHB), which ensure Americans have access to meaningful health care coverage. Enactment of the EHB package has improved access to habilitation for children in need of these services and devices. Prior to the ACA, only a handful of states (i.e., Illinois, Maryland, Oregon) adopted a habilitative services mandate in the individual market. Coverage gains for habilitation were necessary to meet the needs of a wide variety of children with autism, cerebral palsy, congenital defects, development delays and disabilities, and other chronic and progressive conditions; almost all of which—once diagnosed—would typically be considered pre-existing conditions.

Requiring health insurance companies to provide coverage for pre-existing conditions, and the passing of EHB legislation for habilitative services and devices, ensures that children in need of habilitation are able to access care that can lead to functional gains and improved quality of life.

ASHA urges the Committee to take all necessary actions to protect continued access to care for every American, including and especially children, who have pre-existing conditions.

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Pediatric Considerations

Habilitative needs are based on a function or skill that was never acquired due to congenital, developmental, and other conditions (e.g., cerebral palsy, spina-bifida, congenital hearing loss). Children requiring habilitative services and devices depend on habilitative treatments provided through their health insurance coverage to acquire skills and functions never developed due to disability. In some cases, habilitative services are used to maintain a child's health and ability to function. Often, habilitative services and devices yield breakthroughs in functional ability that would not have been possible without access to timely and appropriate habilitation benefits. This reduces long-term disability and dependency costs to society and dramatically improves quality of life for the individual and their family.

ASHA maintains that removing coverage of pre-existing conditions would leave children, particularly those with developmental disabilities and chronic/progressive conditions, with less comprehensive coverage and higher out-of-pocket costs, which negatively impacts their families and themselves. Health insurance coverage must ensure timely, affordable, and high-quality habilitative and rehabilitative care that meets the needs of children with disabilities regardless of when in the child's life the condition developed.

Personal Habilitation Stories

I offer some scenarios that highlight the importance of comprehensive health care coverage so that families can access medically necessary services for their children.

Hearing Loss

Gavin received a newborn hearing screening in the hospital hours after he was born that indicated possible hearing loss. After a comprehensive evaluation by a pediatric audiologist, he was diagnosed with moderate sensorineural hearing loss in both ears. The family chose an auditory-oral approach of treatment for Gavin that used aided hearing and spoken language for communication and learning. The audiologist fit Gavin with hearing aids in both ears when he was 3 months old.

After 3 years of consistent hearing aid use and periodic habilitative treatment services focused on parent education, listening skills, and language development, Gavin entered preschool with the ability to express himself and understand others as well as having access to quality services. He has the best opportunity to develop on par with his peers who have normal hearing.

Stuttering Disorder

James is a seven-year-old child who has stuttered since he was in preschool. His speech deficits, blocks, and facial grimaces impact his ability to verbally express himself in school, at home, and during social interactions. His pediatrician referred James for a speech-language evaluation for stuttering and the increasing anxiety that James experienced when speaking. During the speech-language evaluation, the frequency, duration, and type of stuttering were measured and the presence of secondary behaviors, such as eye blinking, were identified by administering standardized fluency test measures. Treatment was recommended and focused on developing strategies to improve speech through rate control, continuous phonation, easy onset of speech, and light articulatory contact. Reducing physical tension and desensitization strategies were also treatment goals to reduce speaking anxiety. With appropriate speech-language treatment, James can become a more fluent and confident speaker.

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Conclusion

ASHA appreciates the Committee's attention to this issue. It is critically important to maintain pre-existing coverage protections. Otherwise, the nation will revert to a time when too many Americans were worried that they would not have access to medical care when needed or risk financial hardship while accessing treatment.

Thank you for the opportunity to provide this statement for the record. ASHA looks forward to continuing to work with the Committee and Congress to protect health care coverage for all Americans. For more information, contact Brian Altman, ASHA's director of federal and political affairs, at baltman@asha.org.

¹ Center for American Progress (2017). *Number of Americans with Pre-Existing Conditions by Congressional District*. Retrieved from <https://www.americanprogress.org/issues/healthcare/news/2017/04/05/430059/number-americans-pre-existing-conditions-congressional-district/>.

² Henry J Kaiser Family Foundation. (2018). *Poll: The ACA's Pre-Existing Condition Protections Remain Popular with the Public, including Republicans, As Legal Challenge Looms This Week*. Retrieved from <https://www.kff.org/health-costs/press-release/poll-acas-pre-existing-condition-protections-remain-popular-with-public/>.

Comments for the Record
United States House of Representative
Committee on Ways and Means
Protecting Americans with Pre-Existing Conditions

Tuesday, January 29, 2019 - 10:00am

By Michael G. Bindner
Center for Fiscal Equity

Chairman Neal and Ranking Member Brady, thank you for the opportunity to submit these comments for the record to the Committee. As usual, let us preface our remarks in the context of our four part tax reform proposal.

- A Value Added Tax (VAT) to fund domestic military spending and domestic discretionary spending with a rate between 10% and 13%, which makes sure every American pays something.
- Personal income surtaxes on joint and widowed filers with net annual incomes of \$100,000 and single filers earning \$50,000 per year to fund net interest payments, debt retirement and overseas and strategic military spending and other international spending, with graduated rates between 5% and 25%.
- Employee contributions to Old Age and Survivors Insurance (OASI) with a lower income cap, which allows for lower payment levels to wealthier retirees without making bend points more progressive.
- A VAT-like Net Business Receipts Tax (NBRT), which is essentially a subtraction VAT with additional tax expenditures for family support, health care and the private delivery of governmental services, to fund entitlement spending and replace income tax filing for most people (including people who file without paying), the corporate income tax, business tax filing through individual income taxes and the employer contribution to OASI, all payroll taxes for hospital insurance, disability insurance, unemployment insurance and survivors under age 60.

The key issue for patients is the impact of pre-existing condition reforms on the market for health insurance. If people start dropping insurance until they get sick – which is rational given the repeal of mandates – and Congress does nothing private sector health insurance will be lost. This will require a bailout.

Resorting to catastrophic insurance with health savings accounts (another Republican proposal) would not work as advertised, as health care is not a normal good. While mandates could be replaced with a single payer catastrophic system, it will work.

People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate – further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

In what seems counter-intuitive, with the repeal of mandates, should coverage for the poor decline, the best option is to also repeal pre-existing condition reforms. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions. I could end here except that enacting a public option opens wide the issue of funding.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care – with inadequate funding and quality being related.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so I will confine my remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT would be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

The NBRT would replace corporate income taxes and proprietary and pass through taxes and treat all business income the same. It would provide for a public option, the health insurance exclusion or fund single payer insurance.

The NBRT would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid-range of personal income tax collection.

Collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

For further cost savings under an NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through the public option.

Companies who hire their own doctors and pharmacists and buy their own drugs would get a tax exclusion from single payer (third party insurance would be discouraged), and would negotiate with drug makers for lower prices, although this would leave small firms at a distinct disadvantage and would discourage such practices as franchising and 1099 employment. Still, on the whole, it would decrease cost while not discouraging innovation. Expanding the Uniformed Public Health Service into the Medicare and Medicaid markets (edging out HMOs) would also lead to cost cutting on drugs.

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Employer provided health care will also reverse the trend toward market consolidation among providers. The extent to which firms hire doctors as staff and seek provider relationships with providers of hospital and specialty care is the extent to which the forces of consolidation are overcome by buyers with enough market power to insist on alternatives, with better care among the criteria for provider selection.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

Contact Sheet

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Committee on Ways and Means

Protecting Americans with Pre-Existing Conditions

Tuesday, January 29, 2019 - 10:00am

This submission is made on behalf of the American people but by no clients, persons and/or organizations on whose behalf the witness appears.



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Testimony by Margaret A. Murray, CEO, ACAP to the House Committee on Ways and Means

**Full Committee Hearing: Protecting Americans with Pre-Existing Conditions
Tuesday, January 29, 2019**

Chairman Neal, Ranking Member Brady, and Members of the Committee:

ACAP is an association of 60 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 29 states. Our member plans provide coverage to more than 20 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP), the Marketplaces, and Medicare Special Needs Plans for dually-eligible individuals, including over 765,000 Marketplace enrollees. Sixteen of ACAP's SNHP members offer qualified health plans (QHPs) or basic health plans (BHPs) in the Marketplaces, including one that newly entered the Marketplace for 2019.

Since the passage of the Affordable Care Act (ACA), ACAP plans have advocated to reinforce each leg of the law's foundational "three-legged stool": affordable insurance options, a near-universal risk pool, and meaningful coverage. ACAP plans and many other issuers have embraced these ideals and offered coverage that provides high-value, affordable, and comprehensive care to consumers who had previously been subject to underwriting and other exclusionary practices. Without any one of these "legs," the rest is not sustainable. However, Short-Term, Limited-Duration Insurance (STLDI) health plans threaten both these coverage gains as well as the stability of the health insurance Marketplaces.

STLDI plans have been available for many years; however, their intended function has fundamentally changed. STLDI plans had historically been used to fill gaps in coverage for a short period of time. However, they lack comprehensive consumer protections such as pre-existing coverage requirements—not to mention they are permitted to underwrite coverage and even engage in post-claims underwriting and rescissions. As ACA coverage rolled out, brokers and issuers of such plans began marketing them as alternatives to ACA coverage instead of as true "short-term" coverage. In response to this changing nature, the Obama Administration limited STLDI plans in 2016 by issuing a regulation restricting these plans' coverage terms to three months or less with renewals of no more than one year. However, in August of 2018, the Trump Administration changed course and issued a final rule that expands the coverage period for STLDI plans up to 12 months with coverage renewal up to 36 months. Although STLDI plans may be an effective method of stop-gap coverage for consumers with coverage gaps due to changing employment or life situations, these new coverage duration limits permit them to effectively be sold as an alternative to ACA-compliant plans. Yet it goes without saying that



much of the goal of the ACA was to curb the abuses like those that STLDI plans regularly engage in.

Beyond the now twelve-month coverage duration, there are few similarities between STLDI and ACA-compliant coverage. While ACA-compliant plans must have a Medical Loss Ratio (MLR) of at least 80 percent—which requires 80 percent or more of earned premium dollars to be spent on medical care, as opposed to administrative costs and profits—many STLDI plans have an MLR of about 50 percent and this ratio is not regulated whatsoever.¹ While ACA-compliant plans are required to cover Essential Health Benefits (including maternity care, prescription drugs, and mental health and substance use disorder treatment), STLDI plans are not mandated to do so. And, while ACA-compliant plans are prohibited from underwriting, imposing lifetime and annual limits, and excluding coverage for pre-existing conditions, STLDI plans are exempt from these criteria.² For *any* consumer with significant health coverage needs, whether acute or chronic, STLDI plans do not provide meaningful coverage; for consumers with pre-existing conditions, it is safe to say that STLDI plans are wholly inadequate.

The distinctions between ACA-compliant coverage and STLDI plans are clear on paper, yet the marketing of STLDI plans can prove harmful to well-intentioned consumers. During Open Enrollment for 2019, the growing market for STLDI plans was on full display: one marketing scan conducted by the Georgetown University Center on Health Insurance Reforms (CHIR) found that in every state, over half of all results from websites that are designed to suggest appropriate health insurance products to consumers directed them to STLDI or other non-ACA compliant insurance products. In fact, during this year's Open Enrollment, less than 20 percent of CHIR's searches including phrases like "cheap health insurance" or "ACA enroll" returned sites offering solely ACA-compliant coverage.³ These data demonstrate that despite many consumers' initiatives to purchase more comprehensive, ACA-compliant coverage, it may be difficult for them to know what they are purchasing and may effectively be duped into purchasing STLDI coverage when they need something more comprehensive. Or, a consumer may not fully understand the potential impact of purchasing an STLDI product, particularly consumers that don't realize they have a pre-existing condition or what an STLDI plan might deem a pre-existing condition.

For example, a woman in Illinois went to the hospital with heavy vaginal bleeding resulting in a five-day hospital stay and a hysterectomy, only to be denied coverage under her short-term plan

¹ Huth, Erik and Karcher, Jason. "The short-term/limited-duration insurance rule and the potential impact on health insurance markets." *Milliman*, August 2018. http://us.milliman.com/uploadedFiles/insight/2018/The_STLDI_rule.pdf; National Association of Insurance Commissioners. "2017 Accident and Health Policy Experience Report." 2018. https://naic.org/prod_serv/AHP-LR-18.pdf

² Lucia, Kevin et al. "State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market." *The Commonwealth Fund*, March 2018. https://www.commonwealthfund.org/sites/default/files/documents/media_files_publications_fund_report_2018_mar_lucia_state_regulation_alternative_coverage_options_rev.pdf

³ Corlette, S. et al. "The Marketing of Short-Term Health Plans: An Assessment of Industry Practices and Regulatory Responses." *Georgetown University Health Policy Institute*, January 2019. <https://www.rwjf.org/en/library/research/2019/01/the-marketing-of-short-term-health-plans.html>



on the ground that her menstrual cycle constituted a pre-existing condition. Additionally, a man in Washington, D.C. also purchased a short-term plan with a stated maximum payout of \$750,000; when he sought coverage for a \$211,000 bill resulting from a hospitalization, he was

paid only \$11,780, in part due to a denial of coverage based on his father's medical history. While these may be particularly egregious examples, they demonstrate unscrupulous nature of STLDI plans, which generally engage in whatever practices necessary to avoid paying claims. One of the easiest ways to do so is to deem the claims as related to a pre-existing condition.

Finally, the proliferation of STLDI plans will have a deleterious impact on the risk pool and the stability of the health insurance Marketplaces. STLDI plans cost less money because they offer less coverage. These plans are expected to pull healthier and younger consumers out of the ACA-compliant individual risk pool, effectively segmenting risk in the individual market. The marketing research above further demonstrates that STLDI plans will not only be attractive but also readily available to consumers moving forward. To better understand the effect of STLDI plans on the individual market, ACAP commissioned the actuarial firm Wakely Consulting Group to model the impact of the Administration's proposed rule.⁴ Wakely estimated that in 2019, adverse selection would decrease enrollment in the ACA-compliant individual market by between 400,000 and 790,000 enrollees. In addition, Wakely estimated that STLDI plans, in tandem with the repeal of the individual mandate, will contribute to a rise in premiums of up to 12.8 percent and a reduction in enrollment of up to 26.3 percent in the individual market over the course of 4 to 5 years. For ACAP plans and others offering comprehensive QHP coverage that covers pre-existing conditions, this landscape is hostile; if ACA-compliant plans exit the Marketplaces, fewer affordable, comprehensive health insurance options will remain.

It is for these reasons that ACAP decided to file suit about this Administration's short-term, limited-duration insurance regulation. As noted above, the regulation effectively permits the exact type of plan the ACA was intending to outlaw to be sold in direct competition with ACA-compliant plans. We believe this is an inappropriate interpretation of the law. Regulations are intended to carry out law, however, in this case, the regulation is undermining the law and the ability of plans like ACAP's member plans to offer comprehensive, ACA-compliant coverage.

Conclusion

In conclusion, ACAP thanks you for the opportunity to provide feedback to the Committee and for your efforts to ensure protections for consumers with pre-existing conditions and other vulnerable populations. ACAP and its member plans are dedicated to serving Marketplace enrollees, including those with pre-existing conditions and we appreciate the Committee's attention to this important issue. We look forward to providing with additional feedback or guidance. Please contact Heather Foster, Vice President of Marketplace Policy

⁴ Cohen, M. et al. "Effect of Short-Term Limited Duration Plans on the ACA-Compliant Individual Market." *Wakely Consulting Group*, 2018. <http://www.communityplans.net/wp-content/uploads/2018/04/Wakely-Short-Term-Limited-Duration-Plans-Report.pdf>



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